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COPASAH COMMUNIQUÉ

SHARED PRACTICE. GROUNDED KNOWLEDGE.

South Asia Special Issue

Empowered Community Voices and Social Accountability Practices

EDITORIAL

COPASAH

Source:COPASAH Archive, Tamil Nadu, India

E. PREMDAS PINTO

Social Accountability: A Process Oriented Community Practice

THE accountability discourse is gaining momentum globally. However, the dominant discourse of accountability continues to be instrumentalist in its approach, which sees it as a technical report at the worst or merely as an intervention to improve health sector performance, at best. It is also tagged to efficiency, defined as value for money or getting things done at very low financial inputs. To this end, goals without fundamentally touching the core of accountability are set. The language that couches these goals is largely apolitical in its expression. The goals set in this school of thought range from producing a report or a score card to setting the millennium development (MDG) or sustainable development goals (SDG). When the time-period set is complete, as it happened in the MDGs, question was not asked as to why these goals were not met or what the processes that achieved some of the goals are. It simply, moved to setting another set of goals, i.e. SDGs. Even at a micro level, CSOs which implement projects on community participation tend to follow such trends by developing score cards or technical reports, over and over again.

However, at the core of accountability practice the thrust is on questioning of inequity, inequitable distribution of resources and the skewed power relations which keep citizens or communities perpetually in a state of frustration. It also aims at changing the iniquitous power relations of the

CONTENT

health system with the communities. COPASAH has foregrounded the community centred accountability practice which is process oriented that aims to change the power asymmetry of the community with the health care system. Such processes are aimed at advancing human rights of the marginalized with a broader framework of realizing equity and social justice.

This COPASAH Communiqué highlights the process oriented community practice of social accountability. For practitioners of accountability, as highlighted in these stories of practice, accountability is not a finished product. It is a continuous iterative process of engagement, mobilization, strengthening community's power and their ability to question and change things with multiple contextualized methods and tools, as well generating voice and participation.

ABOUT THE AUTHOR

E. PREMDAS PINTO is the Global Secretariat Coordinator for 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 the communities of Dalit Women, rural unorganized labourers and other disadvantaged communities for the last 22 years.

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GLOBAL SYMPOSIUM HRA 2018

HEALTH RIGHTS AND ACCOUNTABILITY

SAHAJ TEAM

Social Accountability for Adolescents' Rights and Citizenship

This article is an account from a collaborative project 'Adolescents as Citizens and Change Agents for Social Accountability' implemented by three non -government organisations SAHAJ, SWATI and SARTHI in four backward districts of the state of Gujarat, namely, Vadodara, Surendranagar, Mahisagar and Panchmahal, in India. The stories of the adolescent girls and boys in the article give voice to their experiences of participating in the project and what it meant for them.

Nisha – an Adivasi girl from Mahisagar District

I am Nisha Parsing. I am 17 years old. I live in Dotawada Village, Santrampur Taluka, in Mahisagar District. I have passed Class 10. We are seven sisters and one brother. My parents are farmers and daily wage labourers. I was adopted by my maternal uncle in my childhood. My uncle is also a farmer and has two sons. He educated all three of us. Our village is very small. It did not even have a primary school. We had to attend primary and middle school in the adjacent village, Daliyati.

Before the Kishori Group[1] started in our village, we did not get our Take Home Ration, nor iron tablets regularly. The Kishori group was started with just ten girls, with the support of SAHAJ

[1]Kishori group is an Adolescents Girls' group part of SABLA programme. SABLA is a Government of India Programme which aims to improve the nutritional and health status of adolescent girls in the age group of 11-18 years and empower them by providing education in life-skills, health and nutrition. (for more details see: http://wcd.gujarat.gov.in/sabla.html

and regular meetings were conducted in the Anganwadi. SAHAJ organized a leadership training programme for us. After being appointed as a peer leader, I have attended all the training workshops conducted by SAHAJ.

After learning about the ways to calculate Body Mass Index (BMI), I started measuring heights and weights of girls in our group. The Anganwadi worker found it difficult to calculate BMI, so we decided to do it ourselves. Initially there was an argument with the Anganwadi worker when the boys wanted their weights to be taken. She said that boys are not included in the SABLA programme and that the weighing scale would break! But we convinced her about the need to measure BMI to gather the nutritional status of children. It is then she allowed the boys to measure their weights too on a regular basis.

