Community of Practitioners on Accountability and Social Action in Health

NEWSLETTER Issue 1, December 2012

Inside this Issue

What is COPASAH

COPASAH is a community of practitioners who share a common interest and passion for the field of community monitoring for accountability in health. This community of practitioners was established as a result of a three day 'Practitioners Convening on Community Monitoring for Accountability in Health' organised by the Accountability and Monitoring in Health Initiative (AMHI) of the Open Society's Public Health Programme in July 2011 in Johannesburg, South Africa. The practitioners interact regularly and engage in exchanging experiences, dissemination of conceptual and methodological outputs, networking and capacity building among member organisations.

COPASAH has members from Africa, South Asia and Latin America. It is currently led by a steering committee of eight members with at least two representatives from each region. COPASAH is supported by the Accountability and Monitoring Health Initiative (AMHI) of the Open Society Foundation.

The mission of COPASAH is to nurture, strengthen and promote collective knowledge, build skills and capacities of community based organisations and health activists, for promoting active citizenship to make health systems responsive, equitable and people-centered.

COPASAH believes that community monitoring in health must empower communities facing inequities to assert their rights and actively participate in bringing about changes in health services and equitable distribution of resources; provide voice to people's perspectives; advocate to influence or change health policies and programmes.

The main strategies adopted by COPASAH are:

- Nurturing the community of practitioners through exchange of ideas, experiences and resources.
- Building strategic alliances and collaborations.
- Creating opportunities for interaction between practitioners.
- Building the knowledge base and production of appropriate conceptual and operational material.
- Facilitating the systematic exchange of knowledge and practices.

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From the Editors desk

The process of bringing out a Newsletter which covers concerns from across three continents as large and diverse as Asia, Africa and Latin America, does contain its fair share of challenges and excitement. So it is with this first edition of the COPASAH Newsletter. In this issue we have mainly focused on sharing case stories from the three regions, articles on exchange visits to two countries engaged in different forms of community monitoring, recent work of some organisations, event reports, other announcements and profiles of organization and steering committee members of COPASAH. The purpose of the newsletter remains essentially to share experiences, inform and learn from each other, and also, to focus on different regions and what they bring to this community.

Editors

Creating Accountability Mechanisms for Maternal Health in India

Recent reports of health system failures resulting in avoidable deaths, especially among those from socially marginalised groups bring home the issue of absence of community demand for services within the health systems.

Introduction

The latest figures show that around 60,000 women die from pregnancy and childbirth in India every year (RGI 2011). Despite the declining trend in maternal mortality ratio over the past few years, with a maternal mortality ratio of 212 per 100,000 in 2004-06, India fell short of achieving the MDG target of MMR below 200 by 2007. Those who survive childbirth but are left with disabling health problems or have suffered the loss of their offspring, are not even counted, policies and programmes pay scant attention to maternal morbidity and perinatal mortality.

The National Rural Health Mission (NRHM) launched in 2005 is India's response to meet the MDG challenges for health. Recent reports of health system failures resulting in avoidable deaths, especially among those from socially marginalised groups bring home the issue of absence of community demand for services within the health systems. NRHM has created spaces for community involvement and significant civil society participation in health development at various levels. In addition, National Guidelines have recently been issued mandating maternal death reviews at the district level in order to bring about systemic changes to improve maternal health care.

It is within this context that SAHAJ (Society for Health Alternatives) envisaged a process of community monitoring in the three year project titled 'Enabling Community Action for Promoting Accountability for Maternal Health.' The project aims at increasing accountability of the health systems and the community in order to improve quality of maternal health, increasing access to health entitlements and counting all maternal deaths.

The whole framework of community monitoring aims at placing various groups such as community members, panchayat representatives, VHSCs (Village Health and Sanitation Committees), community based organisations and NGOs working with communities at the centre stage, allowing them to actively and regularly monitor the progress of NRHM interventions in the area.

The specific objectives that this action project seeks to fulfil are:

1. To enable communities to monitor access to and quality of maternal health care through use of 'safe delivery' indicators.
2. To equip communities with skills to identify and report pregnancy related deaths and perinatal deaths.
3. To build capacity of NRHM accountability mechanisms and other community based organizations to examine the social, economic and gender factors underlying maternal deaths which need to be addressed.
4. To advocate with stakeholders in the health system to facilitate community monitoring of maternal health care and community participation in Maternal Death Reviews.

SAHAJ has collaborated with two partners - Tribhuvandas Foundation and ANANDI - to implement the project in Gujarat covering 32 villages of Anklav and 40 villages of Umreth block in Anand district and 40 villages each in Devgarh Baria block in Dahod district and Gogamba block in Panchmahal district.

Our actions through this project are aimed at creating pressure from below for ensuring account-ability for maternal and perinatal survival and well-being. The project is envisioned as an experiment in enabling NRHM accountability mechanisms that can be scaled up to other districts and states.

The key to desired health outcomes is to voice the felt need of the women. Gilson and Erasmus 2006 observed that an underlying issue is whether committees really are a response to a felt local need, or more a need to comply with policy directives on community participation that are enforced from above, often from outside the country. Zakus argues that community participation in the module programme in Mexico was implemented for its utility in supplying resources, rather than for democratic or intrinsic purposes, leading to major flaws in the participatory process and unimpressive health outcomes. [1]

Keeping these experiences in view, the present project which started in April 2012 has provided community women an opportunity to paint their own picture about desired quality of health care and participate in the community monitoring process that is not imposed from above. There are several success stories of different community monitoring mechanisms. One of them is to train VHSC members – a study conducted in Mayurbanj district of Orissa highlights the positive maternal health outcomes in this district due to VHSC monitoring. [2]

However, who will voice the health concerns of women in those areas where trained VHSC members are dysfunctional due to political or other reasons? In the present project, the core objective is to provide skills to women and give them the reins for monitoring quality of health services and health entitlements.

