Issue No.- 11, June 2015

COPASAH Communiqué

Shared Practice. Grounded Knowledge.

Strengthening Citizen's Role in Governance through Social Accountability

Editorial

Social Accountability in Public Systems Potential for the Marginalised Communities

ABHIJIT DAS

CONTENT

A couple of years ago I was in a meeting discussing health rights and accountability in WHO headquarters in Geneva when a senior functionary with the host organisation asked, partly in exasperation and partly out of genuine interest " Why are we so concerned about accountability provisions around health system interventions now? We didn't have any mechanisms like these for the health system in our countries." Suddenly it seemed that most of the eyes in the room were looking in my direction. It seemed that the group, comprising predominantly of people working in or from a Western European or North American background, was thrown an odd question which they hadn't dealt with while they were happy discussing appropriate datasets, accountability mechanisms and score cards for the developing world. The fundamental question that I needed to clarify then, and which remains a running thread through most of our work and particularly this edition of the COPASAH Communiqué is "Is there an added value of social accountability in public systems meant for the poor or for marginalised communities".

The poor and the marginalised communities are not only situated at the bottom of the social pyramid, but a wide gulf of social power separates them from the more privileged in society. To articulate or recognise them as rights holders is not sufficient for them to enjoy the enshrined rights or entitled services. In some cases their own self-concept and in many more, the perception of the rest of the community, including that of service providers reflects the earlier feudal relationship which doesn't bestow much dignity to the marginalised. In societies of the Global South, especially in South Asia, traditional hierarchies continue to prevail and newer ones get created (like the provider and the user of services). In such stratified societies, those without any economic or social power, need the protection of mechanisms like accountability to ensure that they are able to enjoy their entitlements. Probably, societies which are less hierarchical, where the marginalised are more assertive and self-confident, the need for accountability mechanisms could be less. With social accountability mechanisms there is an added potential of social em-

powerment which is inherent in the mobilisation process that is central to any meaningful social accountability process.

A special challenge lies in securing the health rights of stigmatised and delegitimised communities who are also marginalised. Take for example the rights of manual scavengers or that of sex workers or that of drug users. In the case of manual scavengers they are seen so far down the ladder of social hierarchies that often the providers cannot bring themselves up to even acknowledge their human presence, with sex workers there is often a dimension of moral outrage, but in the case of drug users there is often an association of criminality or illegitimacy. However civil society groups have risen to this challenge in different parts of the world. This edition of COPASAH communiqué shares the story of community monitoring of the Substitution Therapy programme for drug users in Macedonia, where the drug users were able to negotiate better services with the support of a facilitating organisation. We see this as pioneering work for many reasons.

We continue to be inspired by the work of our members and partners. As usual we look forward to your feedback and suggestions, and please do not hesitate to share your stories as well.

About the Author
Abhijit Das, Director - Centre for Health and Social Justice (CHSJ), Delhi, India is one of the co-initiators of the idea of COPASAH. Currently he is the global convener of COPASAH. The global secretariat of COPASAH is now housed at CHSJ, Delhi (India), which is one of the pioneering organisations in the field of social accountability in health and community monitoring in South Asia. (www.chsj.org, www.copasah.net)

Community Monitoring and Advocacy: A Spirit of Activism in Treatment of Drug Dependency in Macedonia

Experiences from Skopje, Macedonia highlight that community monitoring and advocacy has improved the quality of treatment in the drug dependence treatment programs, arousing the spirit of activism in people.

VLATKO DEKOV, IRENA CVETKOVIC, VANJA DIMITRIEVSKI

Community Monitoring and Advocacy: An Introduction to the Idea and Concept

Community Monitoring and Advocacy methodology (CMA), in its broadest sense means an active involvement of a given community in the monitoring of the work public services of concern to the respective community. At the same time, it is expected that the data collected through the process of monitoring should instigate a process of social change among the monitored services.

Community monitoring is more than just a collection of research data. Its primary intent is to serve in the advocacy for social change, as a key strategy in protecting democracy, pushing the requirements of citizens in stepping up for their rights before the state bureaucracy. Community monitoring and advocacy was used for improvement of the quality of treatment in drug dependence treatment programs in Skopje (the capital of Macedonia), financed by the State Budget. The community monitoring and advocacy activities started in December 2011 and ended in June 2014.

Social and Political Context

The public ideological and moral perception about drugs and practices of the use of drug use in Macedonia is related to the political and institutional context. This has an extremely limiting influence on the political self-awareness of people in the treatment for drug dependence, on people who use or have used drugs as a whole. The exposure to permanent stigmatization, discrimination and police persecution because of drug using habits causes the feeling of shame among people who use or have used drugs, forcing them to conform themselves to the marginal status posed by society and the laws.

The social and political context in which community monitoring and advocacy were carried out had an adverse effect on the success of activities. The consequences of social and political transitions have made Macedonia an ethnically and politically paralyzed state. This polarization is reflected in almost all social relations, including public institutions that are susceptible to corruption, nepotism and cronyism. The judiciary is under the control of the Government of the Republic of Macedonia, and freedom of press is extremely limited. A similar polarization is evident in the civic sector. Political parties in their fight for power have destroyed almost every model of civic activism.

In the lack of a supporting environment, people treated for drug dependences avoid public appearances as they suffer discrimination.

The Spirit of Activism in People Treated for Drug Dependence

The key barriers for the emergence of activism in people, in the treatment for drug dependence are stigmatization and discrimination, discouraging legal regulative, fear of

Police, fear from sanctions in drug dependence treatment, imposed feelings of guilt and shame.
To understand the spirit of activism in people who are on drug treatment; a comparison can be made by examining the spirit of activism the LGBT (lesbian, gay, bisexual, transgender) community has garnered. A comparison of the circumstances for the development of activism in the LGBT community shows that the over-medicalization of drug using practice, the dependence on pharmacotherapy in drug treatment and the lack of serious anthropological and sociological studies limit the potential for activism even among those who show a certain initiative to advocate for the rights and needs of the community. Thus, stigmatization and discrimination cause resistance in the community. These same limitations in the drug user's community force people to live in the ascribed social status and become passive.

Hence, coming out of the closet, facing and trying to overcome the stigma and shame, the feeling of belonging to their community are said to be the points where the two communities (LGBT and drug users) share key aspects for (de) motivation for activism.

Key Activities and Results

The applicability of the community monitoring and advocacy methodology reasserted towards initiating activism, motivating people on drug treatment to represent themselves and to affirm their rights and interests. Taking into consideration the existing social and political context, advocacy activities can be assessed as being successful. According to the plan, a team was formed for representation from which several more motivated individuals stood out, prepared to continue to advocate for the rights and interests of people treated in drug dependence treatment programs in Skopje. Though with varying dynamics and with frequent dips in motivation, the team carried out several activities of advocacy, directed at the same time towards improving the quality of programs for drug dependence treatment and towards animating the community for more active self -advocacy. Several team members of the advocacy team held a public appearance in the Macedonian media on 26 June 2014. They supported the "Support. Don't Punish" (IDPC 2013) global campaign. This was an occasion to articulate their opinions about the policies where people who use drugs face criminal persecution. They expressed their condolences for all the drug users who had passed away, and used the opportunity to expose their demands for improving the quality of drug dependence treatment programs. Through community monitoring and advocacy, people in drug dependence treatment programs (financed by the state budget) in Skopje were accepted as equal negotiators by the programs staff members. In three of the five state programs community representatives had the chance to use a room for regular or thematic meetings and socializing, thus enabling better communication with and animating of other community members.

