Draft: Use of ICT for Social Accountability: South Asia COPASAH Initiative

Abstract

Information Communication Technology (ICT) is being accepted as an effective tool for Social Accountability programs and processes and in citizen engagement for community monitoring, evidence gathering, gap analysis and action in health service delivery. Several groups have experimented with the combination of ICT tools and the conventional tools of community based monitoring and in social accountability processes to social measure change and empowerment of communities in demanding quality health care and negotiating for health rights by the community.

Community of Practitioners on Accountability and Social Action in Health (COPASAH) which is a global network of practitioners that places a strong emphasis on the role of community led and civil society initiatives to promote access to equitable and quality health services to ensure accountability for health services has experimented with innovative use of ICTs in South Asia (India) for evidence gathering for advocacy and demanding quality health services using accessible technology and Photovoice methodology supplemented with other methods. Capacity building of 30 community level health accountability practitioners from 18 districts of five states was done using cellphones and basic and digital cameras to take videos, photographs, audio clips for identifying gaps in health care services and generate evidence for the community to demand adequate services. Subsequently, participants used this methodology along with community members to generate evidence on a range of selected themes of community experiences such as those of accessing maternal health services under Janani Shishu Suraksha Karyakram (JSSK), provision of antenatal services through Village and Health Nutrition Day (VHND), quality of postpartum care, functioning of Anganwadi committees, school management committees and health rights of manual scavengers.

Photo documented evidence on gaps and situation in the health facilities and services were collated, reviewed and shortlisted in collaboration with community members and were used for interface with concerned health officials and committees related to grievance redresses through public health dialogues at Primary Health Centers, block and district levels.

The discussion in this document briefly synthesizes the learnings, challenges and experiences of practitioners in using ICT for negotiating of health rights under the experiment initiated by COPASAH from across 18 selected districts of India. It explores the ICT-mediated citizen engagement and how to reach those excluded from technology for accountability initiatives.

Section I

Introduction to COPASAH

COPASAH is a global network with a focus on upholding the centrality of communities and citizens as the core of accountability practice with empowerment, increased negotiating power of the communities and increased realization of health rights as the core of practice. It aims also to develop a body of shared collection of resources, experiences, stories, methods, tools, case studies, documents and ways of addressing problems—i.e. it is a shared practice and developing knowledge from practice.

COPASAH focuses more deeply on health rights and health sector and has the experience of established practice of community monitoring in health which is the distinctive feature of COPASAH. With a view to strengthen the growing community of practitioners in South Asia and other regions a considerable amount of processes have been conducted by COPASAH (in South Asia across India, Nepal and Bangladesh) starting with workshops, different peer learning events such as Facilitated Learning Exchange (FLEs), Targeted Technical Assistance (TTA) visits within different contexts. Following these processes it was proposed to facilitate grass root community practitioners to strengthen the community based monitoring (CBM) work by using technology also.

COPASAH has followed an approach toward building accountability that relies on citizen engagement which is also termed **Social accountability**, i.e. in which it is ordinary citizens and/or civil society organizations that participate directly or indirectly in exacting accountability. In the language of governance, the term accountability has two dimensions, *answerability*, when someone is obliged to explain their actions or decisions, and *enforceability*, when sanctions or punishments can be applied in case the answers are not satisfactory. In the case of the right to the highest attainable standard of health, accountability is referred to as "the process, which requires government to show, explain and justify how it has discharged its obligations" As part of such process, it is also important that if governments or their agents have failed to fulfill the obligations, rights-holders are entitled to effective remedies to redress failure.

Context and Rationale: ICT for Health Rights

The Government of India acknowledging the role of community ownership, participation and management and to promote citizenship and accountability harped upon Community Based Monitoring (CBM) as a strategy to achieve quality health care through the National Rural Health Mission (NRHM) launched in 2005. The NRHM articulates a framework of provisioning of

universal access to equitable, affordable and quality healthcare, especially for people residing in rural areas, women, children and the poor. NRHM now running as National Health Mission (NHM), outlines an intensive accountability framework, 'communitisation' of health services - that includes CBM as an approach not only for improving performance of the public health system, but also as a strategy to reduce inequity, increase people's participation for improving health governance, to strengthen community interface with the health service system, empower community voice for demand of better health services as well to increase the ownership of the people over the public health system and increase accountability of the system to the people. Under NRHM, CBM approach was adopted and piloted in many states in the country and it came forth as an effective mechanism for the community to monitor the provision and quality services and strategise to improve the health services.

In the Indian context a large part of the Community Monitoring and Accountability work in last 10-15 years has also been anchored by a host of civil society organizations. Some of the organizations which have been at the forefront of the accountability for health initiatives in India are pioneer members and co-travelers of the COPASAH community. Many of the COPASAH members and associates- advocacy efforts have been formalized through activities or processes i.e. **Community Monitoring** conducted by communities or a group of community representatives to understand the accessibility, quality and effectiveness of public services that the community is entitled to Community monitoring as an approach and method involves keeping an ongoing watch over the health system, seeking information on regular basis as part of monitoring to check whether specific entitlements are provided and objectives met, involve community in planning also to reform and improve health services and engage in monitoring at multiple levels. As a result of this process members of a community who are the intended recipients of the health services generate demands, suggestions, critiques and data that they then feed back to the public organization implementing the program or managing the services through public hearings and dialogues.

COPASAH member organizations vary in their experience and skills about implementing Community Based Monitoring for accountability. Many organizations have experience of using tools such as score cards, report cards, pictorial tools, sms to gather evidence and using for

community monitoring community monitoring and data sharing in public dialogues and public hearings.

COPASAH's experience on accountability with these member organizations, discerned that many of the grass root practitioners, community leaders and facilitators in the organizations who are associates of COPASAH community may be brilliant speakers and activists but often are reluctant to the use of technology and are less open to using ICT platforms, even with vast penetration of internet and telephone communications in India. It came to light that the spiral of uneven access to and usage of information and communication technologies has led to a divide between those practitioners who are actively participating in information technology processes and those who are not.