Steps towards building the environment for community participation

A. Developing skills

Two training programmes for the project teams (Field level and supervisory level) working in the three organisations were conducted. The first training on Accountability for Maternal Health was held in March 2012 and the second one was held in August 2012. The training entailed production of learning material in Gujarati so that NGO staff members could learn technical aspects of maternal health and maternal death reviews and in turn, train local village health workers. One of the other outcomes in process is the development of simplified training modules on Accountability for Maternal Health from a Gender and Rights Perspective, for community leaders.

Safe Delivery - Perceptions of women in Anand district

1. Caesarian and blood transfusion facilities at government hospitals was prime need for women.
2. Easy access without any extra payments at private hospitals was mostly expected by Chiranjivi Yojna beneficiaries.
3. Kind and caring behavior of health care personnel was also near top priority.

B. Developing tools by women, for the women and administered by the women

Community level discussions on Women's Perceptions of Safe Delivery:

Six group discussions were held in Anand (three in Umreth and three in Anklav) and six in Panchmahals (two in Gogamba) and Dahod (four in Baria) with an average participation of about 10 -15 women in each group to elicit their ideas of 'Safe Delivery'. A second exercise was undertaken to validate and rank these ideas. The boxes show what the women in Anand and Panchmahal- Dahod stated about what they wanted as safe deliveries. Some of the outputs from these discussions are:

- ***A poster***: Capturing the perspectives of community women, to be used to orient community members to the concept of safe delivery and lead to a discussion on maternal health.

- ***A tool for monitoring quality of deliveries:*** The context in the two areas is very different. Panchmahal and Dahod with its lower literacy levels required a pictorial tool. The ANANDI team helped evolve the pictorial tool. About 14 meetings with dais, health workers, project partners and technical consultants were held to design the pictorial tool. The tool is being filled for every pregnant woman in the project villages, once in the 8th month of pregnancy and then between 10 and 20 days after the delivery.

Developing tool for conducting Maternal Death Reviews

The partner teams worked on developing a tool and guidelines on how community representatives could do 'Social Autopsies' (the social and gender related factors that result in maternal deaths) that can complement the MDRs done by the health system. The tool is being field tested and would be finalised by December, 2012. Reporting of deaths of all women would be done from multiple sources in the project villages.

Safe Delivery– Perceptions of women in Panchmahal and Dahod districts

1. Majority of the women gave highest priority (in terms of order) to a civil hospital with a woman gynaecologist and equipped with bed, clean mattress, sheets, pillow, mosquito net, clean bathroom, medicines, 108 ambulance service, delivery room, nutritious meal, blood transfusion facility, incubator for new born babies and accessible drinking water.
2. The second in order was the need to have Mamta Divas regularly during which Hb test should be done and the reading should be disclosed to the women along with information about the desired level of Hb that women should have. Also, weight, TT, abdominal check-up, urine test, registration of pregnant women, Blood Pressure and complete details should be filled up in the Mamta card. They also said that fresh breakfast should be given to them.
3. For home deliveries (high number in these districts) – women said they should get nutritious diet, water and safe (clean and with privacy) bathing place. ASHA, Nurse and Dai should visit women after delivery.
4. For immunization, it would be good if nurse visits each falia in a mobile van.
5. It would be good if the TBA accompanied them to the hospital.
6. Shanti (mental peace/harmony) at home.
7. Sub centre should be near the house with a Dai and Nurse. The centre should have a bed, sheet, pillow, plastic sheet for the bed, curtain for privacy, light, water, generator, facility for heating water, clean clothes for woman who has come for delivery, clean cloth for cleaning the new born and a clean cloth for wrapping it up.

The mechanism of accountability will also follow an evolutionary curve where a time will come when pregnant women themselves would fill the tool and monitor their pregnancies and quality of care.

Organisational team members would then visit to establish whether this was a maternal death or not. If it was a maternal death, local trained teams would visit to do the Social Autopsy and also present the result to the Block Health Officer.

C. *Training local committee members* :

CBO members, members of the VHSC, would be trained to administer the maternal health quality tool. Completed tools would be compiled into a block level report card and form the basis of dialogue with the Block Health Officer and his/her team members and also with the District Health Officer We are hoping to produce the first report card in January 2013 and subsequently every six months.

D. *Orientation Meetings in the Community* :

To orient the village level workers /sangathan workers about the project and for testing the tool, three meetings were held in Anklav and three in Umreth. Similarly, orientation meetings were held in 15 villages of Devgarh Baria and 14 of Gogambha.

E. *Training the users:*

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Challenges ahead

We realize that we have prepared ground for activating the monitoring mechanisms as described in the specific objectives above but are unsure of the forms the community monitoring process might take in future. Local contexts, including the abilities of project partners, external influences, attitude of stakeholders and most importantly the political climate in the health system will determine the success of this pilot project.

Authors: Sunanda Ganju, Renu Khanna- SAHAJ, Vadodara

To know more about the work of SAHAJ, please CLICK HERE

[1] *Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework*

Sassy Molyneux,1,2* Martin Atela,3 Vibian Angwenyi1 and Catherine Goodman1,4 1Kenya Medical Research Institute/Wellcome Trust Research Programme, Kilifi, Kenya, 2Centre for Tropical Medicine, University of Oxford,Oxford, UK, 3Cambridge University, Cambridge, UK, 4Kenya Medical Research Institute/Wellcome Trust Research Programme,Nairobi, Kenya and 5London School of Hygiene & Tropical Medicine, London, UK

*Corresponding author. Kenya Medical Research Institute/Wellcome Trust Research Programme, P.O. Box 230, Kilifi, Kenya.

[2] *Does Community Monitoring Improve Delivery of Maternal Health Services?* –Examining the Role of VHSC in Mayurbanj District ,Orissa – Society for Development Action , Centre for Health and Social Justice. Article from 'Reaching the Unreached' – Rapid Assessment of Health Programmes Implementation in India – CHSJ, 2009

Communities bring positive change in health service delivery in Uganda

"We are happy to have the community involved in providing the direction for service delivery", remarked the District Health Officer of Oyam district in Northern Uganda. This was during a dissemination meeting for community score card results of the Open Society supported project on improving transparency and accountability in health service delivery in Uganda. Such reactions have been echoed in the other areas where the community monitoring exercise has taken place.

