South Asian Practitioners Workshop

"Community Monitoring and Social Accountability of Health Programmes"

20-22 February 2013: Mumbai, India

The Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a network of practitioners with a common interest and passion for the field of community monitoring for accountability in health brought together practitioners, experts and key facilitators in the field of accountability from around India and other South Asian Countries for a three days dialogue from 20-22 February 2013. The primary aim and objectives of the workshop was:

1. **To b**uild a common understanding of the purpose of CBM and its role in empowering people to negotiate improved services with greater accountability
2. Present and discuss the range of community monitoring approaches and share experiences among practitioners of community monitoring/accountability on sustaining these initiatives
3. Enhance synergies between practitioners by inviting new members to join COPASAH and undertake documentation to look at processes of change through community monitoring/ accountability initiatives;
4. Identify and review methods and modules and how it can support community driven initiatives to improve accountability and quality of services.

The key expected outcomes were:

1. To take an inventory of existing practices and learning's of community monitoring processes around the world;
2. Identify gaps in knowledge, skills; share the challenges faced; and develop skills for effective practice and use of community monitoring for accountability in health.
3. Facilitate in strengthening our understanding of the purpose why we use community monitoring approaches.

The four facilitators who took the workshop forward and facilitated each of the session to ensure participation of all the participants were Dr. Abhay Shukla, SATHI; Dr. Abhijit Das, CHSJ, Renu Khanna, Sahaj and Jashodhara Dasgupta from Sahayog. A total of 30 participants from two South Asian countries (Bangladesh and Nepal) and 9 states in India (Bihar, Chhattisgarh, Jharkhand, Gujarat, Maharashtra, Odisha, Madhya Pradesh, Uttar Pradesh and Tamil Nadu participated in the three days workshop. The participants identified their expectations which were clubbed into four main themes as follows:

Challenges, learnings and experience	Challenges at the operational level
Political scenario Privatisation Convergence of departments Experiences of trying to institutionalise into the system Expansion Sustainability	Individual difficulties Challenges/practical difficulties Current status Lessons, learning advocacy
How?	**How do we continue beyond this workshop**
Approaches Methods, techniques	Solidarity Partnerships

Ways how voices of marginalisation (esp women) can be heard Training Awareness raising, How to ensure peoples ownership Evidence based advocacy	Collectivize Make friends Cross learnings How to document work

While there were a number of issues raised on accountability, governance, transparency and community monitoring, some of the issues that were consistently discussed and shared during each sessions by the participants were:

1. The range of social accountability experiences
- Within National Rural Health Mission (NRHM, the flagship programme of Government of India) framework (experiences of CBM from the states of Maharashtra, Tamil Nadu, Jharkhand, Odisha)
- Outside of NRHM framework (experiences from Gujarat, Uttar Pradesh and Madhya Pradesh where CBM through NRHM is yet to take forward).
- Experiences from Nepal and Bangladesh
2. Range of monitoring issues
- NRHM guaranteed services and entitlements
- Maternal health entitlements
- Integrated Child Development Services entitlements
- Youth entitlements
- Determinants of health – Public Distribution System (PDS), Mahatma Gandhi National Rural Employment Generation Act,
- Water and Sanitation
3. Range of methods and tools
- Facility Surveys, Exit Interviews/Polls, Social Autopsies
- Different pictorial tools and report cards
- SMS and Web Based Platforms

Participants identified many challenges and opportunities throughout the workshop. These can be summarised into the following key areas:

Challenges at the Community Level:

- The community often does not have much faith in the system, resulting in disinterest in people towards community monitoring processes
- High level of privatisation of health services leads to higher expectation from public health services, that remain unfulfilled
- Huge gap between demand and supply, the supply is inadequate so community monitoring raises a lot of questions, many of which remain unanswered
- If we do not take demands to their end solution, communities are disappointed and may lose interest; persistent unresolved issues are damaging for CBM;