COPASAH took cognizance of this kind of a digital divide which is a significant barrier for the practitioners, who cannot use the evidences effectively to influence change for the benefit of the marginalized. Recognizing the significance of ICT in citizen engagement for monitoring, social accountability monitoring tools, evidence gathering, gap analysis and advocacy in health service delivery, measuring change in empowerment process of communities in demanding quality health care and attempt to bridge the digital divide, COPASAH experimented with the use of ICTs in social accountability. COPASAH thus facilitated the initiative of promoting practice and process documentation by supporting COPASAH members in developing skills and use of available technology to produce audio-visual documentation (photography, photostories, video clips from mobile phones, voice recordings etc.) of CBM and use them for advocacy and negotiation of health rights.

- The Uniqueness of this experiment was to bring together various community level groups who have used CBM in various aspects of health and experiment with accessible technology. The experiment is an initiative of using accessible technology positioned within the larger context of accountability.

Basically as a COPASAH group our concerns while delving into the experiment were:

• *ICT has been spoken of a method to bridge digital divide in social accountability but not employed by a range of grassroots practitioners who lack in resources, knowledge of accessible technology, following which the concerns were- will it work in the context of grassroots practitioners and communities?*

• *Will accessible technology work in bridging up the digital divide between practitioners?*

•*Will it increase community's confidence and approach in using ICT to raise issues of health rights violations?*

- *Will it work in the context of communities with low literacy levels?*
- *Will it help in data evidence gathering for community monitoring along with the traditional tools used community monitoring?*
- *Will it add value to the evidence gathered in the process of community monitoring in comparison to the traditional tools used?*
- *How to safeguard the communities rights and consider ethical implications while using technology?*

- *How citizen voices are strengthened when mediated through accessible technology?*
- *How ICT affects processes of citizen voice and engagement and connecting with health system and health service providers, and are there chances of achieving greater government accountability through use of ICTs?*

Technology in the Context of COPASAH –South Asia (India) Experiment

By **technology** it is implied that a substantial number of activists and community workers use cell phones with various facilities, basic cameras, digital cameras and computers and internet services. This available technology can be used for facilitating community based monitoring of health services. Hence, COPASAH envisaged that this process could be facilitated to encourage COPASAH members to innovate and strengthen their practice through the use of easily available technology.

The goal was to strengthen the existing community of practitioners to innovate in community monitoring practices especially with the use of **accessible** technology and the technology which is accessible. It also aimed to encourage grassroots practitioners to innovate in promoting community accountability and to explore new issues and practice with the effective use of technology at the community level besides strengthening the solidarity among practitioners with collective learning and decision making and shared practice.

COPASAH's experiment of using ICT for social accountability

The experiment of using ICT for social accountability as carried on broadly in three major steps

1. Participatory discussion with the practitioners
2. Participatory methodology for inputs and Capacity Building
3. Implementation and Outcomes

Discussion of the idea with COPASAH member organizations and capacity building of practitioners on facets of Photovoice methodology and other accessible technology for negotiation of health rights, deliberation on ethical implications and considerations while working with community.

The idea of using ICT for social accountability was discussed at different platforms and in multiple conversations with the proactive COPASAH community member organizations from six different states of India including Tamil Nadu, Karnataka, Uttar Pradesh, Madhya Pradesh, Gujarat and Maharashtra, who had been actively participating in the COPASAH processes. These COPASAH member associates include practitioners from different organizations who are working with excluded populations including marginalized Dalit community members and women from oppressed castes and backgrounds. Focus of some the organizations is mainly on social accountability and rights and many promote access to rights and quality healthcare. Some of the practitioners have experience in using community based monitoring for negotiation of health rights and some also had the added experience of using SMS based technology for the negotiation of human and health rights.

Following consensus on the idea after multiple discussions, proposals were invited by COPASAH from the member organizations on the current work carried on social accountability and information was also sought on how the state groups would like to use the ICTs for value addition in the social accountability work and how would they like to generate a photo voice product. Each team worked on a proposal with a small plan as to how they would take the idea forward and which would be iterated later with in-depth discussions and capacity building exercises. Following the proposals and discussions over proposals through mails and conference calls, it was collectively decided that capacity building of practitioners would be done on use of ICTs.

Section II

Capacity Building

The first capacity building workshop in the series of using accessible technology was organized in January, 2015 at Bhopal in Madhya Pradesh, where 30 practitioners from the six states were facilitated with some practical work sessions to engage with audio visual tools and technology such as photography, video cameras, video clippings from cell phones and other media tools such as website, blogs, facebook etc. The workshop entailed discussions by the community practitioners on community based monitoring in their respective areas and the kind of technology they have had engaged with so far. This capacity building also involved providing hands-on training to the practitioners on photovoice methodology, wherein practitioners gained some practical knowledge of using accessible technology. Under the supervision of information and communication experts, the practitioners in the workshop developed photovoices on range of selected themes.

Concept building on PHOTOVOICE: Methodology and Ethics

In this workshop COPASAH Steering Committee member and health rights expert, Renu Khanna facilitated the session on Photovoice methodology and the potential outcomes of using it in Community Based Monitoring (CBM) and for advocacy of health rights. She also highlighted the ethical issues in CBM and photovoice methodology, which focused upon taking permission from the community and informed consent. The application of photovoice to public health promotion, photovoice as a methodology and analysis of its value for participatory needs assessments apart from development of the photovoice concept, advantages and disadvantages, key elements, participatory analysis, materials and resources, and implications for practice were also discussed. The practitioners were also provided resources apart from a manual on photovoice collated Asha George (Professor at John Hopkins School of Public Health) as a resource base for further reference.

Key characteristics of Photovoice: Highlighted in capacity building workshop

Photovoice is a process by which people can identify, represent, and enhance their community through a specific photographic technique. As a practice based in the production of knowledge, photovoice has three critical characteristics which can be adopted and modified. Photovoice - should record and reflect community's strengths and concerns, promote critical dialogue and knowledge about personal and community issues through discussion about their photos and should be able to reach policy makers.