Prior to the inception of the project, the workload at target health centres was not commensurate to the number of health workers, the attitude of health workers was poor affecting their relationship with the patients and negatively impacting on utilisation and overall status of health, especially maternal health.

The project that is implemented by the Uganda National Health Users'/Consumers' Organisation (UNHCO) upholds the Human Rights principal of Inclusion and Participation through the use of the Community Score Card as a social accountability tool. The tool was applied in the project areas of Kiyumba county and Mukungwe sub-county in Masaka district; and Loro and Acaba sub-counties in Oyam district. Prior to the inception of the project, the workload at target health centres was not commensurate to the number of health workers, the attitude of health workers was poor affecting their relationship with the patients and negatively impacting on utilisation and overall status of health, especially maternal health. A small number of individuals knew of the existence of the management committee of the health centres, medicines' stock-out periods were longer and often frustrated not only the patients but also the health workers. Apart from seeking the services, the communities did not know that they were stakeholders in determining the healthcare that meets their needs.

With the application of the community scorecard, interventions have been either influenced or directly effected by the community members and/or community monitors – the target communities are now more empowered with knowledge and skills on health rights and responsibilities, their entitlements at each level of health care service delivery, and are able to engage duty bearers at sub-county and district levels regarding the quality of services at their respective service points. The community is also energised for participation and ownership of services with specific focus on financial resources and other inputs including medicines and supplies and human resources available, demanding answers and seeing themselves as part of the solution to the problem. Specifically, the communities have influenced the provision of electricity, water and a dental clinic at Mukungwe Health Centre, and construction of staff quarters at the Agulurude Health Centre. The communities, represented by the community monitoring teams, have also been provided with a platform to share community views regarding service delivery with the district councils.

Working with the Health Ministry, UNHCO has shared its model for applying the community-score-card with the Quality Assurance Department and will be working to influence institutionalisation within the health sector framework.

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Author: Robinah Kaitiritimba is the Executive Director of the Uganda National Health Consumers' Organization in Kampala.

To know more about the work of UNHCO, please CLICK HERE

Report of the Satellite Session at the Second Global Symposium on Health Systems Research, Beijing, China

To know more about the Satellite Session, please go to http://www.copasah.net/sattelite-session--second-global-symposium-for-health-systems-research.html

Community Monitoring provided valuable data on the quality of services and the issues in Maternal Health from the users' perspectives. Knowledge based on peoples' lived realities and gathered by the 'people' is as important as the 'objective' evidence generated by researchers.

The session was attended by around 55 persons against the initial expected participation of 35 persons who had pre-registered.

COPASAH Steering Committee members present were: Abhay Shukla (Support for Advocacy and Training to Health Initiatives (SATHI), India); Abhijit Das (Centre for Health and Social Justice (CHSJ), India), Ariel Frisancho Arroyo (CARE, Peru); Barbara Kaim (Training and Research Support Centre (TARSC), Zimbabwe); Renu Khanna (SAHAJ, India); Robinah Kaitiritimba (National Health Users/Consumers Organization (UNHCO), Uganda) and Walter Flores (Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (CEGSS), Guatemala). Vinay Viswanatha (Accountability and Monitoring in Health Initiative (AMHI), USA) was not able to travel due to Hurricane Sandy that disrupted the normal life in New York. In keeping with the ethos of COPASAH, the organisers changed the seating arrangements from the formal classroom setting, to an arrangement of chairs in two semi circles.

After a brief welcome by Walter Flores, Barbara Kaim facilitated an introduction of the participants through a sociogram exercise. This exercise revealed that there was, by and large, a gender balance in the participants. They came from South Asia (including China), Africa, Latin America, a few from Europe and North America. Most were academics/ researchers, followed by NGO representatives, one who identified as a donor/government representative, and two from media. Participants seemed to appreciate this interactive method of introductions.

Abhijit Das initiated the substantive part of the session with a brief presentation on community monitoring. Using the example of the maternal health programme in India, with its emphasis on increasing institutional deliveries, Abhijit built a case for community monitoring. He argued that the Government of India's method of monitoring the programme through the volume and numbers of recipients of the Janani Suraksha Yojna – the conditional cash transfers for institutional deliveries – gave an incomplete picture of the quality of institutional deliveries. Community Monitoring, on the other hand, provided valuable data on the quality of services and the issues in maternal health from the users' perspectives. From the Health Systems Research perspective, Abhijit brought in the issue of what kinds of knowledge and evidence are privileged – he emphasised that knowledge based on peoples' lived realities and gathered by the 'people' is as important as the 'objective' evidence generated by researchers.

This was followed by a panel discussion on Experiences of Community Monitoring from India, Uganda and Peru. Abhay Shukla, Robinah and Ariel were the panellists and Renu facilitated the panel discussion. A six minute video film on Community Monitoring in Maharashtra set the stage for the issues that ranged from a description of the context within which these three organisations situated their community monitoring work, the capacity building and other processes, the methods and tools used, the challenges faced and the lessons learned. The discussion sharply brought out that the community monitoring models implemented by these organisations were characterised by:

- A focus on marginalised sections of society, enabling them to demand for their health rights by informing them of their entitlements
- Attempting to create mechanisms and processes for dialogue between community representatives and the health system at all levels – the village, PHC, secondary care level, province/district, state, national.
- Continuous cycles of essential steps like systematic data gathering and analysis, compilation into some kind of report cards that are used for dialogue with health systems personnel, redressal and corrective action.

After 45 minutes of the panel discussion, the session was thrown open for questions and comments by the audience. The next 75 minutes brought in rich perspectives from the floor through five rounds of questions/ comments. A sample of these is as follows:

- Is democratic context a precondition for community monitoring? What are some of the other preconditions, if any?
- What can be the role of academics and researchers in the efforts for community monitoring?
- How can sustainability of community monitoring be ensured?
- How are private providers brought into the realm of community monitoring?
- How do you balance expectations from the community?
- You described community monitoring at local levels – what is the relationship with international accountability mechanisms for human rights?
- How do you inject this evidence into global forums?
- What are the implications of bringing together health workers with community representatives? How do power relations play out?
- How can less literate, marginal members of even marginalised communities participate in community monitoring? People living with disabilities, the survivors of mental diagnosis, and survivors of violence.
- You described community monitoring efforts for health services? How can we make community monitoring multi sectoral?