Even though not meeting the expectations, it is fair to say that 70% of the members in the community know that there are people representing their rights and interest in the dependence treatment programs, with more than half the members are able to identify the main advocacy activities.

It can be concluded that monitoring and advocacy activities have provoked the spirit of activism in the people in drug dependence treatment. The dependence treatment programs have animated part of the community and have caused satisfactory changes in drug dependence treatment programs. With that, a good basis has been created for further action. The results and experiences described in this document shall be used for further improvement of advocacy drive towards bettering the quality of drug treatment programs in Skopje. We believe that this will also serve other communities who intend to advocate for the common objectives that is the foundation of human rights.

Recommendations

- To continue the activities towards improvement of the quality of drug dependence treatment programs in Skopje and to find a way to make advocacy sustainable.
- To provide strong and continued support to the advocacy team members who demonstrate motivation and initiative, without insisting on reciprocity in the inclusion of certain dependence treatment programs.
- To set realistic and easily achievable objectives.
- To direct advocacy in three directions:
  - First, advocating within the community to strengthen civic awareness that will help harmonize community values and attitudes, consolidate efforts and strengthen the spirit of activism.
  - Second, overcoming institutional stereotypes through community advocacy in policy -making institutions and to introduce humane drug policies and drug dependence treatment.
  - Third, community advocacy in the public sphere, in order to initiate a debate for humanization of the people who use/ have used drugs.
- To dedicate more attention to developing civil awareness among community advocacy team members.
- To enable further moral and professional support for the advocacy team/s, especially

insisting on cooperation and exchange of experiences with other civic organizations and similar for groups/movements from Macedonia and abroad.

- To use successful advocacy stories to motivate other people on drug treatment to become pro-active, and thus create a critical mass for advocacy at higher political levels.

The article has been authored by Dimitrievski, Vanja, Irena Cvetković and Vlatko Dekov. The article has been abridged from the document "Coming out of the closet? Assessment and evaluation of advocacy efforts for the improvement of quality of drug dependence treatment programs in Skopje. 'Skopje: HOPS – Healthy' Options Project Skopje, Coalition 'Sexual and Health Rights of Marginalized Communities', 2014.

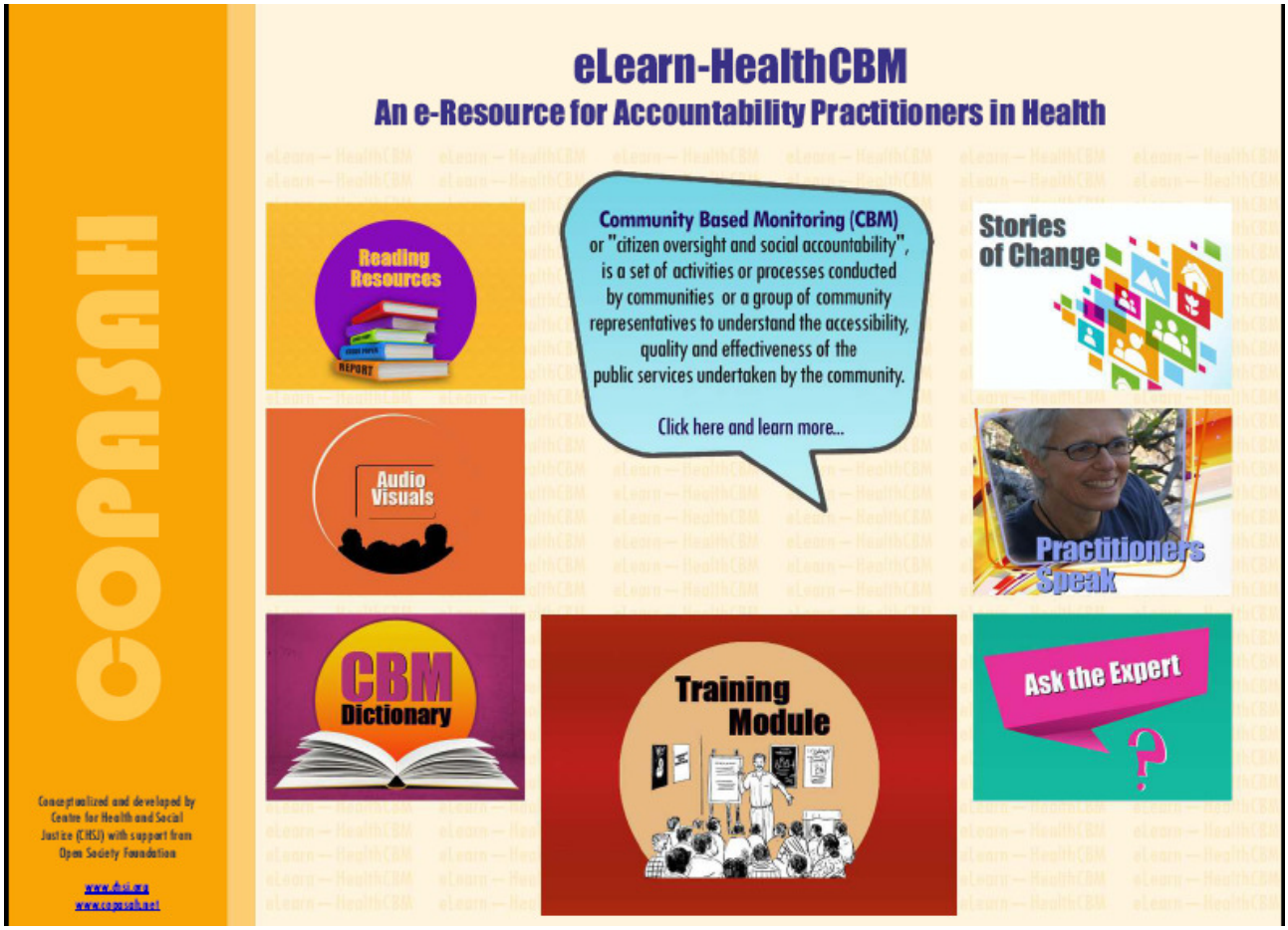
About the Authors

Vlatko Dekov is Manager at the Center for Education, Documentation and Research (CEDR), Department of Healthy Options Project Skopje (HOPS).

Irena Cvetkovic works as a Project Coordinator at the Coalition Sexual and Health Rights of Marginalised Communities. She is working on the research for her PhD thesis on the topics related to the marginalised communities i.e. sex workers, drug users and people living with HIV.