COPASAH Steering Committee member facialitating session on Photovoice

It was noted by Khanna that Photovoice methodology has been used by different contexts and has a lot of potential to generate effective evidence as images teach and pictures can influence policy. The most significant aspect of Photovoice was outlined as it has to be done and used by the **community** itself. Photovoice has been used by different practitioners and Chinese village women in Yunnan Province used this technique to document their everyday work and life realities in late 1990s, has also been used by Youth in Uganda and for Malaria research and in Climate Change, Health and Resilience in Sundarbans in India etc. It was suggested by Khanna that thought there are different dimensions and definitions for Photovoice but to understand it citizen centric context we can understand it as suggested by Chinese expert Wang as "Participatory Action Research to identify, represent and enhance their community through a specific photographic technique (Wang 1999). People in the community photograph their realities and use the photos to dialogue with policy makers/community leaders." Before the capacity building workshop, proposals were invited from the states on the current work carried on social accountability and information was also sought on how the state groups would like to use the ICTs for value addition of social accountability work and generate a photo voice product.

Community people should participate in creating and defining images to shape policy -Voice of the community should reach the policy makers through picture and the effort should be on to involve policy makers/those you want to influence right from the beginning. Depending upon the purpose of the Photovoice the representatives should be selected and recruited accordingly amongst the target audience of policy makers or community leaders. For example if the issue is on Dalit rights, it should focus upon including members of the Dalit community also to reflect their realities and experiences of discrimination.

- The ethical dimensions of photography in the community were also deliberated that it is essential to take informed consent and permission from the community before taking photographs besides ensuring the involvement of community in selection and persuasion of the theme. It was outlined that taking photographs by community is an integral part of photovoice and understanding and respecting the rights of the people is also a significant ethical concern to be taken into account.

Limitations of Photovoice- Everything cannot be captured by photography- there are some limitations attached with this methodology. It is also time consuming as everything cannot be done in the first meeting itself.

- *The main point in Photovoice is that the community should take its ownership and the topic on which the evidence building is to be done should also be decided by the community itself*
- *The final product of photo documentation should also remain with the community*
- *It has to be decided - how to approach the community and first identify the issues in community, then prioritize the issue and seek the informed consent of the people and tell people about the use of photographs.*
- *It requires constant brainstorming on theme of what needs to be photographed and what is to be monitored through the photographs. It is essential to plan a format to share photos and stories with policy makers after second or third meeting and the format can be slide show, exhibition, book etc.*
- *The biggest challenge is to justify the evidence*

The methods and steps of Photovoice were deliberated and discussed as follows:

Methods or Steps of Photovoice	***Exercise/Discussion***
• Select and recruit target audience of policy makers or community leaders • Recruit photographers – 7 to 10 representative sample or volunteers - criteria? • First meeting: issues about use of	• What are the various Power dimensions in Photovoice? • What possible risks can result from Photovoice? • How to approach people for taking photos? • How to take informed consent?

cameras –

- Power, ethics, potential risks and how to minimize them, giving photos back to community
- Aim to influence –so plan how
- Responsibility and authority – how to take informed consent
- questions

Contextualize or tell stories through SHOWeD

- What did you **S**ee here?
- What is really **H**appening here?
- How does this relate with **O**ur lives?
- **W**hy does this situation/concern/strength exist?
- What can we **D**o about it?

- Brainstorm on themes to photograph – what will they monitor through the photographs?
- Distribute cameras and orient to cameras and basic photography (don't stifle creativity)

- Give time to take photos – one week or 10 days

Second meeting to discuss

- Select photos
- Contextualize or tell stories
- Codify issues or themes or theories.
- Plan a format to share photos and stories with policy makers (in second or then third meeting after more photos are collected after a pilot period) Format can be Slide Show, Exhibition, Book

4. Contextualizing and Adapting the Methodology – A Plan of Action by Practitioners through participatory group process

After having gained an overview on Photovoice and attempted practical work in the capacity building workshop by developing audio-visual documentation on selected themes, the practitioners collectively deliberated on the proposals they had sent in before the capacity building workshop at Bhopal as a way forward for the experiment through participatory discussions. Each state team discussed and shared the tentative themes, issues, for which Photovoice would be used. The practitioners discussed how photovoice methodology would be used to document gaps in health service delivery and how data analysis and advocacy would be done on the basis of the evidence and information gathered.

It was decided collectively in the workshop that to take the learning ahead, the state teams would primarily use Photovoice methodology for evidence generation on the tentative themes. In addition it was decided that they will also discuss the issue/theme with the community and finalise it collectively and also select either a video or audio medium on to supplement the same in association with the community people. They would hold engagements with the community as well as health providers using the evidence documented through use of accessible technology and different media platforms.

The themes chosen by the states included the following – (for details see Annexure I)

TAMIL NADU

Issue	**Districts**	**Health Facility/ Communities**	**Methodology**	**Advocacy**
Functioning of Committees • Anganwadi Committees • Gram Panchayat Committees • School Management Committees	• Vellore • Dharmagiri	6 health centres in 2 in each district	Photovoice	News media Photostories Community level advocacy

KARNATAKA

Issue	Districts	Health Facility/ Communities	Methodology	Advocacy
• Health Rights of Manual Scavenging Community	Tumkur	Manual Scavenger Safai Karmacharis (sanitation workers community)	Photovoice	Exhibition Photo Jansamvad

MADHYA PRADESH

Issue	Districts	Health Facility/ Communities	Methodology	Advocacy
Madhya Pradesh Maternal Health Services	Hajuri Block – Bhopal Ambha block – Morena district Ichhawar block – Sehore district Mohkhed block – Chindwara district	Photovoice – Photos, Photostories Video Photo documents -	• Case stories on denial of health rights during pregnancy and delivery •Photovoice testimonies presented in Block level Dialogues in Morena, Sehore & Chindwada	Dialogue with community members • Block level Dialogues • Photo Exhibition in Hospital • Reports in media

UTTAR PRADESH

Issue	Districts	Health Facility/ Communities	Methodology	Advocacy
Quality and availability of maternal health services	Hata Block - Chandauli district	Photovoices – Photos, Videos testimonies developed Reports Photo Exhibition Alliance with media	• Dialogue with community members • Block level Dialogues • Photo Exhibition in Hospital • Reports in media	Quality and availability of maternal health services

GUJARAT

Issue	Districts	Health Facility/ Communities	Methodology	Advocacy
Maternal Health services- ANC services to women in Village Health &Nutrition Day (VHND)	Panchmahal district	Photostories	In process as Gujarat team joined the ICT process late	(VHND)

In the workshop to further facilitate sharing of innovative practices of monitoring, accountability information, evidence documentation using ICTs, and facilitate peer learning, state level COPASAH groups (facebook groups) of community practitioners including that of Karnataka, Tamil Nadu, Maharashtra, Uttar Pradesh and Madhya Pradesh were also created.