Since there were many in the audience from the research community, a long discussion ensued on the role of academics in making a paradigm shift to transforming what can be defined as measures of success for such efforts. Academics and researchers could play a very valuable role in documenting community monitoring experiments, in including them as a legitimate form of health systems research in their teaching as well as research efforts. The role of peer reviewed journals was mentioned – how could this kind of literature be published in the Lancet, for instance? This would then increase its legitimacy.

The rich and animated discussion that ensued after the panel discussion resulted in the organisers' changing the original plan of the session – instead of the World Cafe format on important issues (context, principles and approaches, tools and methods), open discussion was allowed to go on.

The last 30 minutes were spent on an introduction to COPASAH- its genesis, vision and mission, activities and resources including the website (www.copasah.net). The brochure/flier was distributed along with the Community Monitoring in Maharashtra pamphlet. The website could not be shown unfortunately because of a lack of connection to the website. Participants were also told about presentations by COPASAH Steering Committee members at the symposium.

The feedback from participants was very appreciative.

Richard Horton stated "This will probably be the most relevant session of the entire symposium",

Maitrayee Mukhopadhyay stated "This session was really inspiring".

Bjorn Palsdottir asked "How can we forge links between what we do in the Training for Health Equity Network and the Community Monitoring practitioners?"

Academics and researchers could play a very valuable role in documenting community monitoring experiments, in including them as a legitimate form of health systems research in their teaching as well as research efforts.

This and other sessions are available at the HSR website at http://www.hsr-symposium.org/index.php/programme-/plenary-webcasts

Author: Renu Khanna is a Steering Committee member of COPASAH and Founder Trustee, SAHAJ, Vadodara, India.

My Health My Voice, India

Mera Swasthya Meri Awaaz (My Health My Voice)

An Initiative to map informal fees in government health facilities

The project strengthens the monitoring work already being done and is being used to hold the government accountable. Since its launch in January 2012, there have been over 700 complaints recorded. The data generated has been used to advocate with health officials at the district and sub district levels to stop the practice of informal fees.

Although maternal mortality has declined in India in recent years, the rate of maternal deaths remains unacceptably high in many parts of the country. The Government of India has made efforts to protect and fulfill the right to health of its citizens and improve access to maternal health services. According to policy, most maternal health services in public health facilities are free for women in India, especially if they are from states that have high maternal mortality such as Uttar Pradesh.

Yet, throughout the country, women who approach government health facilities are charged informal fees for products and services meant to be free of charge. This puts an incredible burden on poor women and their families and acts as a barrier to accessing services. The problem is rampant and does not seem to be improving with the established accountability mechanisms currently built into the health system. Citizen groups throughout India are engaged in processes and direct actions to improve maternal health and to hold their government accountable. In Uttar Pradesh, SAHAYOG and its partners have been working with a grassroots women's organisation of over 11,000 marginalised women across 10 districts of Uttar Pradesh (called the Women's Health Rights Forum or MSAM) to engage in citizen monitoring of the provisions by the National Rural Health Mission (NRHM, 2005-2012). By providing information on entitlements and capacity building on systematic monitoring, the MSAM has provided feedback to the health department officials on the poor implementation of various schemes. While informal fees for access to maternal health care has been highlighted during these monitoring sessions, these groups have not had the technology needed to generate the compelling visual representation of this practice that is needed to hold their government accountable. Further fearing a backlash, these groups have not been able to indicate the actual health institutions where they were compelled to make these out-of-pocket payments.

The Mera Swasthya Meri Aawaz or My Health My Voice project was implemented by SAHAYOG in two districts in Uttar Pradesh to enable women and their families to use a toll-free service to confidentially report incidents of informal fees. Given the high rate of illiteracy in the project's target area, the Mera Swasthya Meri Aawaz adapted the Ushahidi platform so that citizens are able to use an Interactive Voice Response (IVR) system to anonymously report the demands for informal fees for maternal health services. The reports are then automatically recorded against each health facility marked on a map. The map is available to the public through a website (http://meraswasthyameriaawaz.org/).

The project strengthens the monitoring work already being done and is being used to hold the government accountable. In the event of an emergency where urgent help is needed, the IVRS has a feature which enables the user to directly talk to our CBO partners. On receiving such a call, the CBO partner directly calls the Chief Medical Officer, who intervenes to ensure that the patient is attended to immediately. Since its launch in January 2012, there have been over 700 complaints recorded. The data generated has been used to advocate with health officials at the district and sub district levels to stop the practice of informal fees.

Author: Y.K. Sandhya, works in SAHAYOG, India.

To know more about SAHAYOG, please CLICK HERE.

Women's Health Rights Forum, India

Mahila Swasthya Adhikar Manch (Women's Health Rights Forum) or MSAM is a forum of poor rural women working on their health rights in the state of UP in India. The Forum is facilitated by a group of NGOs working at the district and state level. Over the last six years, MSAM leaders and members have increased their understanding of entitlements in health, nutrition and food security, livelihoods, political participation, social security and violence against women. Today MSAM has a membership of around 11000 women. There are many stories depicting the struggles of women from MSAM, reclaiming their rights.

The stories of two MSAM leaders Dangri Devi and Jhamman are presented here.

Over the last six years, MSAM leaders and members have increased their understanding of entitlements in health, nutrition and food security, livelihoods, political participation, social security and violence against women.

Dangri Devi

Dangri Devi is from Majgai village of Naugarh Block in Chandauli district in eastern Uttar Pradesh.