Vanja Dimitrievski works as a Programme Assistant for Research in the Center for Education, Documentationand Research (CEDR), a Department of Healthy Options Project Skopje (HOPS)

To learn more about Healthy Options Project Skopje (HOPS), please visit: www.hops.org



Strengthening the Citizen's Role in Governance through Social Accountability

A short report of the Global Partners Forum 2015 *

ABHIJIT DAS

The second Global Partners Forum (http://www.thegpsa.org/sa/forum2015) of the Global Partnership on Social Accountability (GPSA) was organised in Washington DC on May 12-13, 2015. The World Bank, which coordinates the GPSA, has currently included Citizen Engagement as a key element for all its support programmes. Within the overall framework of Citizen Engagement it sees Social Accountability as crucial component. Introducing the Partners Forum Mario Marcel, Senior Director on Governance and Global Practice at the World Bank, posited that 'citizens' and government working together can bring lasting change'. He highlighted the need for public systems to listen to citizens and gain their trust. An underlying assumption of his introductory remarks was that Government's are open if not keen to take citizen inputs for its programmes.

Following the introduction Chris Stone, President Open Society Foundations made his key note address on Social Accountability for Citizen Centric Governance: A Changing Paradigm. He congratulated the WB for taking this initiative of involving citizens in its work. He said that it was only through such initiatives that citizens can get a new taste of democracy, and this approach was now being included in a wide range of sectors including extractive industries, public procurement, budgeting in addition to sectors like health and education. However, he also pointed out that civil society space was also getting closed in many places and the World Bank should use its considerable influence with governments to continue opening the citizenship space. In conclusion he alerted the group to the fact that while the World Bank was practicing citizenship engagement practices, other International Financial Institutions were hardly transparent in their operations, and it was necessary for WB to force the pace and emerge as a source of preferred lending for countries.

The first panel discussion on Social Accountability : Paradigm Change in Practice had a range of speakers covering Rakesh Rajani from Ford Foundation, New York, Shaheen Anam, from Manusher Jonno in Bangladesh, Magadlena Lizardo from the government of Dominican Republic, Jan- Willen Schieijgrond of Phillips and Danny Sriskandarajah of CIVICUS joined via video link. The panel highlighted the different perspectives of the speakers. Danny said that idea of citizens coming together to create pressure on the government was not a new idea. He distinguished between CSO led and citizen led efforts and highlighted the fact that a large number of countries across the world had very restrictive NGO regimes. It would be difficult to engage in true citizen engagement in such circumstances. Following the same trend Rakesh Rajani mentioned that social accountability to be successful needs to change the balance of power. It was messy work and this needed to be recognised. There was also a possibility that elite CSO's who engaged in such social accountability work and engagement with government undermine the political mobilisation that was necessary. Shaheen highlighted the need to respect the voice of people and gave examples from her work. Magdalena cautioned the group about the need to be cognizant about the constraints faced by government and Jan Willen from Philips mentioned that corporate bodies like his company were now setting up social goals of improving people's lives within their overall profit motivation.

The presentation by Prof. Jonathan Fox in the session on Strategic Social Accountability Dimensions followed up on the critical nature of citizen engagement that Social Accountability entails. He outlined six key dimensions of social accountability, highlighting the importance of each dimension within the overall accountability process. The six dimensions and some characteristics of each are mentioned below:

Accountability systems – How to shed the spot light, how to shame the shameless.

Political Economy Interventions – Identify interests and incentives of different parties; who wins who stands to lose; what are the power shift potentials, anti-accountability forces.

Constructive Engagement- Can accountability be a 'project' or a

**Abhijit Das represented COPASAH at the Global Partners Forum, 2015 as a Global Convener*

campaign, how to develop autonomy of CSO and promote critical enquiry, how to balance between collaborative and adversarial relationships; bring pressure to bear from the top and bottom – sandwich approach.

Coalition Building – There is need to find common ground across a diverse set of actors – acknowledge difference but keep the common focus.

Citizen Trust – To what extent can citizen trust be assumed in the face of poorly functioning public systems in many countries?

Scaling Up – Not just an issue of multiplying – scaling up horizontally and vertically – across sectors and social groups and at different levels of governance. Just looking at the community level or what may be done at the 'end of the pipe' without considering source level contamination.

The framework presented by Prof Fox subsequently formed the basis for analysing a set of case studies around different sectors. These included Health, Education, Infrastructure, Water, Municipal services, Extractives and Youth. I attended the Health sector workshop where two case studies – one around reproductive health from Uganda and another around medicine procurement in the Dominican Republic were discussed. While the framework presented by Prof Fox was formally kept as a framework of analysis – however the idea of power shift from State to Citizen did not come explicitly. Social accountability was coming out primarily as a participatory feedback mechanism to increase programme performance from the manager's perspective. The limitations of this method were not clearly articulated by the presenters. From my own experience social accountability has clear limitations in resource scarce situations and can be of limited effectiveness when there are deeply ingrained system issues which could range from lack of resources like medicines or providers to issues of corruption .The role of the citizen as an empowered 'agent' was not clear in the Guatemala case study which was primarily an intervention at the higher level of governance. The issue of raising citizen expectation without being able to deliver was raised during discussion. There was also discussion about the respective roles of 'enlightened' bureaucracy compared to 'empowered' citizenship in contributing to the success of such efforts. Also the issue of individual 'grievance redressal' especially in the context of violation of health rights was raised during the discussion.

After the thematic workshops the groups came together to share their experiences with each other. The day ended with the award of social accountability leadership awards to seven individuals at a public function (http://www.thegpsa.org/sa/news/gpsa-presents-awards-7-social-accountability-leaders).

The second day began with a quick recap of the first day followed by a conversation with World Bank President Jim Yong Kim. The key message that emerged from this conversation was that citizen's engagement was a key component of World Banks approach to providing support to countries. However this engagement was being seen primarily with the perspective of 'listening to the poor' and an anxiety for quick results and scalability seemed to underlie this approach. Two interesting terms were introduced – 'pilotprojectology' and 'scaleupology' with President Kim's focus being on the second. However the idea that WB is now looking at integrating citizen engagement into all its lending was very encouraging. President Kim also answered a few questions which were put up to him by the participants. The contentious issue of user- fees for health services as a form of citizen engagement which WB had promoted in the past was raised and President Kim affirmed that WB was no longer promoting user fees. The idea of 'struggle' and 'protest' as forms of citizen engagement within a spectrum of actions was also discussed briefly, with President Kim alluding to his past association with ACTUP an HIVAIDS alliance which had used this strategy successfully. The need for citizen engagement for addressing inequality was also brought out during the discussion.

Following this session the participants broke up into six groups to review the dimensions that had been proposed by Prof Jonathan Fox. I joined the discussion on Political Economy Interventions. Some of the issues discussed during the session were as follows:

Balancing buy-in by policy players/ bureaucracy with community empowerment and demand/claim– how does the power shift take place. Role of 'benevolent' policy players vis a vis 'empowered' community in stimulating social accountability processes

Does stakeholder analysis include vested interests and informal processes and influences? What is our level of honesty when we do such analyses?

What does success or results mean in different contexts – can efficient delivery of services count as the most important success, how do we know that power shifts have actually started?

Who are the 'allies' and what are the nature of relationships necessary for successful Political Economy Interventions

What is the role of INGOs vis a vis community based CSOs in such interventions? What are their limitations?

What is sustainability in this context –service delivery related, political context related, citizen action/ social movement related?

This session was followed by lunch which was organised in a manner that participants from different regions would sit in clusters and they would be accompanied by World Bank Executive Directors from their region. This was an opportunity to meet with other participants from India and South Asia. However we did not have any Executive Director at our table.