Section III

5. Rolling out of the experiment in the field (Five States)

- ***How was it done?***
- ***How was it used?***
- ***Engagement & community involvement?***
- ***How was it documented?***

Following the devising of the plan of action discussed in a collective and participatory manner by the practitioners in the Bhopal workshop, the Photovoice methods were shared by them further with the community members in the respective areas and the methodology was thus tested in the respective fields. Photo documented evidences as Photostories/Photovoices on gaps and situation in the health facilities and health services, free health services were collated on the selected themes and reviewed -shortlisted in collaboration with community members and were used for advocating with concerned health officials and committees related to grievance redresses through public health dialogues at various levels of health system. After field testing of the ICT experiment, the practitioners consolidated their learning and challenges in a South Asia Sharing and Documenting ICTs Experiences meet at Vadodra in Gujarat in July, 2015. In Vadodra each state team shared descriptively, how the initiative of ICT was carried out in the in the respective field and what challenges were countered besides the success and the advocacy methods.

GUJARAT

Maternal Health Care

In Gujarat the methodology of Photovoices was experimented in the Ghomghamba block, in Panchmahal district by SAHAJ in partnership with ANANDI. The community in the villages in the blocks largely comprises of tribal population of Barias, Rathwas etc. The photo voice methodology was conceptualised on the basis of experiences on the ground of the three year intervention on maternal health in association with organisation ANANDI, especially on findings around Village Health and Nutrition Day (VHND) monitoring and lessons learnt from the process. ANANDI has been working since over two decades with around 7000 rural poor population in the block on ensuring food security, child rights, ensuring safety and livelihood of women, promoting women's health rights, strengthening women's role in governance, and knowledge building & research and the local Community Based Organisation (Devgarh Mahila Sangathan) is very active.

i. Process and Documentation

Through the three year project interventions, it emerged from the report card findings that the status of Ante Natal Care (ANC) among the pregnant women was very poor, therefore it was felt that VHND monitoring was of utmost importance to closely track each pregnant woman. Primarily photographs were taken to capture the process, as this technology was available and usable by all. Besides photographs, regular information was also collected through the medium of a checklist developed in a participatory manner. Community members were involved in the process of selecting the issue, i.e. VHND monitoring. Discussions took place before finalizing the issue, majority of the photographs used in the final photovoice were taken by volunteers who are ANANDI field members. The final output was demonstrated during meetings with field teams.

A major concern of the volunteers/ team members was the language constraint, since the captions in the photographs used were in English. The final photostory was shared with some of the volunteers after sometime of development of the product.

Majority of the photographs were taken through smart phone cameras and mobile phone cameras, during on-going VHNDs. Photographs were clicked by team members of SAHAJ, ANANDI and community volunteers. No experts were involved in the process. Initially a script was written and accordingly a folder was made comprising a pool of existing photographs along some newly clicked photographs. From these few photographs were selected on the basis of clarity, quality as well as those which were in

sync with the theme chosen i.e. the ANC services for pregnant women. The photographs which lacked in quality, were rejected and also those different from the theme were rejected (which included photos of meals, immunization of children, etc.

ii. Value Addition

Apart from usual methods of documenting, people realized that ICT could be used as effective evidence too. The technical skills required for taking better photographs was inculcated in participants, and this is evident from the photographs taken post the first photo voice workshop. Supplementing presentations with better photographs helped in conveying strong messages in a simpler way, as reported by field staff. (e.g. Presentation made during CAN workshops).

iii. Challenges

The people closest to the issue, members from the Sangathan and community, could not be involved in taking photographs. The Gujarat team felt that the entire objective of making the product with an approach that was community based, could not be materialised suitably due to various constraints, like non-availability of the community members, time constraints within the team, lack of good cameras and so on. Field teams could take photographs, but creating a photo voice was difficult in absence of a person who was technically sound.

The team expressed that what can be done differently in future is that photographs can be taken and sent to health officials on Watsapp to draw their attention and reflect upon the stark realities through evidences collated by Photovoices. They opined that in further use of ICTs they would develop every product in vernacular languages as it becomes easier to relate with the community in their own language. Identifying various issues for advocacy and then developing ways of creating/ using photo voice products can be done.

They reflected that more intensive work is required to equip the field staff with skills.

According to the practitioners, the advantages of using ICT for advocacy for social accountability they could envision after getting involved in the ICT initiative were that strong and powerful messages can be conveyed in a simpler and effective manner. Supplementing ICT

use with use of social media such as facebook, etc. generating visibility for an issue and advocating for a cause is also simpler and cost effective.

TAMIL NADU

Functioning of committees (Anganwadi committees, Gram Panchayat Committees and School Management Committees)

In the state of Tamil Nadu the photovoice experiment was undertaken by the three organizations DHVANI -MNI, DEEPS and DASCBR. Erupalli in Nallampalli block in Dharmapuri district is the Community Action health intervention area of DHVANI-MNI for more than eight years. The issue of functioning of Mobile Medical Unit (MMU) in Erupalli Panchayat was identified through Community Action on Health monitoring and was taken up twice with the health system but remained unsolved. This inaction by the health system prompted DHVANI-MNI to take it up for the photovoices experiment. Pennagaram block is the most backward block in the Dharmapuri district and DEEPS has been working in the area for more than 25 years.