The nurse was not dispensing Iron tablets to us regularly, but after a discussion with her on the need to get the mineral supplements, she began to distribute the tablets regularly. We are ensuring that our Iron (Haemoglobin) levels are checked periodically. We also organised a Kishori Divas (Adolescent Girls' Day) in our Anganwadi.

I feel a lot of change in myself. Initially I used to feel scared to talk to anyone, especially in front of a group. But not anymore. Today, I can present my views in front of a group. I am able to put forth an argument or thought on behalf of my group in the Jan Samwad (Public Dialogue) in Sangawada.

SHEETAL

A Rajput Girl from Surendranagar District

I AM Sheetalba Danubhai Zhala. My brother Dalpat and I live in Mulada. I belong to a Darbar family (Rajputs). I am eighteen years old, soon to be married.

I joined the adolescent group two years back and was elected as peer leader for the girls. My brother was the peer leader in the boys group. My father is very supportive. He encouraged us to attend meetings. Travelling out of our village on my own was initially not possible. My brother would accompany me should there be a need to travel outside our village to meet with health officers or participate in trainings, outside the village. Gradually I gained confidence. While I focused on demanding

services in the Anganwadi for the girls, Dalpat worked on other issues. He filed an RTI application to find out why the provisions from the Public Distribution System (PDS) shops were not reaching the people. Since the time of filing the RTI application one sees improvement in the distribution of the rations, though the food supplies are of poor quality.

Many girls in my village drop out of higher education because the high school is not in the village. Parents are reluctant to send their daughters out of the village. There are no bus services in our village. The private transporters fill in passengers beyond the vehicles' capacity and drive recklessly. There is a lot of 'chheddti' (harassment) along the way, thus forcing parents not to send the girls on their own.

We discussed the challenges faced by girls in accessing transport facilities and problems like lack of higher educational facilities in the village, public safety of girls etc. in one of our initial meetings and Dalpat wrote an application to the Manager of the Surendra Nagar District Bus Depot (Public Transport) The letter was read out to our group and we got signatures to support the demand. Dalpat personally handed the letter to the manager, who accepted it and acknowledged that he did not have the authority to start a bus service to the village and an initiative such as this would need time. We continue to keep the pressure on this demand.

Meanwhile, the girls, supported by the boys, started demanding services in the Anganwadi centre. There were many concerns like the centre not starting on time; girls denied the "Take Home Ration", no health check-ups for girls etc. We continue to engage with the Anganwadi worker first, helping her measure the height and weight of the girls and distribute the 'red tablets'. Some gaps still remained. I highlighted these problems in the Jan Samvad to the Integrated Child Development Services(ICDS)officer. The girls in my group and staff of the NGO appreciated my systematic representation. I am happy to see improvements in the Anganwadi services since then.

My group is strong, as I train three girls to become peer leaders. I do not want a break in our efforts - we still continue to have the challenges of water shortage in the Anganwadi centre and the demand for safer bus services is ongoing effort.

I wish parents of children in my village understand the value of higher education for girls even if it means sending them out of the village to pursue their dream. I want SWATI to continue to empower adolescent girls and organize vocational training aimed at financial independence for women.

Nisha and Sheetal are two of the 100 peer leaders nurtured by a collaborative project 'Adolescents as Citizens and Change Agents for Social Accountability' being implemented by SAHAJ, SWATI and SARTHI in four backward districts of Gujarat, namely, Vadodara, Surendranagar, Mahisagar and Panchmahal.

The goal of the project is to create a model of leadership and citizenship amongst adolescent girls and boys (11 to 18 years) based on gender and rights perspective. The main

activities of the project are to: increase awareness about gender, sexuality, and rights; promote collective action by local groups of girls and boys; and, advocate with stakeholders – like parents, government functionaries, and village leaders - on adolescent rights. The project is anchored on entitlements related to three government programmes – SABLA (adolescent girls' empowerment and nutrition programme implemented through the Anganwadi centres and the Department of Women and Child Development), Adolescent Reproductive and Sexual Health Programmes implemented by the Health Department (ARSH) and Nehru Yuvak Kendra Scheme implemented by the Youth Department (NYKS).

The project is implemented in 20 anganwadi areas each in Surendranagar, Mahisagar and Panchmahals districts. In Vadodara, 20 slums and 10 schools are included as part of the implementation of the project. The project also addresses parents of adolescents and other stakeholders from the villages / slums such as local elected representatives, Anganwadi workers, and Accredited Social Health Activists (ASHAs - local community health workers) to create an informed support system for the adolescents.

