Community of Practitioners on Accountability and Social Action in Health

COPASAH Communique

Issue 3, July-August 2013

Inside this issue:

Community Monitoring, International Aid and Sustainable Development: Reflections from India

Recently, a colleague of mine had a request from an international Non Government Organisation (NGO) for joining them on a community monitoring related project for which they were putting together an LOI (Letter of Intent). As the twin ideas of transparency and accountability gain credibility as important considerations of good governance for improving efficient utilisation of development funds, more and more large scale development projects require an accountability component. At least, this is what appears to be happening in India. World Bank, Department for International Development (DFID) and the Bill and Melinda Gates Foundation funded projects, to name just a few among the big players, have now started building community monitoring components into their health related grants/funds. In order to encourage transparency and accountability, most of these grants are also being awarded through tenders and bids. Many, if not all the larger development agencies today have resource mobilisation units, which have expertise in identifying appropriate opportunities and responding to them. Since many of these larger organisations have their primary expertise in service delivery, research or training (or some earlier development related competencies) they probably do not have adequate experience in community monitoring. They look for partnerships with indigenous and community rooted organisations to complement their skills, and probably this explained the phone call received by my colleague.

International aid agencies are right to be anxious about the effectiveness of their investments; and tenders and bids have been long been seen as valid methods to promote transparency in awarding contracts for bridges, roads and buildings (where the competencies are widely available). However, I have often wondered about the effectiveness and utility of using this method for identifying the appropriate development agencies (public service contractors) for implementing community monitoring projects.

Community monitoring at its core is an empowering and hence political process. It builds the confidence, capacities and skills of the most marginalised people to ask relevant questions from the public service providers, in our case health providers and managers. It seeks to empower the community with awareness about their entitlements and information about service quality parameters, and skills in documentation to make the process rigorous and evidence based. However, it is not a research process, but a change process. It is expected to induce a process of change, which challenges the existing power structure between the provider and the patient. The service seeker is no longer beholden for services sought, but an assertive citizen. This also challenges some of the collusion that may exist between service providers and the existing community leadership. Organisations which facilitate community monitoring and bottom-up accountability are usually aware of the inherent political tension of this work. Their work on participation and empowerment is usually based on an analysis of the power relations which correlates poverty and deprivation with exclusions and oppressions that are systemic and local at the same time. These groups also have long term relations with the marginalised communities, working with them as

Large scale time bound development projects are usually based on the assumption that short term interventions can strengthen the supply side or stimulate demand, and expect that this change will be sustained by the now strengthened public system (or public private partnerships) to provide the more lasting solutions. Community monitoring cannot be understood in this demand-supply mode (though some authorities do try) because it is essentially a negotiation between the community and the system.

they slowly gain confidence and assertiveness.

Large scale time bound development projects are usually based on the assumption that short term interventions can strengthen the supply side or stimulate demand, and expect that this change will be sustained by the now strengthened public system (or public private partnerships) to provide the more lasting solutions. Community monitoring cannot be understood in this demand-supply mode (though some authorities do try) because it is essentially a negotiation between the community and the system. The data generation and collation process (valorised as 'tool') is just an input into the more nuanced negotiation/ arbitration process which calls for changes - non-repetition, improvements and grievance redressals. These changes while appearing bland on paper are potentially political processes, which will call for either changes in relationships between client and provider – addressing impunity and corruption, clientelism, elite capture of resources and so on. If successful, these changes will redraw the balance of power at the local level, and thus will also be challenged by those who stand to lose their influence.

People in positions of power and influence locally are usually linked upwards to the people in power and influence at higher levels and serve as local fiefs to political masters. Successful community monitoring thus has the potential to upset higher political masters as well. The local facilitating organisation, with a clear interest in the empowerment of the marginalised, may actually see this reorganisation of power lines as a measure of their success. The same may not be true of a large public service contractor organisation, which has taken up community monitoring as another development contract. International organisations engaged in this work may also be vulnerable because of their foreign origins. In India, the laws related to foreign aid for development organisations have also been changed to stop foreign funds being used for what could be perceived as activities of a 'political nature'. This may mean that some organisations would work with communities to apply the tools but not 'push' the process of negotiation.

India has a long history of indigenous organisations working on development and rights. It has a long history of voluntary action for addressing social deprivation that has evolved over the years from charitable work to development action to work on inclusion and social justice. Social audit and right to information have emerged as powerful tools of accountability based on pioneering work done by Indian voluntary/civil society organisations. Now that these are part of the mainstream development aid and projects, the requirements and processes of tendering and bidding exclude many of the most capable organisations from meaningful participation. On the other hand, organisations with little rootedness, or ability or propensity to take 'political risks', may just become the most appropriate choices for implementing community monitoring within large scale projects. I wonder about the future nature and scope of this methodology as it becomes mainstream.