Tamil Nadu team sharing experiences of using ICT for social accountability

The issue of sanitation- and school Management Committee (SMC) of Pavalanthur Panchayat in the Pennagaram block was chosen by DEEPS for the photovoices experiment based on a long term experience in the area. During the discussions with the community members it discerned that the issue of sanitation in schools had remained time unsorted in CBM Pavalandur was found during discussion. A case of lack of availability and accessibility of health services to differently abled

children was taken up in the Thannerpanthal Panchayat of Kandhili block in Vellore district is the Community Acton in Health (CAH) intervention area of DASCBR for more than 10 years. The organization had intervened many times in different ways to negotiate for the rights of the differently abled children but could not find a pathway, thus it was collectively decided along with the community to take up the issue under the photovoices experiment.

i. Process

Across the three blocks the community people were the photographers as they took the photographs. A point person from the organization was the coordinator along with facilitators (from organization and community people) who were trained in photovoices and had experience in using it. Digital

Training on Photovoice for Community Members

cameras were used to take photographs. The perspective, quality and exposure were checked immediately at the time of shooting collectively by the community people and the facilitators. More than 30-50 photos were taken and sorted by the community in the meeting and were selected and finalised in association with the facilitator for the photovoice. The photostory was finalized by the coordinator of the program, and there were several redoes and rejections of the photos by the facilitators and the community collectively before selecting the final photos. In addition to the photographs,

Training of Community members and NGO facilitators on Photovoices

video, voice recordings were also used. The community people highlighted that they felt the use of photovoice is easy and is a powerful medium.

ii. Dissemination and Advocacy Process

A dialogue meeting with stakeholders and health system officials was held where the different committee members and persons form the community participated and presented the stories as photovoice.

Public display of the photos was also done in form of flex and sharing was done in all the hamlets of that village which led to discussion and dissemination of status of the problem and the situation.

Display of Photos in School and Public Places through Flex and Banners

Reports (hard copies) containing the photostories were submitted to the concerned authorities and soft copies as videos, voices were also sent to higher officers via email. The community members, health care providers, Panchayati Raj Institutional (PRI) [local self-government) members and facilitators participated in the dialogues. In Erupalli, the dialogue was held at the Palayampudur Primary Health Centre (PHC) and the dissemination of the photovoices was done in 3 villages. Different officials also responded from and the Block Medical Officer (BMO) also realized the situation as represented though the photovoices and accepted the demand. Village people were also were happy about the service, following the dialogue. As a follow-up after the dialogue every month Village Health Sanitation and Nutrition Committees started monitoring and supporting the function of MMU.

In Pavalanthur the dialogue was held in the Government Middle school and the dissemination process carried out in 2 villages. The village people questioned the village council head (Panchayat President) in the dialogue by supplementing photovoices evidence as to why we had cornered the village by not sanctioning toilets. The Panchyati Raj Institution (PRI) (local self-government) accepted his fault and promised to approve as much as applications he would receive from the village. He also promised to raise the issue in the Gramsabha (village council meeting) and also assured of processing the applications through committee members. Besides this a plan to provide mason training to village people for constructing toilets was also proposed in the meeting.

The public dialogue in Thannerpanthal was conducted at Udayamuthur, PU office and the dissemination was done in 3 villages. Most of the villagers expressed anguish over the lack of health care and education facilities for children with special need. In the dialogue the officials promised to enroll children with special need in regular school and provide them the benefit of the welfare schemes. Following the dialogue meeting the TVHSNC is monitoring the process and it has been planned pursue more on such cases and take them up in public hearings.

iii. Outcomes, Success and achievements

The Tamil Nadu team expressed that community people do participate, and after having attained some experience they become more confident and enthusiastic. The community people felt that photos speak for themselves as phtotos have clarity, depth and trueness. The Tamil Nadu team felt that the experiment helps to move towards positive sustainable change and the chance of biased data are minimal in this methodology. Besides it helps to organize people and the community members, collectively chose the issue and collectively decide upon the advocacy process. In Pavalanthur more rapport and trust was created between both organizations and the community people and belief in the process became stronger. The community people became more confident in using the methodology for problem solving.

iv. Challenges

According to the practitioners from the Tamil Nadu team, the organizations have been involved in community action in health since many years and the experience has been profound, however it was realized that to develop the concept and present it using the photovoices methodology is a difficult task. The process was time bound, so time constraint emerged as a big challenge. Gathering same community people frequently is also a daunting task as community people are not available throughout. To sustain the follow up of the monitoring is also a challenge as it is a continued process and requires constant handholding. After a public dialogue, community and practitioners generally tend to be in a relaxed mood and follow up becomes challenging. Everybody wants their name to be on board if success is achieved in any issue was another raised by the team.Getting concern from beneficiary is easy; But not from the service providers

v. Lessons learnt

The Tamil Nadu team members expressed that when an unsorted problem was found which was pursuing for a long period, then photo voice method was attempted to gather evidences and build a dialogue on it. They expressed that community can handle technical gadgets with suitable inputs. Communities can be trained in Photovoice and it is a very powerful tool in evidence gathering and doing a gap analysis and pursue problem solving action.

UTTAR PRADESH

ICT based monitoring of Quality of Maternal Health Services

i. Process

In the state of Uttar Pradesh (UP), the ICT based experiment was conducted by SAHAYOG (Lucknow) and its CBO partners including Gramya in Chandauli district; Poorvanchal Gramin Seva Samittee (PGSS) in Khushi Nagar district; Baba Ramkaran Das Gramin Vikas Samittee, in Gorakhpur districts. The experiment was pursued in the blocks of Hata, Jangal Kaudiya and Naugarh in the districts of Chandauli, Gorakhpur and Kushinagar respectively. These areas were chosen as Community Based Monitoring (CBM) was being actively done in the areas by the

organizations. SAHAYOG and its partners have mobilized rural women's forum as Women's Health Rights forum which is known as Mahila Swasthya Adhikar Manch (MSAM). MSAM is working towards monitoring of government health facilities and is generating report cards of the health facilities (PHC/CHC/District hospital) situated in their areas in UP. The experiment of ICT was undertaken with the underlying thought that the ICT could facilitate in better monitoring of government health facilities. The MSAM leaders selected the issue of promoting high accountability leading to better quality in maternal health services. The methodology of photovoices was used, as it turned out to be an easy process for the leaders. Following the collection of evidence on maternal health gaps the date was used in dialogues with health service providers. The community members were also involved during the dialogue and they shared their experiences during the dialogue.

UP team members sharing ICT experience in Vadodra workshop

SAHAYOG and its CBO team members delineated that ICT helped them to grasp things quickly as it was helpful in sharing the photograph with community members through presentations.