Outcomes of Success

A midterm evaluation, commissioned in 2016, shows that the project is extremely relevant for building citizenship and rights awareness among the adolescents. There has been marked increase in awareness among adolescents about their entitlements. Children have reported that the skills imparted during the project period equipped them to claim these entitlements. A key instrument has been the training in filing Right to Information applications. As observed in Hetal's story, the boys and girls wrote RTI applications going beyond the three schemes that the project was focused on. They have successfully mobilised other youth and member of the community to get new school building, improvements in the Anganwadi centres, regular water supply, bus service to their remote villages, computer classes for the youth in the villages and so on.

The project has led to increased self-expression and 'voice' amongst the girls and boys. They have been able to negotiate for their rights and freedom within their families, even in very conservative and patriarchal Rajput families such as that of Hetal. They have represented their collective issues in public fora like the Jan Samvaads (Public Dialogues), and in government offices which are steeped in power and typically regard young people as immature.

The Jan Samvaads (Public Dialogues) were helpful in establishing accountability of the program managers for adolescent related schemes. Continuous and constructive engagement of the adolescents with service providers of the three different departments – and especially with the Anganwadi workers implementing the SABLA programme - has resulted in increased interest and motivation amongst these workers.

Yuva Manch (Youth Platform - federation of the adolescents' groups) at the block and district levels have contributed to the peer leaders' sense of empowerment – the solidarity of belonging to a larger collective has expanded their sense of self. As Yuva Manch members they have extended their demands at the state level questioning why the programmes are not working well in their districts.

One sees the increase in participation of the young people in public affairs.

Vinod Savjibhai of Mahisagar District gives us a glimpse of being a young leader:

All the young boys and elders of my village have - selected me as the head of the Gram Sanjivani Samiti. The Samiti received funds of Rs. 10000 and I have taken the responsibility of utilising the fund for solving the health issues of the village.

I have written an application to the ICDS Department for the construction of a new Anganwadi Centre (AWC). Since the old building is dilapidated now, I made sure that all the adolescent boys and girls are with me on this and everyone readily signed the application.

Belonging to the tribal community, my aim is to get out of the "labourer" and "migrant worker" stereotype. During my computer classes, I grabbed the opportunity of enrolling about 300 adolescent girls and boys from Dahod and Mahisagar in "Digital India" computer literacy program run by the government.

Someone carelessly ended up causing a fire in the jungle which is a part of our village; I gathered all the boys of my group and we doused the fire.

Apart from their public function as citizens, the project has also made an impact on the adolescents – especially on the boys - in their private domains. As Anil Kumar of Jainabad (Surendra Nagar District) states:

Gender equality, masculinity and sexuality were very new concepts for me ... I had a lot of misconceptions about women and men. I thought of women as inferior to men and that they should do all the household chores. And, I should not talk to

girls, not help in household chores, I kept away from such things. ... But after the discussions in our group, I have started respecting women and begun to understand their value. I try to help my mother and sister as much as I can.

Suvar Kaushik Kumar Rameshbhai (Dahod district) explains

When a session on Gender Equality was taken in my group, we became aware about the discrimination amongst boys and girls especially in household chores and what the boys in the group should do to bring about a change. All of us (boys in the group) , decided that we shall help our mothers and sisters in house hold chores by cutting vegetables, filling water, washing clothes etc. Six of us (Suvar Kaushik, Dilip Kumar, Saurabh, Ankit Kumar, Jignesh and Pravin) have already started doing all the three chores regularly in our homes.

Challenges faced

It was very difficult to involve especially the school going adolescents in the community based programme of the project. Many of them work in the fields or look after cattle and have to travel long distance to block or district headquarters where their schools are located. With their- school, work and travel schedules, they were unable to attend the project activities. Initially it was difficult for the girls to get permission from their families to attend the group meetings. It took repeated visits and discussions and building of trust by the NGO field staff before the girls were allowed to participate in the -- project activities. In addition, it was difficult to have a continued intervention with the adolescents due to seasonal migration.

Confrontation is an integral aspect of rights based work. This creates friction between the duty bearers

and the claimants of rights. In few cases, after the Jan Samwad, the peer leaders who presented the findings about non-availability of services in the Anganwadi centre, faced backlash of the concerned health workers. In one case the husband as well as in laws of the Aanganwadi worker threatened the peer leader and warned her about the implications of raising such issues in public fora. There was a strong reluctance amongst the ICDS officers to admit the need for external monitoring of the SABLA scheme. The officials claimed that the internal monitoring mechanisms of ICDS Department were robust enough to identify the areas which need correction.