Article by: Dr. Abhijit Das

Dr. Abhijit Das is a Steering Committee member of COPASAH and also, Director of Centre for Health and Social Justice (CHSJ), a policy research and advocacy institution around health and human rights and men and gender equality in India. His areas of interest include maternal health rights, equity, human rights, accountability and governance in health programming, quality of care of health care service delivery and health and population policy.

To know more about the work done by CHSJ, please **CLICK HERE**

Community Monitoring for Health System Performance Towards Making Service Delivery Accountable for the People in Bangladesh

Background

Chakaria Community Health Project is being implemented in Chakaria, a south eastern sub-district of Cox's Bazar in Bangladesh since 1994. It is operationalised in partnership with the village based self-help organisations (SHOs) using participatory planning and implementation strategies for active engagement with the community in monitoring health related functions. The SHOs regularly meet and discuss the issues related to health service delivery and seek redressal from the public sector authorities.

The organisation ICDDR,B initiated community empowerment and monitoring of the services through local health watches in 2007.

The specific aims of the project were:

1. To increase the accountability of the health system towards the community and local leadership by formation of local health watches.
2. To empower communities by training them in monitoring, data compilation and interpretation techniques, and by increasing their knowledge on health and health systems.
3. To measure the impact of the local health watches and community monitoring on the performance of the health system and its utilisation by people of diverse socio-economic groups.

Designing the process

The project was piloted in 3 unions of Chakaria, a remote rural area under Cox's Bazar district of Chittagong division in Bangladesh, which is a low performing area in terms of health and development indicators. The project took place over a two year period from January 2007 and was scaled–up in another 3 unions for two years up to December 2011. The project developed community empowerment tools for monitoring health services in three phases.

Phase one included engaging and rapport building and community discussion. In the second phase, community monitoring teams and progress review committees were formed, knowledge translation done and a monitoring plan was developed. In the third phase, analysis of data collected and sharing of the outcomes was done.

Phase 1: Rapport building and community discussion

At the initial stage of the process, union parishad members and other local leaders in the community in each of the intervention unions were contacted. (Note: union councils - *union parishad*s or just unions - are the smallest rural administrative and local government units in Bangladesh. Each union is made up of nine wards. Usually one village is designated as a ward). Discussion meetings were held to generate and increase knowledge of community members regarding their health status, health needs and rights, health systems and to build bridges and facilitate better communication between the different stakeholders in the community.

The process involved discussions on situation analysis of health in the community, to explore solutions to existing health issues and to formulate an action plan to improve the health services. The concept and the process of monitoring health services was part of these discussions too. Lists of likely candidates for participation in the community monitoring process, indicators for monitoring the use of facilities and quality of services were discussed by the community members. Some of the indicators discussed included: types of health problems faced by the community, demographic profile of people accessing health services (by gender, socio-economic status, age distance of dwelling from facility), availability of facilities, the barriers to utilization, etc.

The process involved discussions on situation analysis of health in the community, to explore solutions to existing health issues and to formulate an action plan to improve the health services. The concept and the process of monitoring health services was part of these discussions too.

The union parishad members were made part of the core team to build leadership and to take the process forward and special attention was given to have a wide variety of representation.

The monitoring teams also conducted community surveys using the LQAS technique to collect data on health or the coverage of health services, thereby the functioning of the health facilities was drawn up. The PRC members regularly visited the facilities and held meetings with the providers to solve the issues of concern.

Phase 2: a) Formation of community monitoring teams and progress review committee

Participants of community monitoring teams and leaders guiding these teams were selected during the course of meetings with the community and union parishad. Twelve community monitoring team members were selected from each union. A progress review committee (PRC) consisting of twelve leaders was formed in each union. The leaders included members of the union parishad as well as other community figures who were willing to contribute time and effort to the process.