Grassroot practitioners from organizations of SAHAYOG, Gramya, PGSS and BRDGVS had attended a COPASAH - ICT workshop on photovoices in Bhopal and taking the process further the practitioners took photos on various themes in the government health facilities in their respective areas. The themes for the photographs included cleanliness, quality and availability of services, staff in government health facilities. The practitioners used digital cameras and mobile phones to take the photographs. Around 100 photographs were taken, analyzed and sorted, with the help of supportive team and some photos were discarded while sorting.

ii. Dissemination and Advocacy

The team members reflected that photovoice stories pin-points the issues effectually and this method is an effective method for presentation also. The photographs were used for presentation at the community level, for sharing with community members (in MSAM Area) and for presenting to local PRI members and political leaders. They were also shared with media during dialogues and exhibition in the public hospitals also.

The photographs were also shared with health service providers including the Rogi Kalyan Samiti (Patient Welfare Committee) members and health officials at block level through dialogues and through photo exhibition at the public hospital. Reports, videos and photos were also shared with district and state level official through the use of ICT (by mail and on social media platforms like facebook). Photographs were used to highlight issues during community discussions and during dialogue with the health care providers and were also submitted with reports

iii. Advocacy was done with community members, health care providers, community leaders' and media and social media were also utilized in the advocacy process. In the block level dialogues service providers and media persons were included. In the dialogues the Government officials gave positive responses for ensuring the betterment of health services.

Block Level Dialogue, Chandauli (UP)

iv. Plan further

The team expressed that they would continue to follow up with the MSAM leaders who will monitor health facilities along with the CBO partners and Government health officials by using ICT.

v. Outcomes, Success and Achievements

The team reflected that the experiment helped them garner positive responses from individuals, organizations and the use of ICT helped improvise upon the existing campaign of CBM process. Individual- Identity creation, how to liaison with the government, understand the process of CBM. Organization- Innovative ideas in betterment of CBM like use of ICT. The Government officials gave a positive response during dialogues; they accepted the findings and ensured the necessary steps would be taken to bridge the health gaps. They also promised to take up grassroots voices with higher officials and various committees for welfare of patients like Rogi Kalyan Samiti (RKS). Media also gave good coverage to the dialogue held at the block level.


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Information on Use of ICT for Maternal Health included in a local daily

vi. Challenges

Taking permission for collection of photographs in health centres and from community people was a difficult task. The photographs could be taken after several rounds of discussion and explanation of the purpose. The team outlined lack of resources for photo and video collection, technical expertise of CBO partners, short time for ICT based work as other challenges. They reflected that liaising with government officials is another daunting task.

vii. Lessons learnt

The team highlighted that would want to continue the use of ICT for evidence gathering, and Continue Photo/Story collection and sharing at different levels including from village, district to state levels. In the next ventures they would form groups and train them for ICT based data collection. According to the UP team, photovoices gave a clear picture of the condition of

health facilities and it was easy for the community to be more aware about their entitlements. This methodology helped in building pressure on the government for accountability.

KARNATAKA

Health Rights of Dalit –Manual Scavenging/ Safai Karmachari

In Karnataka the ICT experiment was undertaken in the Pavagada and Madugiri blocks of Tumkur district for the marginalized manual scavenging communities, the Madigas/ Safaikaramcharis by the organization Thamate. Thamate is community based development organization, formed by grassroots level activists from the Dalit community in Karnataka. It has experience of more than 14 -15 years in highlighting the Safaikarmacharis/ manual scavenging community health denials issue. The Thamate team used ICT to explore mobilize the community members of the scavenging community and collect evidence on health rights denials of the manual scavenging community. The team developed photo stories, photos with captions, voice recordings, to identify the vulnerable situation of Safaikarmacharis and their dependents to visibilize the issue. The community members were supported in documentation and provided several inputs on function of ESI hospital.

Process

Before developing the photostories several community meetings were organized along with multiple discussions with the community. Besides this door to door visits were conducted to strengthen relationship. The areas were visited several times and the concept of photovoice was shared with them. As ICT was a very new method for Safaikaramchari/ manual scavenging community, multiple interactions and discussions were carried on with the community members. Recording of narration of community stories was done followed by writing, translation, discussion amongst the team. The text was finalized for the photos along with the captions. A second round of meeting was done with community members to discuss and finalize the photographs.

Concerns and Questions

When the concept of photovoices was discussed with the manual scavenging community, the community members were apprehensive and fearful that their photographs would be utilized

for demonstration in different localities with officers. The practitioners however made it clear that the photographs would be taken with permission and consent and involvement of community to document evidence and demand action on individual and systematic problems. It was also made clear that community members would also be involved in selecting the issue and finalizing the photographs.

Success

According to the Karnataka team the photo stories led to a positive response from the health care providers and the concerned civic body where some of the manual scavengers were employed. Photostory of a woman Safaikaramchari was taken up with the civic body for health entitlements and the municipality took up the grievance application and refunded a surgery cost to her. Inspired by the problem solving action of the authorities on the photostory, other women Safaikaramcharis also came forward for redressal . The local public hospital officials assured of taking the medical and treatment issues of the manual scavenging community on the priority basis. According to the state team the woman Safaikarmacharis whose photostory was shared with the civic body, expressed that she became aware of her health entitlements and became more confident in raising her voice for ensuring proper guidelines and accessing treatment in public health centres and hospitals.

Challenge

The biggest challenge according to the state was that initially the Safaikarmachari /Manual Scavenging community were not ready to be part of the photovoices and refused to provide voice recordings also. The local civic body was also not ready initially to take up the issues of the manual scavenging community.

Advantage

The state team members opined that use of technology emerged to be significant tool for strengthening public health system through the ICT initiative.

MADHYA PRADESH

Maternal Health – Access to ANC, PNC and referrals

In the state of Madhya Pradesh, the experiment of ICT was carried across five districts for the theme of access to ante-natal and post-natal care and referrals. The experiment was pursued in Bhopal by Maternal Health Rights Campaign (MHRC), in Morena district the organization Dharti took the initiative in Ambha block, Sathiya pursued it in the Ichhawar block of Sehore district, Gram Sudhar Samiti (GSS) pursued it in Kusumi block of Sidhi district, while Satyakam Jan Kalyan Samiti (SKJS) pursued the initiative in Mohked block of Chhindwada district. Digital cameras were used by the state team for developing photovoices.