The poor implementation of NYKS scheme and the ARSH programme resulted in non-response towards peer leaders' efforts to claim entitlements. The NYKS program officials in one district did not respond to the demands of the peer leaders. Non response from the officials disheartened the children as they get frustrated quite easily.

Lessons learnt

The adolescents as a group are effective change makers. The impact of inputs given to this group gets amplified once they acquire the necessary skills and information to claim their rights. However, there is also a need to take a differential approach considering the age group, educational levels, and socio economic and cultural contexts of the children.

The project activities need to be planned in such a way that they do not hamper the studies of the children – acquiring education is their primary function at this stage in their lives.

Where adolescents are central actors in programme implementation, it is necessary that the parents and community members, such as local elected representatives or members of the Village Health and Development Committees are also involved. This lends greater seriousness and credibility to the adolescents' efforts to demand accountability of service providers.

Since adolescents are a vulnerable group, there is a need to undertake additional measures to safeguard them from a backlash faced by them in such endeavours.

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IFTIKHAR UR RAHMAN

A Story of Success of Stakeholder Participation

The Community Uplift Program (CUP), is a NGO registered with the Security and Exchange Commission of Pakistan under Section 42 of the Companies Ordinance 1984. This is a story of the impact of social mobilization through the journey of what began as a pilot project to look at social accountability. The pilot project was funded by DFID in the District of Peshawar where the "Community Score Card (CSC)", a tool designed to look deeper into social accountability to improve healthcare. Today, CUP is implementing a scale-up of a CSC to help improve the primary healthcare services in Charsadda District.

The first step of CSR is social mobilization and engagement of stakeholders. This is story of drawing together people through the skills of social mobilization and involving local elected representatives in problem solving related to healthcare. Take for example, the problem of storing vaccine in cold chain units that faces periodic and long hours of power outage in clod chain units in BHU Akbarabad. The "cold chain" refers to the process used to maintain optimal conditions during the transportation, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the user. Excessive heat or cold exposure can damage vaccines leading to a "cold chain breach".

Due to the strong liaison and mobilization of the CUP Project Field Teams, a local Nazim of Union Council (UC) Dargai, Mr. Sajjad Khattak expressed his concerns on storage of essential drugs and vaccines, and went a step further by allocating funds for the installation of solar panel system at BHU in Akbarabad.

He allocated funds for installation of a solar panel system Today; the cold chain sustainability is secured and has ensured that essential vaccines like OPV are protected from the risk of damage. Furthermore, he also assured his full support to the project teams and its activities.

ABOUT THE AUTHOR

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GUEST ARTICLE

INAYAT SINGH KAKAR

Community Action and Health

Experiences from a tribal mass movement in Madhya Pradesh, India

THIS ARTICLE documents the struggle of Jagrit Adivasi Dalit Sangathan (JADS) a voluntary citizen's group comprising of people belonging to a tribal community based in the central state of Madhya Pradesh in India. JADS has been waging struggle to achieve equality, dignity and non-discrimination; the fundamental principles enshrined in the Indian constitution, in the Barwani district of the state. JADS follows a rights based approach to secure constitutional and legal guarantees to the tribal community and has been active for nearly two decades in the state.

Barwani District is one of the most backward districts in the state of Madhya Pradesh and is situated on the South West corner of the State. The district has a hilly terrain with uneven rainfall and irrigation. According to the 2011 Census, Barwani has among the lowest female literacy in the State. With 85.28% of the district population living in rural areas, agriculture is the main economic activity of the population.

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To highlight the nature of the work and its impact that the rights based work has led to, one incident draws attention to the complex nature of the cultural-political-economic-social and welling lenses that JADS has navigated through in the last two decades persistently.