In each union, the PRC was responsible for guiding the local community in the monitoring process and evaluating the impact of the monitoring process. The PRC accomplished this by coordinating the activities of the community monitoring team members through regular meetings, and by regularly sharing the information gathered with the community. The PRC received data and feedback from community groups. Finally, based on this feedback, the PRC made the necessary revisions to the monitoring techniques and communicated these with the monitoring teams.

b) Knowledge translation and developing monitoring plan

The training sessions provided training to the community monitoring team members and PRC members on different aspects of the monitoring process, particularly on the purpose of the monitoring, method of conducting interviews, formulation of the questionnaire, the importance of maintaining accuracy in the data collection process, and strategies to conduct community surveys using a simplified Lot Quality Assurance Sampling (LQAS) technique. The components of a health system were also discussed. In each union, a schedule for monitoring the facilities by the monitoring teams and a date for compilation and analysis of data was also set.

c) Community monitoring

The community monitoring team members in each union conducted exit interviews at the Union Health and Family Welfare Centre (UH&FWC) in each union as well as in the Upazilla Health Complex to collect data on who are visiting the health facilities and the barriers to healthcare they face. They followed a schedule for monitoring set up by the PRC. The monitoring teams also conducted community surveys using the LQAS technique to collect data on health or the coverage of health services, thereby the functioning of the health facilities was drawn up. The PRC members regularly visited the facilities and held meetings with the providers to solve the issues of concern.

Phase 3: a) Data compilation and data analysis sessions

After each round of data collection, the community monitoring team and PRC members of each union regularly met for data compilation and data analysis. The teams were also trained in how to analyse and interpret the data they compiled. Hence, they took part in exercises to produce key messages interpreting the data for dissemination to local leaders and all community members.

b) Dissemination of monitoring results and engaging the community in dialogue

Discussions were held with the community at the end of each cycle of data collection, compilation and analysis. The participants at these meetings included the community monitoring team, PRC members, community leaders, and interested members of the community. The charts showing the compiled data and key messages interpreting the data were displayed at these meetings. The community monitoring team and PRC members presented the data collected and discussed its interpretation. The elected officials present at the meetings were asked to respond to these issues.

Community monitoring, data compilation and data analysis sessions, dissemination of monitoring results and engaging in dialogue with the community are the core activities of a local health watch. These activities were repeated in 4 months cycle till the end of the study period when an endline survey was done to assess the impact of the monitoring by the local health watches.

c) Measurement of the impact

The project involved baseline and endline surveys carried out by project staff, collecting data from facility records, from the Chakaria Health and Demographic Surveillance System, and data collected through community monitoring activities.

The baseline and endline surveys were carried out and each took place over a period of three weeks. Information was collected through exit interviews outside each UH&FWC in the intervention unions and outside the Upazilla Health Complex. Data collected included demographic and socio-economic status of the clients in the facilities. Data was also collected on the regularity of the health staff and the duration of the availability of services in a day. Comparison of these data gave a before and after picture of the local health watch activities. Patient register records kept in health facilities were collected at the end of the study. This was the source of continuous data of patient attendance throughout the study period and beyond. Also, data on health indicators chosen by the community was collected using the LQAS methodology of the clients in the facilities.

Major changes

The health facilities in the intervention villages were 50 percent more likely to have written schedule of service hours compared to none at the beginning of the intervention. A successful and continued dialogue with local government and service providers was established. Sixty four percent more people came from far away, where most of the patients were female. The community monitoring teams and PRC were still active and formed a central level coordination body for continued monitoring of health services.

Present Status

The community is still active in monitoring the health services at local level with their own efforts. The health watch process is ongoing even after the project funding is closed. Ongoing projects in the area incorporate the monitoring process with active role of the communities which ultimately creates accountability. Local health watch committees were taking initiatives to monitor public health system for increasing the sense of accountability and to increase the use of health services.

Conclusion

Community engagement in health service monitoring and utilisation could be a vital element of public health system as the government is mandated to serve the people equitably without any discrimination based on socio-economic status. However, the public sector is reluctant to engage local people in monitoring though health policy recommends it. Policy level advocacy is needed to integrate the community monitoring process in health services. It is possible to mobilise the people to engage in this process in order to create people oriented health system.

Information was collected through exit interviews outside each Urban Health and Family Welfare Centre (UH&FWC) in the intervention unions and outside the Upazilla Health Complex. Data collected included demographic and socio-economic statuses of the clients of the facilities. Data was also collected on the regularity of the health staff, the duration of the availability of services in a day.

Article by: Shahidul Hoque
Shahidul Hoque is the Field Research Manager in ICDDR,B (International Centre for Diarrhoeal Disease Research, Bangladesh), Chakaria, Bangladesh. ICDDR,B is involved at the district and sub-district level in monitoring of health services and creating accountability of health services.