The participants came together after lunch to share the discussions that had taken place in the Dimensions workshops. I am summarising my key takeaway lesson around each of these dimensions (Political Economy Intervention excluded) below:

Citizen Trust – It is difficult to achieve in the context of the history of poor public services, and it is easy to lose as well. Does trust indicate a 'mutual' or bilateral relationship or an implicit or 'naïve' trust of citizen in public services? What is the role of responsiveness of services in building trust? Can trust building be an independent goal in service delivery? How do we measure it?

Constructive Engagement – Is there a role of 'disruptive' engagement vis a vis constructive engagement – maybe one follows another. Champions of constructive engagement are needed 'within' government. There is a need to identify and engage with these 'champions' inside the system. How to move from a person/champion centred approach to a system based approach? What are the limits to constructive engagement in a culture of impunity?

Coalition Building – Who should be in? It has to be linked with the Political Economy analysis and Intervention. Need to be clear who 'controls' the agenda – the possibility of corruption/distortion of the agenda by powerful coalition partners. The role of donors and INGOs vis a vis social movements. Is there a role for the Government in the broader coalition?

Accountability Systems – What is the historical context – social and political background of the 'state' and governance processes. What is the nature of 'representation' and mediation within the accountability processes? Is there a difference between 'compliance' of standards of service delivery and accountability? How to achieve both? How to achieve alignment of interest of the citizen and service provider and also have 'accountability'?

A larger question of political integrity and rebuilding trust in the social contract with the 'State' was also raised. Interestingly the role of 'market' and corporate interests was not similarly interrogated.

The final business session of the forum was a role-play/simulation on Social Accountability in Action in which all the participants were divided into different interest groups who would participate in a discussion around a news report of financial irregularities in the execution of a road construction contract. The different stakeholders/ interest groups included CSOs, Chamber of Commerce, the Contractor, Finance Ministry, Public Works ministry etc. The exercise was 'interesting' without providing much insight because the emphasis of the moderators was to find ways of 'moving ahead' without addressing some of the core issues which had been identified. This for me highlighted the need to look at relationship between accountability and justice and developing clarity between negotiation and impunity.

Concluding Thoughts – The Partners Forum, under the aegis of the World Bank, represented the middle ground of the field of Social Accountability. While it presented extremes of representation from corporate sector participants on the one hand and willing government representatives on the other, it also provided for a range of participants and opportunities to engage in meaningful and thought provoking discussion on the topic of social accountability. It is too optimistic to expect a large inter-governmental body like the World Bank to represent the cutting edge of political thinking, but the organisers had made a brave effort in inviting Professor Fox to present his framework of 'Strategic Social Accountability' which was the subsequent framework of analysis. The morning panel on paradigmatic change also challenged the somewhat normative assumption that social accountability was short hand for 'demand generation for improved service delivery', a somewhat naïve notion introduced through the 2004 World Development Report. While a large body of the participants was made up on donors, government and INGOs, there was sufficient critical thought to challenge the assumption of the benevolent disposition of the 'state' towards its citizen, and social accountability as a mechanism for domestication of citizen disaffection. Unfortunately, there were few in the room who truly represented the 'citizen interest' and most could be seen as 'concerned mediators' and current and potential grantees. But this probably is an unrealistic expectation in such a global assembly of development managers, which for me is also its strength and an opportunity for COPASAH. We should build further linkages with the platform through both informal and formal relationships and share our member's insights generated through practice. ■

Paving the Way for Primary Care Management Committees through Citizen Engagement

GULBAZ ALI KHAN & SYED ISHFAQ-UR-REHMAN

Background

Citizen Engagement for Social Service Delivery (CESSD) centers on strengthening communities towards their engagement with the government in order to improve social services. CESSD centralizes itself around building community organization as a primary and preliminary step towards citizen engagement with the government. Local communities are organised, capacitated and consolidated as Social Service Committees (SSCs) to achieve gender responsiveness and social accountability. The SCC has similar core objectives. These committees are government mandated community bodies that are recognized in different social sectors, some of which are Parent Teacher Councils (PTCs) in Education Sector; Primary Care Management Committees (PCMCs) in Health Sector and Water User Committees (WUCs) in Water Sector. These organized communities have evolved through different stages from formation of the committees to now achieving maturity as independent community institutions.

The Primary Care Management Committee (PCMC) is the Health Department's community participation mechanism, elaborated in standard 1.1 of Khyber Pakhtunkhawa Primary Health Care Standards (Standard 1.1). Realizing the critical role of the community in improving service delivery for the people, the Health Department Khyber Pakhtunkhwa (KP) has

Jean Frederic, Project Field Manager, CESSD, Khyber Pakhtunkhwa, Pakistan sharing his thought on accountability

institutionalized community participation by including Standard 1.1 as approved standards for primary level health facilities. At the heart of Standard 1.1,lies the objective that every health facility has to constitute Primary Care Management Committees to actively involve itself in the processes of community planning and decision making aimed at improving the health facilities. These committees are entrusted with important and key responsibilities of maintaining the efficacy of Primary Health Care. It is envisaged that the PCMC will not only manage the resource utilization but also take major decisions that involve planning, resource generation, monitoring and improvement in service delivery.

CESSD has provided support in the formation of PCMCs in more than 210 primary health facilities in five selected health districts of Khyber Pakhtunkhwa (KP). After the formation of PCMCs, CESSD builds the capacity of PCMCs through series of trainings in relevant disciplines including role and responsibility of PCMCs, Primary Health Care Standards, social accountability and gender mainstreaming, facility development plan and financial management. Additional areas include orientation and training programmes on facility development plans, adult literacy centers, and exclusive trainings for women members of PCMCs and sub committees etc. CESSD also assists PCMCs in linkages development through synergy workshops. Other areas include demonstration of classic and innovative social accountability tools and methods for supporting good governance.

The Concept

PCMCs have been established in

more than two hundred primary health care facilities. Some guidelines have been developed for PCMCs that steer them in their operation and activities. Monitoring mechanisms are developed for monitoring the performance of the service providers under PCMCs. Training, development of resource materials is available for the capacity development. It is vital to raise the visibility of PCMCs to work around the challenges in order to move forward. Keeping this vein in thought, CESSD convened a PCMC Conference on March 19, 2015 in Islamabad, titled 'Paving the Way for PCMCs' at the provincial level to encourage PCMCs to overcome challenges at the policy level.

Objectives

The conference was organised to provide increased visibility to PCMCs. It aimed to examine the key challenges and offer recommendations that emerged during the provincial dialogue.
The forum saw a congregation of people from diverse backgrounds including people from communities, district and provincial governments, representatives of relevant government and non-government organizations under one roof. The event witnessed rich discussions on the theme of PCMCs; its achievement so far, challenges ahead and ways to smoothen the way for PCMCs. The participants included representatives of PCMCs and PCMC Networks, non-government partner organizations, policy makers; Government of Khyber Pakhtunkhwa representatives, CESSD colleagues and district and facility level government officials.

Proceedings

The conference was divided into two sessions: the inaugural session and technical dialogue. The inaugural session opened the floor to discuss the broader objectives of the Conference.