This was in the year 2008, where a young tribal woman gave birth to a child in the streets of Menimata, Madhya Pradesh after being denied help and medical aid at the Primary Health Centre (PHC). She had made the 15 kilometre journey to the PHC with her family on a bullock cart. The compounder and the nurse at the PHC

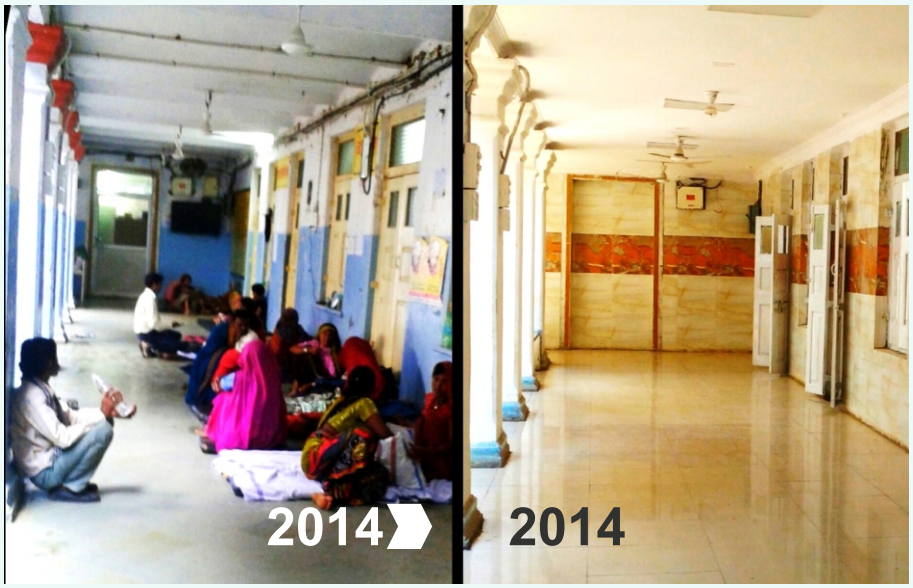
told the family that she would have to be taken to the District Hospital and demanded a bribe of Rs. 100 from the family. The family was unable to pay the amount. The driver of the government ambulance refused to take them saying that it was too costly and the family was told to make their own arrangements. During all this while the young woman was in immense pain. She eventually delivered on the road outside the hospital.

A group of JADS members protested against the unjust treatment of the woman by the PHC staff. The denial of medical care, risking the live of the mother and the unborn child was a violation of the human dignity, and the right to life of both the mother and the chid. This grave violation of health rights was brought to the notice of local authorities. No action was taken against the staff at the PHC while various charges were slapped on the JADS members- section 147 (Punishment for rioting), 332 (Voluntarily causing hurt to deter public servant from his duty), 353 (Assault or criminal force to deter public servant from discharge of his duty) and 427 (Mischief causing damage to the amount of fifty rupees). This travesty of justice saw the birth of a woman lead campaign demanding their

voices heard. The case was documented in civil society reports and also led to a petition before the MP High Court to investigate maternal deaths in the Barwani District Hospital. The campaign demanded improvement in healthcare, particularly maternal healthcare, services being provided in the District. It also demanded for the false charges against JADS members to be dropped unconditionally.The police showed a complete disregard to investigation. They took statements only from the PHC staff and did not care to speak with the young woman or her family members. On the basis of this one sided account, they arrested the young woman's husband who was not even present at the time of the incident. The law enforcement agency abdicated its responsibilities of ensuring justice is prevailed and the rights of individuals are honoured. This followed a public outcry with demonstrations, public rallies, protests and litigation to restore the abysmal condition of public health services. The agitation went further to demand adequate maternal health care for tribal women.

JADS has demanded execution of tribal rights under the government schemes that impact the social determinants of health (conditions of daily life, employment, economic policies, social norms, social policies and political systems). For example, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), in which half of the beneficiaries is women, guarantees minimum wages and 100 days of employment to every

household. It focuses on reducing migration by developing villages to be self-sustaining by creating village level assets through water harvesting, water conservation, land development and road construction. Furthermore schemes such as the Public Distribution System (PDS), Integrated Child Development Scheme (ICDS), Old Age Pension and Panchayati Raj Act are essential schemes meant to create an equitable balance of protecting communities from the risks of poverty, hunger and unemployment. JADS



The Mahila Ward, Barwani District Hospital has upgraded infrastructure to accommodate the patient load.

continues to actively fight against mining, land acquisition, deforestation and corruption in the area. The health impacts of these are significant higher risk of respiratory tract infections, displacement from land, loss of livelihood, loss of forest cover and its bearing on population's nutritional status and adverse impact on the environment. JADS has exposed local mining, liquor and timber mafias, and embezzlement of public money by people in power in the District.