To know more about the work done by ICDDR,B, please CLICK HERE

West Meru District Hospital offers Examination Bed and Drug Supplies at Shishtone village Health Post in Tanzania

The district medical hospital was made aware of challenges faced by community members and service providers in delivering better health services to the poor. The district reproductive and child health coordinator said *"If it was not for DSW, I would have not have known all these challenges because these villages are very far from the district hospital and we rarely visit them"*

Civic education may be defined as the process of educating citizens on their rights, duties and responsibilities to empower and motivate them to identify what areas of the political and governance processes they can effectively participate in and what they can do to influence political outcomes and thereby improve the quality of governance at both local and national levels.

DSW Tanzania through Healthy Action Project, conducted civic education training in three villages of Meru district to build capacity of community members in areas of good governance, health system and to enable them to understand their health and civil rights. Issues of transparency, citizen's participation and empowerment, government responsiveness, accountability, and equity were also discussed.

After different presentations on health systems, good governance, health and civil rights by DSW, community members were able to identify challenges faced while accessing health services. Major challenges identified by community members include:

1. Inadequate number of medical personnel at lower level health facilities.
2. Insufficient drug supplies.
3. Lack of examination/delivery beds at village dispensary.
4. Lack of family planning services and reproductive health education.
5. Community members were unaware of the importance of contributing to the community heath fund.
6. Lack of standby ambulance to rescue seriously ill patients upon referral.

The district medical hospital was made aware of challenges faced by community members and service providers in delivering better health services to the poor. The district reproductive and child health coordinator said *"If it was not for DSW, I would have not have known all these challenges because these villages are very far from the district hospital and we rarely visit them."*

DSW interventions in these villages have brought hope and change to the community because the district medical officer was informed of these challenges and in less than a week positive results were seen. District medical officer has offered one examination bed to Shishtone village dispensary. The bed was taken to the village on 7th September 2011 together with one mattress, bed sheet and different drug supplies to cater for three months – up to December 2011.

Apart from that, the district medical hospital has scheduled outreach activities in collaboration with PSI to provide mobile clinic services for pregnant women and children under five as well as providing family planning services and education from 23rd September 2011.

One of the biggest roles of civic education is to empower people, promote and help them understand their rights so that they demand the government to take responsibility or hold their leaders accountable. The project has done justice and built trust among community members.

One of the biggest roles of civic education is to empower people, promote and help them understand their rights so that they demand the government to take responsibility or hold their leaders accountable.

Article by: Manka Martin Kway

Manka Martin Kway holds Masters degree in Community Development from Mt. Meru University in Arusha and BA degree in Sociology from the University of Dar es Salaam. Previously, Manka has worked with different international organisations such as World Vision and UNHCR in facilitating and promoting sustainable community development and humanitarian aid assistance to Congolese refugees in Tanzania. Manka joined DSW in August 2007 and is right now serving DSW as Impact Tracking Coordinator.

Community Based Monitoring and Planning Committee in Pune, Maharashtra (India) 'Convinces' Rural Hospital Gynaecologist to Return Rs. 38,000 charged from Patients

While this action exemplifies the activeness of monitoring and planning committees, especially highlighting the proactive role of elected representatives, it also underlines the ongoing failure of the public health system in Maharashtra to control illegal private practice by public health system doctors.

About 40 km from Pune city, a well known and technically competent gynaecologist is appointed in the rural hospital (RH – equivalent to Community Health Centre) and he also runs his private hospital in another nearby town. He has been diverting pregnant women who had registered in the RH, asking them to get their delivery conducted in his private hospital, and was charging Rs. 5,000/- for normal delivery and Rs. 18,000/- for a caesarean section. This issue was raised in the multi stakeholder block level monitoring and planning committee (BMPC) which has been formed during the community based monitoring and planning (CbMP) process. This committee has taken action against the doctor and as a result of this, he has recently returned Rs.38,000/- to the patients, whom he had charged after diverting them from the RH to his private hospital. While this action exemplifies the activeness of monitoring and planning committees, especially highlighting the proactive role of elected representatives, it also underlines the ongoing failure of the public health system in Maharashtra to control illegal private practice by public health system doctors.

On 21st August 2012, in the first meeting of Maharashtra State Monitoring and Planning Committee (SMPC), the issue of illegal private practice by doctors in the public health system was discussed.

The Directorate of health services clarified that a Government Resolution (GR) has been issued, in which it is clearly mentioned that Non-Practicing Allowance (NPA) for all doctors who are appointed in RHs and higher levels has been increased by 35% and now they are not allowed to do any kind of private practice. However, despite issuing of this GR, in reality in many areas of Maharashtra, illegal practice by government doctors has not stopped. Hence, as decided in the State MPC meeting, implementing organisations have identified such doctors in CbMP areas who continue to do illegal private practice, and the list including documentary evidence of such doctors has been submitted to state government, but unfortunately, the state government has not yet taken any action against them.