Dr. Qaisar Deputy Director Reproductive Health and Nutrition, Health Department addressed the conference. He lauded the efforts of CESSD's in health sector. He acknowledged that due to the efforts of the PCMCs initiated by CESSD, the communities can access quality health services at grassroot level. He endorsed the expansion and scaling up of the CESSD Health model across KP province for better interests of the community. He requested the Department for Foreign Affair and Trade (DFAT) and other donors to fund CESSD interventions for the whole of KP.

Technical Sessions

Different technical sessions facilitated the dialogue on PCMCs from different regions.

The theme of the Government and Citizen's voices panel, session was titled as "*Effectiveness of Development Interventions through community participation*". During this session, government and community representatives from the five health districts shared their experi-

Snapshot of PCMC Conference

ences of best practices derived from the field.

Jahangir Khan Mughal, Chairperson PCMC BHU Pakha Ghulam representing Peshawar district shared his presentation on "*History/Background of the PCMC*"**.** He highlighted the achievements made by CESSD through PCMC's apart from the challenges faced at grassroots level.

Saeda Feiroz, Chairperson PCMC BHU Mandani and Member PCMC District Networking Committee Charsadda, representing Charsadda spoke about "*Gender Mainstreaming*". She reflected upon her role as a women leader working for the improvement of health services in her commnuntity where access to community health service for all and women in particular was important to integrate a pluralistic approach to heath. Saeeda explained her mission as a women leader was to enhance gender mainstreaming at all levels of health care

BHU Badrashi- Nawshehra was represented by Naila Naz. Ms Naila is the Member of PCMC BHU Badrashi and Vice Chairperson, District Networking Committee, Nowsher. She highlighted the key acquirements for the betterment of community based health services through the PCMCs.

Shahab Uddin, Chairperson PCMC RHC Bilitang, Chairperson District Networking Committee, representing Kohat district outlined the theme of "*Social Accountability*". He elaborated on the importance of using social accountability tools such as the Public Information Boards (PIBs) and Complaint Management System (CMS) to enhance transparency, exacting public accountability, raising health user voices and opening up government towards citizen demands.

Dr. Fazal Akbar, Medical Officer RHC, General Secretary PCMC, RHC Shetyal, highlighted that the Facility Development Plan (FDP) was an effective tool for facility development and services improvement through community participation.

A group work was conducted where the participants were divided into four groups representing the community, CESSD and government representatives to provide the participants some practical inputs. The groups worked on the following themes:

i) Financial delegation to PCMCs and provision of regular funds to PCMCs on the analogy of PTCs.

ii) Making available a permanent human resource team within DOH for social mobilization of PCMCs at district level.

iii) Building a sustainable mechanism for capacity development of PCMCs

iv) Increasing ownership and better collaboration between stakeholders around PCMCs.

Outcomes

The conference proved to be an interactive platform for community leaders to express and share their experience to build a wider understanding of the subject and help replicate the models across the province. Many grassroot stories and local experiences were shared by the stakeholders including donors, government representatives, CSOs and communities. The issues of gender mainstreaming, social accountability, capacity development and networking committees were discussed in detail.

It discerned from the dialogues that District Network Committees (DNCs) can collectively raise the community voices for greater PCMC visibility, adequate funding and appropriate capacity development needs. The DNCs decided to collate the findings to the forum at the provincial level. These findings would be rooted to legislatures and decision makers to impact policy level changes. It was mooted that the PCMC funding and institutionalized capacity development effort would be mobilized through the legislatures. The DNCs decided to approach their respective MPAs/ MNAs, and Administrative Secretary to create civil society pressure for concrete actions on the PCMC actualization. It was discussed that specifically a committee of DNCs will meet the Minister and Secretary to remove concerns over the financial delegations to PCMCs. It was also deliberated that initiatives such as of developing a framework of partnership amongst all the stakeholders to institutionalize social mobilization and trainings in the health services will be undertaken. Provincial Health Services Academy (PHSA) and its affiliates will be considered as prime training institution for delivering trainings to the PCMCs.

Way Forward

It was decided that collaborated efforts with all stakeholders is a growing need requiring mobilization of resources to help in the full integration of PCMCs into primary health care services. Though, PCMCs is now a notified body health department, one sees a reluctance and resistance within the

Continued on page 20

Participatory Audit and Planning of *Rogi Kalyan Samiti* (Patient Welfare Committee) Funds

A tool for monitoring and ensuring 'Decentralized Planning' in the utilization of Health Management committee funds[1] in Maharashtra, India

NITIN JADHAV

'Social Audit' as a process is now well known in India, especially in the context of the National Rural Employment Guarantee Act[2]. Today, social audit has provided a platform for ensuring accountability and transparency in the Employment Guarantee scheme. This process provides a space for dialogue between beneficiaries and service providers.

The word "Audit" has its origins from a Latin word ''*Audire''*, which means '*to hear'*. In ancient Greece, the word '*audire*' was used in the context of the process of 'hearing of accounts'. It was usually associated with cross checking of different financial documents by authorities, declaring and sharing the findings of the financial expense, work accomplished and gaps in the implementation of the programs openly with the community.

Today, the 'Audit' process has become immensely technical and 'expert oriented' driven, where the community's participation is very limited. Take for example, the financial audit of Rogi Kalyan Samitis funds conducted by the state government. The financial audits are carried out by appointing Chartered Accountants. Although financial audits might bring in accountability, where government officials are accountable to their superiors, one sees a lacuna within the financial auditing mechanism as there is often no system to receiving feedback from beneficiaries.

Participants of PAP process examining records related to RKS funds at Telkhedi PHC of Nandubar district

Keeping this context in mind, the 'Participatory Audit and Planning (PAP) process of RKS funds' has taken the core essence of social audit and created a space for Community Based Monitoring Planning Process.

The Participatory Audit and Planning process was conducted in a total of nine health institutions of Nandurbar, Thane and Raigad districts of Maharashtra, during December 2014 to March 2015.

Objectives of the PAP Process

- To ensure decentralized planning of Health Services, focusing on active participation of various stakeholders such as elected members, Health por-

[1]In 2005, the Government of India began implementing the National Rural Health Mission (NRHM), which provides flexible funds for local health institutions to promote accessible and effective health care for the rural population. As part of NRHM, Health Management Committee known as 'Rogi Kalyan Samiti' (literally, 'Patient Welfare Committees') have been set up in each public health facility, which is expected to manage annual untied funds for improved functioning of the facility.

[2]Mahatma Gandhi NREGA seeks to enhance the livelihood security of the households in rural areas of the country by providing at least 100 days of guaranteed wage employment in every financial year to every household whose adult members volunteer to do unskilled manual work. The unskilled manual work include water conservation and water harvesting; drought proofing (including afforestation and tree plantation); irrigation canals including micro and minor irrigation works; provision of irrigation facility, horticulture plantation

viders and Civil Society Organizations in decision making of planning and utilization of Health Management Committee (HMC) funds.

- Identify gaps in the expenditure of HMC funds and also to evaluate functioning of HMC.
- Build the capacity of Health Management Committee members on their roles and responsibilities.