JADS undertakes awareness programs to mobilise people against the injustices meted out to them. Through community monitoring they keep a check on the functioning of government schemes and track the spending of public money. They routinely petition Courts and local government functionaries to take action against violations of human rights. Taking the aid of legal recourse is a sure way of securing the constitutional guarantees of the communities.. The struggle is mostly to demand transparency, accountability, preservation of fundamental rights under the Indian constitution and universal human rights from the custodians of law and the government. The members and local leaders have been bogged down by a mire of troubles- they are threatened, bullied and attacked, and many a times slapped with legal notices. Fighting legal battles to claim their innocence is a fight for justice that is often endless and excruciatingly painful and slow. The only beacon of hope lies in the coming together and further strengthening of people's movements of solidarity, civil society engagement and a galvanized union who champion the causes of the tribal people in the country.

ABOUT THE AUTHOR

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COPASAH ORGANISATIONAL DEVELOPMENT

COPASAH is currently undergoing an Organizational Development (OD) exercise. The overall objective of this OD exercise is to provide COPASAH with an externally facilitated process that will help in developing a vision for the future and to suggest a suitable organizational structure, mechanisms and processes for realizing the vision.

MAQBOOL AHMAD

The Abysmal State of Public Health Service Delivery in Punjab (Pakistan)

Health plays a fundamental role in determining the quality of human capital. The health and economic progress of a nation are interdependent as it is the health of its people that has a direct bearing on the productive qualities of labor force, thus contributing to the economic progress of a country and its people. Unfortunately, this has not been the case with most third world countries as the fiscal spending on health and the desired budget to improve health facilities is far less and wanting. As a result, people living in such countries suffer from neglected health concerns that bare a direct consequence to human resource capital of the countries. The public health sector in Pakistan, like other South Asian countries is suffering from this malady. Government neglect can be seen in poor allocation of resources for strengthening the health capital of its country and corruption in public services has contributed to the failure in public health service delivery.

The public health service delivery system in Punjab of Pakistan as in rest of the provinces is in crisis. It lacks quantity as well as quality. The health care system is unattended to the socio-economic transformations, shifting demographics and changing disease patterns. The public health service in Punjab has failed to fulfill the demands of quality health care as a result of absence of delivery mechanisms. Government neglect of the public health service delivery, rampant corruption, low clinical care quality and unwillingness of doctors to serve in far-flung districts have caused major blows to the health care system. Several rural health centers have been closed due to the non-availability of doctors. The provincial government has failed to solve the concerns raised by young

doctors who have resorted to strike from work, as a tool to force the government to pay heed to their demands. The young doctors demand special pay packages and service structure equal to the bureaucrats.

The recent strike by the drug manufacturers and chemists organized by drug manufacturers associations outside the Punjab Assembly resisting the new act and to continue with the old practices is an evidence of the failure of health governance system in Punjab. The drug manufacturers and chemists were resisting the government's imposition of Punjab Drug Act, 2017[1]. The Government has failed to curb the supply of spurious drugs in the market. In fact most of the drug manufacturing companies are hand in glove with the provincial legislators and bureaucracy. This has led to increase distrust in the public health service delivery system among the masses. The private health care sector too has mushroomed making health care expensive for families thus taking a severe toll on families' income. The lack of accountability on the part of employees of the health sector employees is a reason of the desolation of the public health care system in Punjab. A point in case is the recent event that came to light of the sale of low quality stunts at the Mayo Hospital in Lahore is a proof of the failure of government to nab these merchants of death.

Most public health service delivery units and hospitals run out of stock of essential life saving drugs. There is an ineffective mechanism of supply chain management and as a result, most of the drugs meant for public health care units end up in private clinics. In addition, there are also issues of storage capacities for medicines in the public sector hospitals. Most of the districts in South Punjab lack the state of the art medical stores with better and bigger storage capacities. The government has failed to conduct a periodic review of the Essential Drugs List since 1998. The drug Regulatory system in Punjab is unable to implement quality guidelines because of lack of skills in health care administration, inadequate staff, failure to implement existing laws and lack of proper equipments.

The government should take immediate steps to stall the degeneration of public health service delivery in Punjab through the implementation of Punjab Drugs Regulatory Act, solving the concerns that young doctors have through the process of dialogue and engagement, increasing health budget spending and affordable universal health insurance. Only through a robust public health service delivery mechanism, can the government ensure a productive human resource capital that is essential for economic progress.