Process

The teams conducted different meetings with women's health group in the respective regions to discuss the theme and apprise the community about photovoice and their involvement in the initiative. Besides this, the team along with the community members conducted visits to Primary Health Centers, Sub Health Center and Gram Arogya Kendra and observed Village Health & Nutrition Days (VHND). In association with community members the team collected photo evidences by using digital cameras. Photostories were developed and small video clippings were also developed, with voice recordings recorded by cellphones also to supplement the photos. The photo-documented evidences collected by use of ICT on health rights violations were used for dialogue with the service providers to press for maternal health services. However the dialogues were conducted in three districts only that of Morena, Sehore and Chhindwara. Denial case stories during pregnancy and post-delivery, women's experiences of accessing maternal health services and accessing health services under provision of Village Health and Nutrition Day (VHND) services and at the health centres were presented in the dialogues.

Challenges

According to the state team the biggest challenge was that women and lactating mothers whose photovoices, voice recordings and video clips were taken, were apprehensive in letting the photdocumented evidences present in the dialogue with health service providers. They

reasoned that the Auxiliary Nurse Midwife (ANM) and other health workers would refuse to provide the whatsoever health services were being provided if any testimony is provided against them, through photographs or voice recordings. It was after several rounds of discussion and meetings that the women agreed to allow the information to be used for the dialogue. There was variance in the response of the service providers, across the districts. In Morena and Sehore, the service providers were supportive and acknowledged the use of evidence as presented in health level dialogues through ICT, however there was much resistance and backlash from service providers in the Chhindwada district on the evidences generated using Photovoices on gaps related to health services. The service providers targeted the community and asked to reveal the names of those who given testimony in Chhindwada district.

Learnings

According to the state team, it was a new experience for the community as well for the team leaders, coordinators and the facilitators to use photo-documented evidences in dialogues and the audio visuals –facilitated in providing a clear picture of the health gaps.

Section

5. Reflection and Analysis: Collective participatory analysis

After the field testing the practitioners consolidated their learning and challenges in a South Asia Sharing and Documenting ICTs Experiences meet at Vadodra in Gujarat in July, 2015. The practitioners from each state shared their experiences on use of ICT for social accountability, through the medium of audio –video and oral presentations. Some of the issues which were discussed and deliberated upon by the practitioners included – How use of the ICT was viewed by them, what were their concerns and questions and how the experiment was conducted, in what context and the process followed including for dissemination and advocacy process, the outcomes and achievements they witnessed besides the faced including the lessons learnt.

The discussions aimed to solicit the practitioners' viewpoints and experiences on some broad themes like:

- *How citizen voices are strengthened when mediated through accessible technology?*
- *How ICT affects processes of citizen voice and engagement and are there chances of achieving greater government accountability through use of ICTs?*

It discerned from the sharing by the state teams that a majority of them have been carrying on Community Based Monitoring (CBM) initiatives with varied experiences ranging from more than 10 years to 3-4 years. However the states had experimented with the use ICT for strengthening CBM under COPASAH's initiative of using Photovoice methodology and use of accessible ICTs for social accountability for the first time. However the practitioners pointed that Photo voices, photostories, were used to collate evidence and strengthen citizen voices by photovoice with captions, audio visual recordings and voice recordings, banners in conjunction with various form of social-media and media.

A majority of the practitioners have experience of working with marginalized communities; the power relations and engagement with the processes were also explored during the experiment.

Representative of THAMATE, an organization working for the rights of the manual scavenging community, K B Obalesh from Karnataka said that capacity constraint is a significant aspect when digital divide is the issue, for example ICT surfaced as a very new method for members of the manual scavenging(*Safaikarmachari)* community as well as facilitators of the organization.

Practitioner from Tamil Nadu, Suresh D from MNI, pointed out the partner organizations had identified issues of gaps in health services through Community Monitoring and had taken up the issue twice at different levels of health system, but it remained unsolved and unsorted through CBM, and there was no pathway. The use of technology however led to positive results. It surfaced from all the states that relative to traditional report cards in Community Based Monitoring, photovoices, photostories emerged to be a strong medium of reflecting gaps in delivery of health services and health rights denials. The use of ICT was able to supplement evidence for the maternal health rights violations, denials of health services, discrimination in health services, demand of illegal charges and poor health conditions of the socially excluded communities and it has to be a combination of different approaches and communication technologies.

The practitioners from Tamil Nadu and Uttar Pradesh pointed upon the positive experiences of on handing of technology; through the experiment as they highlighted that Community can handle technical gadgets with proper inputs. Communities can be trained in PHOTOVOICE and it is a very powerful tool in evidence gathering and gap analysis and action. In Tamil Nadu the facilitators held rounds of training in ICT with the community.

Across the states the practitioners pointed out largely that Community members were the photographers and were facilitated by the practitioners in the field, digital cameras and mobile phones were used to capture the stories and voices. The technical aspects like the perspective, quality and exposure were verified during the time of shooting. More than 50-80 photos on an average were taken and sorted by the community in the meetings but were finalised by the facilitators for the photovoice. Photo stories were created by the coordinator and redoes and rejections were also done by the facilitators. It emerged from the discussions from all states predominantly, especially from Tamil Nadu, Uttar Pradesh, Madhya Pradesh that community

members were enthusiastic to take photos and community can handle technology, work towards generating evidences for health gaps but were not much involved in analysis, review, selection and conceptualization of photostories.

Earlier we use to conduct fact findings on denials of health care and health entitlements among marginalsed manual scavenger community. With the use of ICTs for social accountability initiative with COPASAH photostories were documented and shown as evidence of neglect of health services and denial of health rights of marginalised women. The photostory of 50 year old B. Gangamma form Tumkur district in Karnataka was showcased to the civic body authorities where she is working as a contract work and involved in cleaning and maintaing toilets without any protective gear thus violating her dignity and health rights which increases her vulnerability to disease and injuries. This reflects the lax attitude of municipal authorities towards such workers especially women contract workers, who face the triple burden of caste, gender and occupation-related violations. She was not provided any sick leave, or financial support by the civic body authorities for a surgery to be undertaken for a gynecological problem and the public health service providers refused to conduct her surgery. After sustained advocacy with use of Photostory, the concerned municipality where she works has had taken cognizance of her application for refund of the surgery cost undertaken in a private hospital with 22.10% allocations. Gangamma will get the refund soon.