In the PAP process, various stakeholders such as representatives of Rogi Kalyan Samiti, Monitoring and Planning Committee, active community members, elected members, health officials and representatives of civil society organizations, and staff of respective Health institutions were involved. Based on the above mentioned objectives, the following steps were taken in conducting the PAP process-

Preparatory Phase- To understand the pattern of expenditure of RKS funds, a representative of Civil Society Organizations collected information for the financial year 2013-14, from the Health institution. The analysis of the financial audit was to assess the components that incurred the maximum financial spending. Based on the findings, a poster has been developed and is displayed in the premises of the Health Institution providing the details of financial statements

Examples of pattern of expenditure - In three Health institutions, maximum HMC funds were utilized for printing logos, photocopying of case papers and stationary during the year 2013-14.
- In the sub-district hospital of Thane district, maximum funds were utilized to purchase electrical equipments and building maintenance.
- In Khandas Primary Health Centre of Karjat block of Raigad district, maximum HMC funds were utilized towards building water facility and on payment of internet and telephone bills.

Actual Participatory Audit and Planning (PAP) event- A meeting was organized in the premises of the Health institution with participation of RKS members, Monitoring and Planning committee members under CBMP process; District and State level Health officials and representatives of Civil Society Organizations. The PAP event began with an orientation to RKS members about their roles and responsibilities. This was followed by a presentation of poster and sharing pattern of last year's RKS funds expenditure. All the participants were involved in the examination of financial documents and records that included books of accounts, vouchers, supportive documents, and proceedings of RKS meetings etc. After the examination of financial documents, the participants took a tour of the health institutions in each ward. They interacted with patients and staff of the institution. This activity helped in cross-checking the verified financial records and physical availability of purchased items through RKS funds.

Examples of the gaps that emerged and resolved during PAP event - In one of the PHCs, the existing constitution of the RKS committee was not as per guidelines such as no representation of elected members and Civil Society Organization. Hence, it was suggested that the committee be reconstituted. Within fifteen days of the audit, with the initiative of the accountant of the facility and the CSO representative, the committee was reconstituted.

In one of the PHCs, the expenses incurred from RKS funds were for

PREPARATORY PHASE

Information related to last year's (2013-14) expenditure of RKS committee funds was collected from Health institution by representative of CSOs and analyzed to figure out the heads which had incurred maximum spending.

Based on the findings a poster has been developed and displayed in the premises of Health Institution. The Findings were shared with the participants during the audit event.

PARTICIPATORY AUDIT AND PLANNING EVENT

Joint meeting was held in the premises of the health institution where HMC members and Monitoring and Planning Committee examined the financial documents and records related to RKS Committee expenditure such as vouchers, bills, tenders etc. as well as glanced through the minutes of RKS Committee meetings.

Participants visited the health institution to cross check the verified financial records and physical availability of items purchased through HM Committee funds.

IMPACT OF PAP PROCESS

Based on positive experience of PAP process which was conducted in 3 districts the State Government has decided to implement the PAP process in 22 blocks from 14 districts of Maharashtra where Community Based Monitoring and Planning process of Health Services is being implemented.

the repair of television, subscriber recharge for dish TV. However during an inspection it was found that there was no television in the facility. The team conducting the PAP found out that the television was under repair. Further, villagers shared that they had never seen a television in the PHC. The investigation revealed that the television was placed in the ward boy's house. During the meeting he was asked to return the television to the facility. The very next day of the audit, one of the villagers informed a representative of SATHI that the television was returned and now placed in the facility.

- In Son Primary Health Centre (PHC) in Dhadgaon block, Nandurbar district, Rs. 33,705 was spent on purchase of equipment such as microscope, centrifuge machine, slides, test tubes etc. for the PHC. This was the HMC fund for the previous years. As per the process, any purchase that requires a large sum of money, quotations from vendors must be sought first, and then the acquisition and purchase is made. However, in this case, the equipment was purchased in March 2013, while the quotations were invited in April 2014.

Dialogue between various stakeholders- The PAP event concluded with a meeting where all issues and findings were discussed and decisions were taken. This was an essential step to consolidate the process and take it to its logical conclusion.

The planning of the RKS funds for the year 2014-15 was done taking into consideration the findings, recommendations and physical verification of items purchased through RKS funds.

Examples of decisions taken during a dialogue between various stakeholders- A Community Health Center had purchased a fridge and cooler that was placed in the in staff quarters at the time of the committee's visit. A district level official recommended that the items must be immediately placed in the CHC. The items were returned to the hospital.

- A decision was taken to utilize the current RKS funds to fix mosquito nets on all the windows of the health centre and replacement of a leaking water tank in the hospital.

- In one Health Institution, curtains for doors and windows were fixed. Earlier the curtains were put up only in the doctors' cabin. The doors of other wards like General Ward, Women's Ward, did not have any curtains. This issue was discussed and curtains which were purchased through RKS funds were put up on the doors of all wards.

Lessons learnt during the implementation of PAP

The role and involvement of Civil Society Organizations is crucial and important for the facilitation and coordination between various stakeholders.	In order to move towards decentralized planning of RKS funds and functioning, the multi-stakeholder body is a non-negotiable component in the PAP process. However, consensus building among a multi-stake holder body could be challenging for civil society organizations. These multi-stakeholder bodies must have the authority to take decisions and action on issues that are raised during PAP process.	The state and district level officials must provide unambiguous directions to the field level Health providers such as Medical officers, nurses and other staff. The directions help in understanding their administrative duties, job roles, responsibilities and obligations, and any other financial information pertaining to the RKS funds.	Ensuring some concrete actions from health officials especially at district and state level, is one of the major challenges faced during PAP process. This challenge can be overcome by continuous, rigorous follow up with Health officials.

About the Author

Dr. Nitin Jadhav is working with SATHI (Support for Advocacy and Training to Health Initiatives), Maharashtra, India which is mainly involved in advocacy for ensuring accountability in Public Health System of Maharashtra. He works as a State Coordinator; Community based Monitoring and Planning (CbMP) process under NRHM, Maharashtra, India.

Employing ICT for Social Accountability: COPASAH South Asia Initiative

A Short report on COPASAH South Asia Learning, Sharing and Documentation workshop

SUREKHA DHALETA & DEEPAK KUMAR

Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a global community platform of practitioners in the field of health and human rights. The community uses tools of community monitoring for accountability and health rights.

Health and human rights practitioners from across different regions of South Asia, East- Southern Africa, Latin America and parts of Central Europe interact regularly.

They exchange experiences and lessons from the field, share resources, capacities and innovative methods in accountability and knowledge products. Since its genesis in 2011, COPASAH has emerged as a strong 'community of practice' which focuses upon accountability practices which are community driven and citizen centric and strive for empowerment of communities wielding increased negotiating power, with an enhanced realization of health rights.

Practitioners receiving tips on Videography

Concept and Objective

COPASAH has taken cognizance of the digital divide that has been a major barrier for the grassroots practitioners in the developing countries who fail to use the evidences effectively to influence change for the benefit of the marginalized. Recognizing the significance of Information Communication Technologies (ICTs) in citizen engagement for monitoring, evidence gathering, gap analysis and advocacy in health service delivery, measuring change in empowerment process of communities in demanding quality health care, COPASAH has experimented with the use of ICTs in social accountability.