In March 2007, when Dangri Devi went to the Naugarh hospital she was surprised to see around 80 women already present in the hospital. On enquiry she found out that these women had not received cheques of Rupees 1400/- from Janani Suraksha Yojana (JSY), which is a cash incentive given for institutional deliveries. When Dangri Devi and the women decided to go and meet the local politician, he was unavailable. Following this, the group decided to go and meet the Head Clerk as he was the one who will be disbursing the cheques. When all the women went to the Head Clerk's office, he was scared and immediately informed the Chief Medical Officer (CMO). The CMO ordered that all the women should be given their cheques immediately. That day 80 women received their cheques. Since then women receive their cheques within a week of their deliveries without any problems.

Jhamman Devi

Jhamman, is from Attri village of Rajgarh block in Mirzapur district also in eastern Uttar Pradesh. She is single, illiterate and a daily wage worker.

When Jhamman received the information and understood that health is a right and the government is responsible for providing facilities to women, she along with other women from her village, fought with the Local Self Government (*Panchayat*) and the Block Development Officer (BDO) for better health facilities and *Anganwadi* (pre-school centre for mother and child care). She even placed their demand at the district level. Today their struggle has led to better health facilities for their village and the villagers have a lot of respect for Jhamman and other members of her group. Recently, Jhamman also gave an interview to BBC radio.

To know more about Women's Health Rights Forum, please CLICK HERE.

Community Vigilance for better health care services in the Highlands of Guatemala

We travelled across four locations meeting with members of citizen's councils, municipal authorities as well as health providers to learn of how members of the citizen's councils had started becoming more active and articulate to demand their health rights from the local authorities.

It was to be our third day on the road, and the first two days hadn't gone well to say the least. It was 6 am in the morning and we were all gathered in the courtyard of Hotel Don Gabriel in the city of Uspantan in the Guatemalan highland province of Quiche. It was cold and there was no morning cup of coffee or tea to warm us up when we set off with the headlights of our two Toyota Hiace vans piercing the mist. After a short ride of twenty minutes or so we suddenly left the tarmac road behind and started descending on a wet slushy mud track. I had remarked just the last evening to my friend and host Walter Flores how I found the hill roads of Guatemala to be in excellent condition in contrast to the hill roads in the Kumaon Himalayas in India where I am a regular visitor. I immediately remarked to Walter that I would like to take back the compliment I had paid earlier. Walter smiled and said welcome to the 'cloud forests' of Guatemala. These moist, inaccessible, forested areas were home to the indigenous Mayan people where Government services were skeletal and inadequate to say the least. We bumped along the wet, winding and mostly potholed road for the next couple of hours before we came to the broad valley and market town of La Parroquia where we were supposed to meet with the members of the Citizen's Council of Zona Reina and learn how they were negotiating with the Municipal Government and the Ministry of Health to get better health services for themselves.

I was part of a twenty member group that had come to Guatemala to learn about the social accountability work around health that was being done by *Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud* or CEGSS in the remote municipalities in the highlands of Guatemala. Over seven days we travelled across four locations meeting with members of citizen's councils, municipal authorities as well as health providers to learn of how members of the citizen's councils had started becoming more active and articulate to demand their health rights from the local authorities. The Mayan people are the original inhabitants of Guatemala, but today the communities we visited were among the most marginalised in the country. Though free health care is a constitutional right of citizens of Guatemala, the situation on the ground was very different. Most of the group that had come to see the social accountability work were from Eastern Europe (from Macedonia and Bulgaria) and they were taken aback by the lack of health care facilities; however they were also very impressed with the degree of social mobilisation among the rural Mayan communities and their collective struggle to obtain better health care services for the community.

The Ministry of Public Health and Social Welfare (MSPAS) is the main provider of health services in Guatemala and this is done through mobile paramedic teams that visit communities once a month, a network of health posts staffed by paramedics, primary health care clinics with doctors and hospitals. First level care is mainly targeted towards maternal and child health and emergency care. The health problem that was mentioned to us most frequently was the lack of emergency transport for women requiring emergency obstetric care services. We were told that most births took place at home under the supervision of TBAs (Traditional Birth Attendants), however, in

MORTALITY FIGURES IN GUATEMALA (1990-2005)

	NON–INDIGENOUS	INDEGENOUS
General (/1000)	2.4	4.1
MMR (/ 100,000)	70	211
IMR (0-1y)	40	49
Child Mortality (1-5y)	52	69

(from Health Systems Profile Guatemala– PHO, 2007)

cases of emergency there were hardly any ambulance facilities available to transport women to the hospitals where emergency obstetric care facilities were available. In Zona Reina and Nebaj (province of Quiche) and in Ixchiguan (province of San Marcos) the main struggle of the Citizen's Council was to obtain regular ambulance services and they had been successful in doing so. The members of the citizen's councils also conducted regular facility surveys at the hospitals through which they identified gaps in supplies and medicines and then pushed for adequate stocking and supplies.

The Citizen's Councils of Health were the key citizen's group with whom CEGSS worked to strengthen the work of social accountability around health. These councils are mandated by law and work as platforms that encourage citizen participation in governance. The membership of the citizen's council comprises of leaders from different villages and they are expected to function as watchdogs over the work of the municipality and the MSPAS, however in the case of health, the division of roles and responsibilities is not always very clear since the municipality is expected to contribute with resources to local social services and at the same time the MSPAS is responsible for maintaining the network of public health services. But in Tectitan (province of Huehuetenango) we found that the citizen's council had been successful in working with the Municipality to add more beds and equipment at the local hospital and in Ixchiguan to improve the hygiene in the local market place. In Tectitan the citizen's council had also started a programme to address malnutrition with the Municipality providing inputs for vegetable gardening. At Nebaj we learnt that the Citizen's Council had raised the issue of disrespectful treatment with the authorities at the municipal hospital. The Hospital Director had no hesitation in concurring that the issue of treating the local Ixil Maya respectfully was being discussed regularly during staff meetings and citizen's council noted that there had been an improvement over the last few months.