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[1]The prime object of the proposed amendments in the Act is to plug the loopholes in the existing provisions of the law and to enhance the punishments for the persons involved in the offences relating to spurious and substandard drugs.

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Source: COPASAH Archives (Latin America)

COPASAH SECRETARIAT AND THEMATIC HUB ANCHORS

Strengthening of Accountability Practice and Influencing Policy Formulation and Implementation through Thematic Hubs

Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a global network of social accountability practitioners in the global south, engaged closely both with the disadvantaged communities as well as in the policy discourse. The goal of COPASAH is to synergise and bring community (civil society) voice at the national as well as global level through the practice of citizen led social accountability practice and knowledge generation.(For more details please see www.copasah.net)

Why Thematic Hubs?

COPASAH has continually engaged in a dialogue with the COPASAH community, undertaken systematic internal reviews and sought critical reflections from Steering Committee (SC) and from close group of academicians and accountability experts to look for future pathways and directions in strengthening social accountability practices. In 2016 such deep deliberations and introspection were steered, along with seeking the COPASAH community opinion on COPASAH's future directions and it discerned from these reflections that the COPASAH group should strive to intensify accountability practice through thematic hubs to include multiple stake-holders also to bring in variety of accountability practitioners on board. It came out from the discussions that so far COPASAH's activities were related to the general practice of social accountability in health and were organized around regional secretariat. The idea of thematic hubs has also emerged as policy making now is virtually thematic and within each theme it is again verticalised or thematised and hence requires a thematic approach. Since policy making is primarily thematic, globally and regionally, this way is thus envisaged for COPASAH to become more policy relevant in the global space on issues which the communities are already engaging with.

Following the discussions three thematic hubs were envisioned in COPASAH for strategic alliance building for advocacy, deepening accountability practice and knowledge building. The three hubs are Reproductive and Maternal Health Rights and Accountability hub; Indigenous People's Rights and Accountability hub and Patient Rights and Private Medical Sector Accountability hub. Anchored by key thematic experts, the three hubs have been rolled out since January, 2017. The Reproductive and Maternal Health Rights and Accountability hub is led by COPASAH Convener and CHSJ (India) director, Dr. Abhijit Das. The key responsibility of anchoring the Patient Rights and Private Medical Sector Accountability hub has been taken on by COPASAH SC member Dr. Abhay Shukla from SATHI (India) along with experts from his organization. The Indigenous People's Rights and Accountability hub is anchored by COPASAH SC member and director of CEGSS (Guatemala), Dr. Walter Flores.

Through the thematic hubs, COPASAH strives to field building for intensified focus on issues that concern citizen lives, through thematic consultations with various stake holders (primarily the community leaders), capacity building of practitioners and accountability advocates. The thematic hubs aim to create a policy and knowledge agenda, for participatory evidence building, and build alliances for influencing policy processes and actors.

Introducing the three COPASAH Thematic Hubs

The Need to Stimulate Community Action and Accountability in Reproductive Health Governance- **Dr. Sana Contactor and Dr. Abhijit Das**

Maternal Health and subsequently Family Planning have emerged as important agendas of global health programming over the past two decades. In the years leading to the Millennium Development Goals(MDGs), reduction of Maternal Death became a key indicator of improvements both of population level health as well as health systems. Multiple systems for promoting safe childbirth, as well as monitoring progress were established through mechanisms like the Partnership on Maternal Neonatal and Child Health (PMNCH)

headquartered in WHO, Maternal Health Task force headquartered in Harvard University, the Countdown to 2015, the WHO Commission on Information and Accountability (CoIA) on Women and Children's Health and the UN sponsored movement Every woman Every child. Similarly, access to contraception has received a boost through the Family Planning 2020 partnership which aims to expand access to family planning information, services, and supplies to an additional 120 million women and girls in 69 of the world's poorest countries by 2020. In the SDG paradigm maternal health has lost its primacy but remains an important target along with family planning, within the Goal 3 on health and well-being.