In this vein of nurturing, strengthening, promoting collective knowledge and skills; developing and implementing peer led learning strategies of ICT methodologies in social accountability, COPASAH convened a three day COPASAH- South Asia Sharing and Documenting Information Communication Technologies workshop at Vadodra in Gujarat (India) from July 2-4, 2015 in association with CHSJ and SAHAJ. The workshop saw a congregation of 32 community practitioners from six states of India including Tamil Nadu, Karnataka, Uttar Pradesh, Madhya Pradesh, Gujarat and Maharashtra where the practitioners were involved in sharing and learning experiences of using ICT for social accountability in health. The aim of the workshop was to document the learning experiences i.e. the methodology, processes and challenges in the practice of employing ICT for social accountability in health. The workshop also endeavoured to equip practitioners with basic skills of film/ video making apart from strengthening the network of practitioners in South Asia as well creating solidarity with other resource groups in the field of ICT and social accountability.

Backdrop of the Workshop

Capacity building of 30 community level health accountability practitioners from the aforementioned six states was done using accessible technology like cameras in cell -phones, basic digital cameras on how to take photographs,

Snapshot of Use of ICT for Social Accountability across States

Issue	Districts	Methodology	Advocacy	Result
TAMIL NADU				
• Mobile Medical unit (MMU)– Erupalli Panchayat • Sanitation -School Management Committee – Pavalanthur-Panchayat • Case studies - Health services to differently abled children- Thannerpanthal Panchayat	• Nallampali Block –Dharamapuri district • Pennagaram Block- Dharmapuri district • Kandhili block – Vellore district	• Photovoice – Photographs, Videos, Testimonies prepared Voice records • Banners • Hard copy reports	• Dialogues at PHC level • Dialogue with Village Health Sanitation Committee members and School Management committee • Dialogue with concerned authorities of ICDS department and school	• VHSC monitoring functioning of MMU • SMC monitoring sanitation &water availability in school toilets and VHSC taken issue of construction of toilets in village • Differently abled child would be provided nutrition services by ICDS and admission in school
UTTAR PRADESH				
• Quality and availability of maternal health services	• Hata Block - Chandauli district • Jangal Kaudiya block –Gorakhpur district • Naugarh- Kushinagar district	• Photovoices – Photos, • Videos testimonies developed • Reports • Photo Exhibition • Alliance with media	• Dialogue with community members • Block level Dialogues • Photo Exhibition in Hospital • Reports in media	• Positive response of health service providers during dialogues, accepted findings and ensured action • Issues taken up by mainstream media/ follow up pursued
MADHYA PRADESH				
• Maternal Health Services	• Hajuri Block – Bhopal • Ambha block – Morena district • Ichhawar block – Sehore district • Mohkhed block – Chindwara district	• Photovoice – • Photos, Photostories • Video • Photo documents - Case stories on denial of health rights during pregnancy and delivery	• Photovoice testimonies presented in Block level Dialogues in Morena, Sehore & Chindwada	• Prompt action in Sehore – Ambulance service started for village/ deliveries conducted in PHC which were earlier conducted at CHC • Health service providers in Morena gave a positive response after seeing the photo evidences and promised prompt action
KARNATAKA				
• Health rights of marginalised community of manual scavengers	• Pavagada & Madugiri blocks - Tumkur district	• Photo story, photo with caption (narratives) • Voice record	• Photo documentation -case stories dialogue with civic body officials • Photo exhibition & health dialogue to be held	• Case stories –photo documentation led to hearing of denial of health rights and adequate compensation
GUJARAT				
• Maternal Health services- ANC services to women in Village Health &Nutrition Day (VHND)	• Panchmahal district	• Photostories	• In process as Gujarat team joined the ICT process late	
MAHARASHTRA				
• Sanitation in Primary Health centers	• Gadchiroli • Amravati	• Photostories	• PHC level Health dialogues	• Photo evidence presented in dialogue led to improvement in sanitation at PHCs

make photostories and record voices for identifying gaps in health care services and generate evidence for advocacy of health rights in two successive workshops respectively in January and April, 2015. Subsequent to these workshops the practitioners developed an action plan to generate evidence using accessible technology in 18 districts on selected themes of women's health and those of marginalised communities for accessing free health services and health rights. Photo documented evidences as Photostories/ Photovoices on gaps and situation in the health facilities and services were collated, reviewed and shortlisted in collaboration with community members and were used for advocating with concerned health officials and committees related to grievance redresses through public health dialogues at various levels of health system. These photo documented evidences were created as Audio Visual products. [1]

Proceedings

Advancing from the experiences of the two earlier workshops and experiment of use of ICT in the field, the six teams shared their experiences in the three day Vadodra workshop. The state team members made presentations revolving around the context of the place where ICT was used, the detailed processes- on how and which issue was selected, and the kind of ICT was used, how community members were involved in the process. Each team discussed the production process- in detail i.e. how photographs/videos were taken, the conceptualisation of photostories/ photovoices etc. and also demonstrated the dissemination-advocacy process, responses from health service providers, besides focusing on outcomes and challenges.

- It discerned from the sharing by the teams that the states had experimented with the use of Photovoice under COPASAH's initiative for the first time.
- The findings indicated that audio- visual documentation drew the attention of the heath authorities prompting them to problem solving action. The visual report cards were effective in generating awareness in the community with low literacy. The community strategically used evidence to communicate with providers at various levels of health system. It led to building greater visibility of issues related to maternal and child health through social media/ press releases and women and marginalized community members demanding quality health care services.
- It emerged from the discussions that community members were enthusiastic to take photos and community can handle technology and work towards generating evidences for health gaps but community members were not much involved in analysis, review, selection and conceptualization of photostories. It surfaced from all the states that relative to traditional report cards in Community Based Monitoring (CBM), photovoices emerged to be strong medium of reflecting gaps in delivery of health services and health rights denials.
- All the practitioners outlined that short time interval was a limiting factor in the process of carrying out the initiative.

Reflections for Further Deliberations

COPASAH Steering Committee member, Renu Khanna who was the co-facilitator in the workshop reflected that deliberations were required on some points on use of ICT for social accountability. She noted that the practitioners need to understand the nuances of modes of testimonies i.e. testimonies as shared in person in Jan Samwads (health dialogues) relative to testimonies presented through films/ videos or through photos. She said that it was evident from the shared

Practitioners learning how to use video camera

[1]An AV product representing each state (in form of Photostory) has featured in the 10th issue of COPASAH Communiqué. These can be accessed at : http://www.copasah.net/uploads/1/2/6/4/12642634/innovative_use_of_ict_in_community_based_monitoring_practice_in_india.pdf

experiences of the practitioners that Photovoice methodology is useful, but practitioners need to cull out from the experiences, what has been a value addition of ICT in CBM while involving local community members.

COPASAH coordinator, E Premdas Pinto noted that the practitioners had actively pursued the COPASAH initiative of using ICT for social accountability; however he cautioned that the idea of community should not be romanticized. It should be realized that the bottomline of the CBM is community and empowerment. It should be gauged that who is closest to the community i.e the grassroot practitioner and these grassroots practitioners should be involved intensively in the bottom up approach of CBM.

Skill Building on Video Making and Editing

The second day of the workshop focused on skill building of the practitioners on video making and video editing. The practitioners learnt about nuances of video/film making under supervision of independent filmmaker Vijay Kumar and deliberated upon how to choose a theme, prepare for an interview, how to take shots, techniques employed while taking shots along with editing videos. The practitioners were divided into four groups for practical session on making videos, wherein the groups explored the city of Vadodra by making videos on selected themes.