- Making health a priority for community members and motivating them to take out time regularly for meetings, monitoring activities is a major challenge
- CBM is very process intensive and to reach the most marginalised in remote areas may be difficult
- There is also threat involved in some areas (e.g. naxal dominated areas, even in some other areas pressure from dominant sections not to carry on)
- Working in project mode inhibits voluntarism in the community. So making CBM sustainable is difficult and requires special kind of efforts
- Caste discrimination and gender bias does impact in formation of community groups/VHSCs
- Involving PRI members has been difficult to start with, however now with adoption of various strategies this has increased somewhat

Challenges at the Health Service Level

- **Major systemic deficiencies** in many states lead to 'CBM resistant' services which do not improve despite being repeatedly raised through CBM at various levels
- Community based monitoring activities have been maximally effective regarding *local health services* whereas ***actions and decisions at higher levels*** (esp. State) have often not been taken as required
- **Staff deficiencies** esp. of specialist and general doctors lead to 'structures without function'
- **Shortages of essential medicines** require change in medicine procurement and distribution systems (on lines of Tamil Nadu)
- **Entrenched corruption** at various levels becomes a major barrier to health service improvements

Challenges related to accountability mechanisms:

- Generally **lack of institutionalised and displayed service guarantees,** publicising entitlements and accountability mechanisms
- Most states lack effective **grievance redressal mechanisms**
- **Rogi Kalyan Samitis (patient welfare committee)** meetings often not held regularly, tend to be dominated by officials with minimal space to civil society organisations and neglect of patient priorities
- **'Untied funds'** may be 'tied' by formal or informal orders from above
- **PIP preparation process** often done in very short time period with minimal broader participation or consultation, need for addressing issues emerging from CBMP process

Resistance to CBM processes from State health departments:

- CBMP accountability processes have met **significant resistance from State health departments** in many states

- **Various forms of backlash** from local to district levels in certain states have adversely affected activities; pressurising activists to not raise critical issues
- Reluctance to include **NGO representatives in RKS** and to incorporate **community based suggestions during planning process** esp. related to district PIP formulation
- **Diluting role of NGOs,** downgrading their status in committees (contrary to NRHM guidelines), questioning their selection, trying to marginalise role of nodal NGOs or asking for **untimely 'exit'** of facilitating organisations
- **Reluctance to implement CBMP in full fledged manner**; delay or avoidance of key provisions such as State monitoring committee
- **Control by State health departments over financial and administrative mechanisms** has been major basis for constriction of CBMP processes
- Has led to delayed fund flows, infrequent installments, tedious reporting requirements, overly demanding auditing procedures, raising technical objections, all leading to interruption of activities
- Reluctance to include adequate funds for CBMP in state PIPs, resistance to support progressive expansion of CBMP, non-transparent mode of finalising CBMP sections of PIPs

Some immediate steps:

- AGCA members and state civil society representatives to be involved in **review of CBMP sections of State PIPs** from 2013-14 onwards
- As soon as feasible, **MOHFW should organise a national review of CBMP in various states** with involvement of State health depts. and nodal CSOs; such reviews should be held on annual basis as a facilitating platform
- **Administrative and financial guidelines for CSOs** implementing accountability activities with support from state NRHM
- NRHM supported **plan with dedicated budget (as % of total NRHM budget)** for generalising CBMP in all states

Some of the short term steps to facilitate community monitoring and accountability process as suggested by the participants were:

- Standard display and publicising of Guaranteed health services in all villages and Health facilities
- Grievance redressal cells (with PRI, civil society and health officials) to be set up and publicised in all villages with phone numbers
- Toll free help line for lodging complaints, seeking redressal to be made functional and widely publicised
- Developing generic model of Community monitoring which can be supported through capacity building, tools and space for dialogue and accountability
- ownership and active involvement of state health departments without constrictive financial control

Given the broader context of increasing privatisation of health services, the participants strongly felt that community monitoring is a process of winning back people's confidence in the public health system, while making the system much more accountable and functional. Hence there is a need to actively welcome and promote the process.