Dr Walter Flores, Director CEGSS explained that their approach to social accountability was based on the legal commitments of the Government of Guatemala to its citizens. They believed that it was possible to work together with local communities to collectively analyse and reflect upon their current situation of health needs and existing gaps to develop a critical consciousness on health equity and rights. This consciousness of rights then becomes the basis for examining the existing health policies and provisions and for collective demands for reform and change. Dr Ismael Gomez, Field Director of CEGSS explained that they had four steps in their approach. First they approached communities to assess the status of their mobilisation. They conducted a rapid assessment of existing community council and their leadership. If they found that leadership was committed, legitimate and representative, they moved into their second step

which comprised of capacity building of the members of the citizen's council. In those cases that community councils have limited capacities for mobilisation or representation, CEGSS would support an initial community organisation strengthening through supporting community assemblies that would expand the number of community leaders in the council and its representation.

The capacity building process extended over six to nine months and comprised of a once-a-month interactive session discussing issues like legal and policy framework, participatory planning, monitoring of public policy, tools and methods and so on. Capacity building is based on popular education and other critical pedagogy approaches. In the third step the citizen's councils actually engaged in a process of vigilance through in-depth data collection at the family level and by conducting health facility surveys. In the fourth and final step the citizen's councils engaged in a process of strategic advocacy using different tools like media advocacy, lobbying and negotiation, public

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demonstrations and so on. CEGSS was currently working with citizen's councils in 15 municipalities in the more remote regions of the country, and we met with four of these groups.

Guatemala we learnt is still recovering from a 36 year long civil war which ended in 1996. The indigenous Mayan population had to face the brunt of this war because of their demands for land reform and fair wages and nearly 200,000 were killed during this period. This prolonged period of violence and repression has led to continued sense of insecurity and a shrinking of space for community or public participation among the Mayas. Today even though half the country's population is of Mayan origin, less than 10% of the deputies of Congress are from this group. Within this overall atmosphere of insecurity where the situation of the indigenous Mayan people continues to remain precarious, the mobilization and empowerment of local Mayan leadership that has been fostered by CEGSS is impressive. They have been able to create pockets of community leadership where local Mayan women and men are able to negotiate with public authorities for improved public services. However, the overall state of health services available to the communities living in the remote highlands continues to be very poor and one hopes that the continued vigilance and pressure from these increasingly articulate communities will be able to change the situation in the near future.

This prolonged period of violence and repression has led to continued sense of insecurity and a shrinking of space for community or public participation among the Mayas. Within this overall atmosphere of insecurity where the situation of the indigenous Mayan people continues to remain precarious the mobilization and empowerment of local Mayan leadership that has been fostered by CEGSS is impressive.

Author: Abhijit Das is a Steering Committee Member of COPASAH and also Director, Centre for Health and Social Justice, India.

To know more about the work of Centre for Health and Social Justice, please CLICK HERE

Citizen's Council for Health Ixchiguan : The Municipality is our Ally, Guatemala

Ixchiguan is located at an altitude of over 3500 meters. It is a municipality in the province of San Marcos in Guatemala . CEGSS has been working with the citizen's council of Ixchiguan for over five years. Oswaldo Munez the president of the Citizen's Council of Health rues the fact that over these years the committee membership has constantly been changing as people migrate from this area. But still he is proud that their council has been able to work with the Municipality and the Mayor to bring about some changes. Monitoring conducted by the members of the Citizens Council for Health in June 2010 and May 2011 had brought to light a large number of problems. There was a lack of medicines and beds in the Mother and Child Care Centre and incubators were shabby. Patients were also mistreated by the staff. The status of health services was very poor and the health care provider contracted by the Ministry of Health visited the community only once a month. There was a shortage of medicines at the health posts. There were hardly any services beyond those for children and pregnant women and the rest of the population was ignored. There was no free ambulance transfer of seriously ill. Added to this the city market had poor hygiene.

The results of the enquiry were presented before the Municipal Development Council and a number of changes have resulted. The Mayor has also become an ally and is providing some financial resources from the Municipal funds.

- The municipal authorities have entered into an agreement with the Spanish development cooperation for an additional 12 health posts.
- The incubators have been repaired through negotiation with the Director of Maternal and Child Care centre
- The ambulance service was re-established in October 2012
- The local market place has been cleaned and overall hygiene has improved and municipality has agreed to look into the hygiene of the slaughterhouse.

However, some problems continue. While the local municipal authorities have been cooperative, the Department of Health has not. There are ceilings in budgetary support for the supply of medicines and fuel for ambulance and these cannot be solved locally.

Author: Walter Flores is a Steering Committee Member of COPASAH and also Director, CEGSS, Guatemala.

To know more about the work of CEGSS, please CLICK HERE

Reducing Maternal and Child morbidity: Valuable lessons from India

The lessons from India were very valuable and provided a platform and possibility of change in Nigeria. We learnt that if the needed change must occur there must be a very sustainable advocacy on the parts of CSOs, CBOs and citizens in Nigeria.

The conditions of the health sector in Nigeria seem to be plummeting. Yet the size of the annual national health budget is not downsizing. With a growing population of 160 million people, medical care at the moment is in a dire stress and much greater decline. The matter is not helped by the growing trend of medical personnel migrating in huge number in search of greener pastures elsewhere.

Drawing from this grave indicator, the rate of infant mortality in Nigeria has been depressing. The deaths of newborn babies in Nigeria represent a quarter of the total number of deaths of children under-five. The majority of these occur within the first week of life, mainly due to complications during pregnancy. Evidently troubled by this reality, the John D. and Catherine T. MacArthur Foundation (MAF), the Centre for Development and Population Activities, Nigeria (CEDPA/ Nigeria) under its three-year safe motherhood project, organised a study tour for Nigerian health workers and stakeholders to learn from the Indian experience.

The tour had as its aim the need to improve Nigerian CSO's ability to demand accountability for maternal health practices in Nigeria. The lessons from India were very valuable and provided a platform and possibility of change in Nigeria. We learnt that if the needed change must occur there must be a very sustainable advocacy on the parts of CSOs, CBOs and citizens in Nigeria. In India with lots of struggles, the space for CSOs has improved in running the affairs of the government. Government now perceives maternal health as a human right issue. Voices of ordinary Indians are now heard and adopted in the process of reaching a decision. However the "two child norm" and caste system demands more action by the CSOs in India, once a woman has more than 2 children, she is denied access to free maternal and other rights.