Interaction with Video Volunteers

On the third day of the workshop, practitioners interacted with representative of Video Volunteers (VV), Kanika Singh. She briefed on the ways, VV is working towards empowering voices and training community members as community correspondents wherein members of the disadvantaged community are imparted with story and data gathering skills. Bipin Solanki, Community Correspondent (CC) with VV in Gujarat, elaborated that as a CC he was able to highlight issues related to denial of rights of marginalised communities. Representatives of VV expressed their keenness to forge an alliance with COPASAH in raising the voice of the margianlised communities.

Way Forward

Following intensive discussions on the experience of using ICT for social accountability, the six teams collectively reflected upon how to take the learnings forward on use of ICT for social accountability and outlined their expectations from COPASAH. The practitioners decided that they would use the skill of video making to develop video testimonies on health right gaps and use them for advocacy at different levels of health system.

Many grassroot practitioners opined that it was their first hand experience in handling video cameras and engagement with editing software.

The practitioners also reflected that a continuous engagement and handholding in terms of technical support on editing and on use of ICT for social accountability was required from COPASAH to take the initiative ahead. It was mooted and agreed under the facilitation of COPASAH coordinator, E.Premdas and COPASAH SC member; Renu Khanna that COPASAH would be providing technical support to the practitioners. As a step ahead, it was proposed that the teams would deliberate on the action plan developed at the workshop and develop proposals on the basis of the discussions and then take it forward with COPASAH.

Conclusion

Convergence of practitioners from diverse states at the three day workshop turned out to be an interactive avenue, as it enabled discussions and consolidation of understanding on use of ICT in social accountability. It provided an opportunity to work out ways for enriching communication between practitioners, COPASAH and Video Volunteers also.

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 communication platforms of COPASAH- COPASAH listserv, social media (facebook, twitter) 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.

Deepak Kumar works with the Public Health Rights and Accountability (PHRA) team at CHSJ. He is also coordinating the ComAct4Health_India listserv for regional social accountability practitioners in India.

The Eclipse of State Accountability in the Global Reference List of 100 Core Indicators by World Health Organisation

The Global Reference List of 100 Core Health Indicators is a standard set of 100 indicators prioritised by the global community to provide concise information on the health situation and trends, including responses at national and global levels.

E. PREMDAS PINTO

World Health Organisation (WHO) has proposed the Global Reference List of 100 Core Health Indicators for health information management and its application. Agreeing upon a set of core health indicators will certainly help in standardising the health system data globally. The health indicators such as health status, risk factors, service coverage will also help broaden the scope of understanding the functioning of the health system from diverse perspectives. The proposal of WHO of a Global Reference List of 100 core indicators is a welcome step in that direction. *(http://www.who.int/healthinfo/indicators/en/)*

Inspite of the positive take away of this proposal, as practitioners seeking accountability, we note discordance in the tone, tenor and language of the WHO reflected in their various reports. Moreover these reports published in different points of time do not sync with each other and strikingly lack in coherence and consistency, especially when seen from the perspective of Universal Health Coverage (WHO 2010) and from the social determinants of health (WHO, CSDH, 2008).

State compliance and accountability to the framework of right to health, minimally proposed in the General Comment 14 as the agreed upon indicator in striving for the "highest attainable standard of health" (Universal Declaration of Health and International Covenant on Economic, Social and Cultural Rights). Unless the state commits to adequate financing to strengthen the public health system, puts in place oversight and regulatory mechanisms for the private sector, and prioritises primary health care, the data will hardly make any difference to the populations, especially the disadvantaged communities world over. The communities world over are already reeling under the impact of declining state commitment to people's health as seen in its withdrawal from the provision of health care and is seen to be invariably promoting private health care to the detriment of state led public health services.

It is appropriate for COPASAH to ask WHO : where and why the key elements of Alma Ata Declaration (1978), Commission on Social Determinants of Health (2008) and Universal Health Coverage (2010) which directly or indirectly imply state accountability to the citizens, have disappeared?

"Universal coverage brings the hope of better health and protection from poverty for hundreds of millions of people - especially those in the most vulnerable situations. Universal coverage is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma-Ata declaration in 1978. Achieving the health Millennium Development Goals and the next wave of targets looking beyond 2015 will depend largely on how countries succeed in moving towards universal coverage"(WHO, http://www.who.int/health_financing/universal_coverage_definition/en/)

The rights of communities to access health care as citizens, the accountability of the governments to ensure health care services (keeping in mind the core components of right to health as evolved in General Comment 14 – Availability, Accessibility, Affordability, Quality) and the communities right to participate in shaping the health system do not occur in the core indicators.

By and large, ***the Global Reference List of 100 Core Indicators*** is informative and would be useful for furthering research and to compare health systems. However, being primarily disease oriented with its predominant bio-medical approach, leaves a lot to be desired on the issues of accountability and health rights as far as the communities and their health rights are concerned. WHO has lost an opportunity to make accountability of the state and aspirations of the community for health rights, part of the global core indicators. ■

About the Author

Edward Premdas Pinto is the Global Secretariat Coordinator of COPASAH. As an Advocacy and Research Director at Centre for Health and Social Justice (CHSJ), India, he facilitates the thematic area of social accountability with a special focus on processes of community monitoring 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 and 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

Paving the way for ...

Continued from page 11

government service delivery system. This was jointly agreed upon that DNCs (in conjunction to existing efforts) will create awareness and enable the process of engagement of both government departments and legislative members to donors and CSOs will also provide concrete support to DNCs for effective mobilization and advocacy. The donors showed interest in the replication of PCMC model in Federally Administrated Tribal Area (FATA) for improving primary health care services. In this regard, CESSD will provide a detailed presentation on PCMC mechanics to interested donors and provide documentation support including PCMC Guidebook. ■

About the Authors

Gulbaz Ali Khan is Senior Manager- Governance and Capacity Development, Citizen Engagement for Social Service Delivery (CESSD), Khyber Pakhtunkhwa, Pakistan. He holds a masters degree in Economic Development & Policy Analysis from University of Nottingham, UK. He is a Social Accountability Practitioner in the primary education, basic health and rural drinking water sectors in Pakistan. He is the author of "Pro- Poor Growth: Cross Country Analysis Focusing on South Asia." He conducts trainings, delivers lectures and writes in English newspapers on social accountability, budget analysis and transparency and local governance.

Syed Ishfaq Ur Rehman is a development expert with more than fourteen years of experience in the area of community driven development. He is currently managing project of DFAT (AusAID) for improving service delivery by government institutions as Provincial Program Manager Khyber Pakhtunkhwa.

COPASAH COMMUNICATION CHANNELS

Community of Practitioners on Social Action in Health

facebook

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

Community of Practitioners on Accountability and Social Action in Health

Platform for Sharing		Forum for Dissemination	Resource for Learning
COPASAH BLOG	COPASAH twitter	COPASAH WEB	eLearn Health CBM
www.copasah.wordpress.com	www.copasah.net	www.copasah.net	www.copasah.net/cbm-e-learning-resource.html

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