As in the case of the MDGs, in the SDGs and FP2020 as well, the approach is based on the Government partnering with International agencies, philanthropies, business and large social service NGOs to improve delivery of services. A large number of international agencies, bilateral donors and private philanthropies are providing funds and other support to governments to achieve the set targets. Many INGOs, Universities and in-country organizations are involved in a multitude of activities to bring about changes. The idea of accountability has been accepted, within the overall framework of evidence-based practice, and the need for data for monitoring progress is acknowledged. However the importance of involving the citizens or the communities who experience the services is still not universally seen as important. There is much greater emphasis on 'fixing' the inputs – e.g. human resources and technological options and so on. The idea of involving citizens as the main stakeholders of this process is not being considered and consequently, the thrust on community engagement and ownership is not well articulated. The role of communities is seen as passive recipients and beneficiaries. However if the SDGs have to reach the last mile and include the most marginalized, this approach which appears mostly based on a concept of 'stewardship' may not

be enough. A more comprehensive approach to development must not ignore the stake that communities themselves have in the designing, delivery and monitoring of health programs.

COPASAH's Maternal and Reproductive Health Hub looks to fill this gap by engaging more vigorously in promoting the practice of social accountability in the field of reproductive health in different ways. It will do this through stimulating a conversation around the role of communities in reproductive health governance, especially around issues of autonomy and self-determination which are central to human rights and participation in governance which is essential to sustainability. A core group of experts and practitioners from across the globe have been identified to be a part of this hub, who will collectively strengthen this discourse through writing articles, conducting research and participating in global platforms to establish this agenda. We also look forward to the members of COPASAH to enrich the discussions by sharing their practices around engaging communities' key stakeholders and active participants in the planning, monitoring and delivery of key services.

Patients' Rights and Private Medical Sector Accountability- Dr. Abhay Shukla and Dr. Arun Gadre

Large numbers of patients in most developing countries today access care in the private healthcare sector. For example, overwhelming majority (60-80%) of patients in South Asia (SA) today seek care from private providers. In India every year 35 million people are pushed below poverty line, due to out of pocket expenses incurred on accessing healthcare in the private sector. The situation is not very different in other South Asian countries like Pakistan, Nepal and Bangladesh, though the exception is Sri Lanka, which has a predominance of public health services. The proportion of patients accessing private health care is also significant in many other regions of the globe, such as South East Asia, Africa and Latin America.

The private health care sector is often unaccountable and poorly regulated, and driven by commercial pressures to maximize profits; it may be involved in various malpractices and exploitation of patients. State supported or commercial insurance, where applicable, may not always adequately deal with these issues. Patients' rights are likely to be frequently violated within private

hospitals. A patient's basic rights to information, emergency medical care, access to all reports and records, dignity and freedom from discrimination, privacy and confidentiality, freedom to seek second opinion, and transparency regarding rates and costs of care may not be protected in many situations.

Given this context the COPASAH thematic hub – "Patients' Rights and Private Medical Sector Accountability" would strive to build a policy discourse and networks related to private health sector regulation and patient's rights, with a focus on South Asia, though having relevance for low and middle income countries across the world. SATHI, a Health rights organization based in Pune, India will anchor this thematic hub. The thematic hub will work through organizing global thematic webinars, networking and alliance building in South Asia, regional consultations, and capacity building of key activists. The thematic hub will engage in relevant knowledge generation through publication of papers and policy briefs. It is expected that this hub will orient and galvanise health activists and civil society members, enabling them to raise key issues related to the private healthcare sector, in the spirit of accountability and rights.

Indigenous People's Rights and Accountability- Dr. Walter Flores

Indigenous people around the world suffer historical exclusion, exploitation and socio-economic inequalities. In Latin American, the largest number of extreme poverty and health and educational deficits are concentrated in indigenous populations of Guatemala, Perú, Colombia, Bolivia and Ecuador. Indigenous people are also dispossessed and evicted from their territories. The history of exclusion and dispossession of indigenous populations observed in many low and middle income countries is also present in rich countries-The situation of aboriginal population in Canada, USA and Australia is quite appalling. The

key issue regarding health accountability is the lack of equitable health system, allocation of resources and equitable health services supported by required resources to meet the health needs of the indigenous communities in a way that is relevant and appropriate for them indifferent socio-cultural settings.

This thematic hub will focus on the specific health related issues affecting indigenous populations in different regions of the world. Through this thematic hub, it is aimed to expand and adapt the strategic approaches and tools that have recently been developed in the accountability field, to the specific demands in health, education and other key public services, as put forward by indigenous populations. The hub also aims to develop new conceptual frameworks, develop case studies and enhancing the skills and knowledge of organizations who will be members of the thematic hub. It also aims to establish an active collaboration between practitioners working with indigenous populations in different parts of the world. Many organizations in México, Guatemala, Ecuador, Perú and Brazil have shown interest towards this thematic hub.

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