Centre for Health and Social Justice made commendable efforts to ensure that the visit achieved set objectives: We got firsthand knowledge on best practices in community based monitoring and accountability for maternal mortality; We saw a model of public health and right based advocacy approaches that could assist in the reduction of maternal death. Fresh insight in obtaining information, skills and approaches in engaging the legislature and stakeholders in appropriating sustainable funding for maternal health was obtained. We also understood how to track budgetary allocation for maternal health which has to be done at all stages from preparation, to formulation, enactment, implementation and audit.

We have learnt and understood how civil societies in India work in partnership with other groups and in collaboration with communities to reduce maternal mortality and hold public officers accountable. Lastly we are now enriched with how to transfer ownership to communities by educating them to form groups and demand government to fulfill its commitments. The team had a one on one encounter with the structure and process of accountability in maternal health. The adaptability of CBMP which is the key strategy India is currently using to improve accountability in MCH is possible in Nigeria. Further lessons learnt below that will help in changing the tide of the maternal health care are:

1. Capacity building and training of trainers: Training of stakeholders is imperative for effective community monitoring, capacity building of beneficiary representatives, community-based organizations (CBOs), NGOs, voluntary organisations and Panchayat representatives, who will eventually be providing the feedback.
2. Accountability building, health rights with clarity of role and concomitant authority should be well-defined at the outset of the assessment process. NGOs and CBOs would contribute to the collection of information relevant to the

monitoring process at all the levels from the village to the state level community assessment.

These include developing /tools and techniques– in-depth Interviews, FGDs, case studies, record review and citizens report card. The Report card is a technique used to generate public feedback on the degree of citizen's satisfaction with the quality of service provided by public agencies. It serves as a diagnostic tool for service providers and others to identify problem spots or deficient areas that need attention within an agency. It also helps to encourage public agency to initiate consumer friendly practices and policies, internal performance measures and increased transparency in operations. It has three colour codes on the basis of the progress of the various activities.

3. Interface meeting: the Inter-face Meeting (a collection of data/feedback and dialogue) from PHC and block level community monitoring exercises should include a public dialogue or public hearing. Here individual testimonies and assessments by local CBOs/NGOs would be presented. These would be facilitated by the district and block facilitation groups in collaboration with Panchayat representatives and CBOs/NGOs working on the issue of health rights.

Most importantly the exchange visit availed the participants a unique opportunity to see how India benefits from a well-structured form of governance that encourages the Civil Society Organizations to serve as referees. Interestingly, the CSOs in India have strategised by reaching the nook and crannies of the society by partnering with NGOs at the grassroots levels. The result of this strategic partnership between the CSO's and governments in India has made ordinary people to have a sense of ownership of nearly every health centre and services across the country. For Nigeria to succeed in overhauling its health sector, it must replicate the Indian example.

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Ahmad Salkida is a leading journalist who has worked in several leading newspaper and journals since the past 11 years.

Community based Monitoring and Planning of Health services, India

Community based Monitoring and Planning of Health service is being implemented in 615 villages, 35 Blocks and 117 Primary Health Centers (PHC) in Maharashtra, India. After five years of regular and systematic initiative by people, various improvements are being observed, especially in the quality of services and utilization of public health facilities by the people.

35 stories of change have been documented in Marathi in detail and the collection has been published in the form of a book *'Paule chalati badalanchi vat.'* These stories are published by SATHI, State Nodal Agency with inputs from 30 districts and block nodal agencies for CBMP process in Maharashtra, India. Three stories from the collection are presented here.

After five years of regular and systematic initiative by people, various improvements are being observed, especially in the quality of services and utilisation of public health facilities by the people..

Treatment for patients of diabetes and hypertension in the PHC: Identified through CBMP and addressed by district planning committee.

(This story has been collected with the help of MASUM Sanstha, Purandar Block, of Pune district)

CBMP processes have expanded the perimeter of available services at the PHC beyond its traditional mandate, to meet people's genuine needs.

A workshop was conducted at Malshiras PHC in Pune district as part of the community based health planning process. Among the participants were Radhabai and Sushilabai. With very low earnings and no family support, they were not in a position to afford the cost of medicines for diabetes, even the small cost of Rs. 20/day, for 10 days. Neither could they afford to spend on travel to go to the government Cottage hospital for the same. Based on suggestions given by CBMP committee members, the Medical Officer took the lead, investigated patients, and with the help of a specialist, started organising a Medical Camp once a month in the PHC to examine and treat patients with Diabetes and Hypertension.

After positive responses from the community to these camps and in order to sustain this activity, a proposal was prepared and submitted by MASUM- the District CBMP civil society organisation and the PHC Medical officer, and this was included in the district Programme Implementation Plan (PIP).

However, this genuine demand did not get included in the state PIP. In spite of this, the issue was again strongly raised in the District Monitoring and Planning meeting. After regular and continuous dialogue with the Chairperson of the Zilla Parishad (District Council) Health Committee, he took interest and with the help of District Health Officer, funds have been allocated from the Zilla Parishad to supply these medicines. Now due to this initiative, medicines to treat patients with Hypertension and Diabetes are being made available across Primary Health Centres in Pune district.

Kavita chooses the PHC for her delivery and 'Trupti' is born.

CBMP is gradually winning people back to the Public health systems, helping them to escape impoverishment from health care expenditure.

Inability of the public health system in many areas to convince even poor people about its quality of services is an ongoing tragedy. No wonder Gopal Sonar, a poor landless labourer in Ajara taluka of Kolhapur District sold his only buffalo for fifteen thousand rupees, anticipating the expenses that would be required for his daughter's first delivery in a private hospital. His daughter Kavita, during her pregnancy attended meetings conducted in the village related to CBMP. The local activist, Shivaji briefed her about improved functioning of the local PHC due to CBMP, and entitlements around free delivery and care. Kavita became convinced that her delivery should take place at the PHC and not in a private hospital, even though her father was reluctant. Repeatedly assured by Shivaji, the family took Kavita to the PHC when labour pains started, and she delivered normally at the PHC. Gopal was jubilant as he had to pay just five rupees at the PHC for the delivery, as against the huge amount that he would have paid in a Private hospital. The newborn girl has been named Trupti (meaning 'satisfaction')!