Inspired by the success of photostory of Gangamma, other manual scavenging workers have come forward to undergo the pre-medical checkups and have started negotiating for their health rights. The Local government general hospital officials have also assured that the medical treatment issues of manual scavenging community will be will the priority now.

K B. Obalesh – Health Rights activist and representative- THAMATE(Organization working for rights of Manual Scavenging Community) Tumkur district, Karnataka(India)

6. Discussion: on the process, challenges and employing ICT methods in social accountability and Conclusion

- *How does community respond to the use of Photovoice and ICTs for social accountability process?*

- *What are the potentials and limitations of technology and ethical dilemmas in using ICTs for social accountability, the ethical dilemmas?*
- *How feasible it was for the practitioners – to use ICTs, the challenges accessing technology/ accessing the community?*

- *Can scaling up of the ICTs experiences be considered in different contexts so that it can have a greater impact*
- *The question of achievement of short term and long term impact (sustainability) through technology?*

In contrast to the state of Tamil Nadu, Uttar Pradesh, Maharashtra the experiences from Karnataka and Madhya Pradesh provided **reality checks on the potential challenges** in use of Photovoices and ICTs. In Karnataka the manual scavenger community members feared that their photos would be demonstrated before health system officials. THAMATE representatives had to assure that the photos would not be showcased without their prior permission and consent. In Madhya Pradesh, while photos were captured to collate evidence on the lack of access to ante natal services; pregnant women and lactating mothers (women) were reluctant for display of photostories and photo evidence to service providers and in the public domain. The Madhya Pradesh team described that most service seekers (women) from the community refrained from voicing the names of the frontline health workers in voice recordings publically, citing that if the health service providers names were made public, they would refuse to provide services whatsoever minimal services were being provided.

Within the state of Madhya Pradesh also, it came to surface that there were two contrasting responses to use of ICT in CBM in different contexts (districts) of Chhindwada and Morena. It discerned that getting concern from beneficiary was easy in the district of Chhindwada ; but from the service providers it was a difficult task. In Morena the service providers were supportive and acknowledged the use of evidence as presented in health level dialogues, however there was much resistance and backlash from service providers in the Chhindwada district on the evidences generated using Photovoices on gaps related to health services. The practitioners from Chindwada highlighted that what emerged as one of the reasons besides other factors for the variance is the context of the two districts. Chhindwada is dominated by Dalit communities and it is easier for the higher caste service providers to suppress the voices of the deprived, whereas Morena is dominated by higher caste people.

All the practitioners outlined that as CBM is a process, short time interval was a limiting factor in the process of carrying out the ICT initiative. Gathering same people frequently turns out to be cumbersome at times and sustained monitoring and follow-up remains a big challenge.

Conclusion

The experiment of ICTs in social accountability and the experiences of the grass root addressed a range of questions and challenges of practitioners. Communities do participate with more confidence and enthusiasm and as according to the practitioners PHOTOVOICES supplemented with other communication modalities speak as there is clarity, depth and trueness and they help to move towards positive sustainable change. More rapport and trust is created between the community and the organisations and the belief in the process gets which leads to confidence in problem solving collectively. Use of technology (photovoices, photostory, photos with story, voice recordingsto supplement evidence with a range of mediums like electronic and print media, banners, social media can be synergistic.

- COPASAH has innovatively engaged with community level practitioners to learn the use of ICT (Photovoices and other technology) in generating evidence and using it for negotiation of health rights. Through this innovative initiative COPASAH has endeavoured to address the digital divide which is a major barrier for the community level practitioners in using the evidences effectively to influence change for the benefit of the marginalized. The value addition aimed to the traditional Community Based Monitoring through this experiment was capacity building of practitioners, as a move from theory to practice in learning use of technology to document evidences for accountability and social mobilization. And the capacity in ICT skills to enable them to collect, package and disseminate information on poor health service delivery and neglect of health rights from their localities to the wider public.
- COPASAH takes it as an achievement that the learnings of the Innovative Use of ICTs for Community Based Monitoring in Health initiative indicate that through the audio- visual documentation drew the attention of the health authorities prompting them to provide solutions to the health problems. The members of the disadvantaged community are imparted with using ICT skills to gather stories and data on health rights denials.
- The findings indicated that audio- visual documentation drew the attention of the authorities prompting them to problem solving action. The collated visual report cards were effective in generating awareness in the community with low literacy. The community strategically used evidence to communicate with providers at various levels of health system. It led to building greater visibility of issues related to maternal and child health

through social media/ press releases and women and marginalized community members demanding quality health care services.

- ICT is an interactive avenue, as it enabled discussion and consolidation of understanding on use of technology in social accountability, Photovoices and ICTs in different modalities. Photostories, photos with captions, audio –visual recordings turned out to be major tools to help organise people, in community building effective advocacy- community mobilization and creating awareness in the rural community.

Annexure I

Plan of action developed by the participants for using technology in CBM

State	Issue	Districts	Communities	Methodology	Advocacy
Tamil Nadu	Functioning of committees(Anganwadi committees, Gram Panchayat committees, School management committees)	2 Vellore, Dharmagiri	3	Photo	News media, 3Photostories, Community level
Maharashtra	Sanitation and Hygiene in Primary Health Centres (PHCs)	3 Thane, Amravati, Gadchiroli	6 PHCs, 2 in each district	Photo/video	6 photo stories Jansamwad
Karnataka	Health Rights and Manual Scavenging and Safai Karamchari community	1 (Tumkur)	3 blocks Manual Scavengers	Photo	Exhibition, Photostory, Jansamwad
Madhya Pradesh	Maternal Health – Access to ANC, PNC and referrals	5	5 PHC, 5 SHC, 10 Villages Women in marginalized communities	Photo story, video audio	Photos story, community level
Uttar Pradesh	Quality of care in maternal health services	3 Chandauli, Gorakhpur, Kushinagar	6 blocks, 18 sub health centres, 6 block hospitals	Photo story, video	Block level Dialogue, RKS, use media and use ICT for sharing with officials
Gujarat	Quality of Ma-ternal health care	Dahod,Panchmahal,Anand	6 PHCs	Photo/ video	News release, Blocl level dialogues with Creating community voices by using photos and videos

Annexure -II

Snapshot of Use of ICT for Social Accountability across States

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

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