(This story has been collected with the help of Sangram Sanstha, Ajara Block of Kolhapur district.)

Community monitoring helps to complete the half-built Sub-centre

The CBMP process creates a valuable space for the community to raise issues, follow them up, and make public health facilities functional.

It is a story known to everyone, even though the details might change from place to place. People in Jamshet village in Dahanu block of Thane district required a health sub center. The sub center was sanctioned but the 'politically connected' contractor, who was supposed to build the sub-center, delayed the construction which lingered on for over two years, resulting in a half-built useless structure. Villagers visited block level authorities and complained, but no one responded. In such a scenario, the CBMP process made a difference! The village level committee members of CBMP discussed the issue in a series of Gram Sabhas (Village Meetings), and then raised this in the block level monitoring committee meetings on repeated occasions. Further, given the inaction of the contractor, one day scores of mobilised community members took their implements and landed up at the Sub-centre to 'complete' the construction on their own through 'Shramdaan' (Volunteer work)! This moved the local authorities and contractor into action. The Sub-center building got completed and has become fully functional. Even an additional Auxillary Nurse Midwife (ANM) got posted and now this is a full fledged sub-centre with active utilisation by the community. The ANM Ms. Vasawale reports that 'in the last six months, there have been 83 deliveries in this sub centre'.

(This story has been collected with the help of 'Kashstakari Sanghatana', Dahanu block of Thane district.)

These stories are published by SATHI, State Nodal Agency with inputs from 30 districts and block nodal agencies for CBMP process in Maharashtra, India.

To know more about the work of SATHI, please CLICK HERE

COPASAH participation at the 3rd People's Health Assembly

Please visit COPASAH website (http://www.copasah.net/community-monitoring-for-accountability-and-equity-in-healthcare-services.html) for accessing the presentation from the workshop.

Several of the COPASAH Steering Committee members organized and facilitated a workshop at the third people's health assembly held in Cape Town, in July 2012. Over 60 people from different parts of the world participated in this activity.

The two hour workshop included an introduction to community monitoring and accountability in health, followed by short video clips and presentations depicting accountability work in different parts of the world. The session concluded with an interaction with the audience through questions and answers and the invitation to visit the COPASAH website and join our community of practice.

Overall, the workshop was highly appreciated as evidenced by the evaluation questionnaire that was filled by nine of the participants (see below). The secretariat also produced and printed a colour flyer with information around COPASAH and its website. The flyer was distributed among all participants in the workshops and also within other key session at the People's Health Assembly.

Author: Walter Flores is a Steering Committee Member of COPASAH and Director, CEGSS.

To know more about the work of CEGSS, please CLICK HERE

Summary of Participants' responses to evaluating questionnaire- COPASAH Workshop at PHA3

Sl. No.	Comments about the session on community monitoring at PHA3	Do you think the session increased your knowledge about the topic? (YES or NO)	Was the session well organized? (YES or NO)	What did you like the most about the session?	What did you like the least?	Any comment or suggestion	Overall rate for the session (from 1 to 10)
1	This is very educational session challenging, thank you	Yes	Yes	Very educational, challenging	Different ways of striving for positive previous achievement	—	7
2	Very interesting and informative topic. I learnt a lot	Yes	Yes	Presentations really showed that empowered communities can drive change and hold duty bearers accountable	Short time	Well done	10
3	Very useful	Yes	Yes	Yes	No	No	9
4	The acknowledgment that knowledge is at the heart of participation and power and the public health is very important in CBM of health services	Yes	Yes	Probability that we will be part of the networks formed after the session	The video documentation	No	9

Sl. No.	Comments about the session on community monitoring at PHA3	Do you think the session increased your knowledge about the topic? (YES or NO)	Was the session well organized? (YES or NO)	What did you like the most about the session?	What did you like the least?	Any comment or suggestion	Overall rate for the session (from 1 to 10)
5	The element of community mobilization/ consultation and engagement in monitoring the health system (arrow) positive	Yes	Yes	The videos communicate better than too many presentations. But the presentations were appreciated and insightful as well	I don't much like the group work, the sessions are too short for adequate group work to be done well	No	6
6	Very relevant and very challenging. They were rich in taking home tools and information facilitating involvement for our civil societies and communities	Yes	Yes	Monitoring tools used by each country and the intensiveness of communities involvement	No	Presentations should be made available in hard paper for many of us from the rural areas where internet facility lacks	9
7	Central! To me this crux of PHM's objectives -the detail of how to get communities mobilized and capacitated to keep governments accountable	Yes	Yes	Practical experience shared, passionate presenters, clear themes and focus, way forward through COPASAH	Not long enough	No	8
8	Yeah the sets plenary clearly emphasized the fact that the government should be held accountable	Yes	Yes	The models that are implemented in Guatemalan and Indian people.	The facilitators were spot on while responding to questions	Information from presentations should be available on a website	—
9	This topic is timely! We as agents of change at all levels must come one more boldly to disseminate the information to the people at all levels -using the bottom up system which gives you full powers to them to air out their views towards health and development	Yes	Yes	The session gave participants chance to learn from near and from the importance of community participation aspect of stakeholders at all levels	More people should have attended but it appears they did not know!	Continue linking with CSOs, who are the ground for community work	8

Steering Committee of COPASAH

- Abhay Shukla– SATHI (India)
- Abhijit Das– Centre for Health and Social Justice (India)
- Ariel Frisancho Arroyo– CARE (Peru)
- Rene Loewenson– Training and Research Support Centre– TARSC (Zimbabwe)
- Renu Khanna– SAHAJ Society for Health Alternatives (India)
- Robinah Kaitiritimba – UNHCO (Uganda)
- Walter Flores – CEGSS (Guatemala)
- Vinay Vishwanatha– Accountability and Monitoring in Health Initiative—AMHI (USA)

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