As mentioned, in this block of Pune district, overall CbMP process is being implemented by MASUM (Mahila Sarvangin Utkarsh Mandal); the issue of illegal practice by the RH gynaecologist was identified by BMPC during data collection as part of the CbMP process. Subsequently, this issue was discussed in the BMPC meeting, which was conducted in April 2013; the committee asked the concerned gynaecologist to give justification regarding this issue. The doctor accepted his 'mistake' and committed that he will not do it again. The committee members observed that despite the commitment given by this doctor, he continued his private practice and was taking illegal charges from patients.

In order to take definitive action, the monitoring committee decided to collect concrete evidence; committee members visited villages and talked with persons who had made such payments. In total 55 cases were identified and 12 cases were interviewed. Based on concrete evidence, this issue was raised in the district level Jan-Sunwai (Public Hearing).

As part of the follow up of Jan-Sunwai, the committee concluded that in spite of continuous dialogue with the gynaecologist, he had not stopped illegal charging. Keeping the seriousness of this issue in mind and lack of prompt action by health officials, the committee decided to take direct action and informed the doctor that he should reimburse money that had been illegally charged from patients.

Under pressure, especially from the PRI members who took a strong stand on this issue, the gynaecologist accepted the decision of the community monitoring committee; on 20th June 2013, the doctor reimbursed Rs.38,000/- to the committee. It was decided that this money will be given back to the respective patients in their villages itself, to help people become aware about their rights. The gynaecologist has assured that he will not take any illegal charges from now onwards and also that he will provide services to patients in the RH only. He expressed certain problems related to functioning of the RH such as vacant post of anaesthetist as well as other staff, lack of equipments, quarters for staff, etc. The community based block monitoring and planning committee has decided to organise a meeting with the deputy director and civil surgeon of the district for resolving these issues.

This incident illustrates how the routine administrative processes could not take action on an outstanding issue, and on other hand, how the community monitoring process has empowered the local community, especially PRI members to take decisions on their own and bring about a positive change. ☐

It was decided that this money will be given back to the respective patients in their villages itself, to help people become aware about their rights. The gynaecologist has assured that he will not take any illegal charges from now onwards and also that he will provide services to patients in the rural hospital only.

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

To know more about the work done by SATHI, please **CLICK HERE**

Mera Swasthya Meri Awaaz (My Health My Voice): A Pilot Project (India)

"If you were not getting a salary from the government I would have paid you more. And I have this pamphlet which gives me information about my free entitlements. If you demand for more money, I will call the number printed on this pamphlet and complain about you".

On hearing this, the nurse returned the Rs. 50/- taken earlier for administering the intravenous drip, and pleaded with Sita not to make a complaint. Sita later said that if she did not have the Mera Swasthya Meri Awaaz (MSMA) pamphlet and the information, she would have been forced to pay.

Although there has been a decline in maternal mortality in UP from 359 per 100,000 live births in 2010-11 to 300 per 100,000 live births in 2011-12 (Annual Health Survey Bulletins) owing to the JSY and JSSK schemes, there are a number of women who are not accessing maternal health services because of the hardships faced due to informal payments.

Informal payments, poor health services and apathetic behaviour of the health staff often discourage a majority of women from using public facilities for maternal health services, despite the provision of schemes such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).[1]

Since the launch of the National Rural Health Mission (NRHM) in 2005, SAHAYOG has been working with rural women in 12 districts of Uttar Pradesh (UP) to increase awareness about NRHM and disseminate information about the entitlements available for the poor. Although there has been a decline in maternal mortality in UP from 359 per 100,000 live births in 2010-11 to 300 per 100,000 live births in 2011-12 (Annual Health Survey Bulletins) owing to the JSY and JSSK schemes, there are a number of women who are not accessing maternal health services because of the hardships faced due to informal payments. With the aim to increase and systematise monitoring efforts, in late 2011, SAHAYOG and its CBO partners launched a new strategy to collect data on informal payments[2] for maternal health services using information communication technology (ICT). This two-year pilot project was designed to test whether an existing open-source software platform could be adapted and successfully used to document informal payments for maternal health services and to learn whether it would be suitable for replication expansion to other areas.

SAHAYOG with support from Averting Maternal Death and Disability Program (AMDD) at Columbia University (New York, USA) implemented it with two of its partners from MSAM- Gramin Punarnirman Sansthan (Azamgarh district) and Shikhar Prashikshan Sansthan (Mirzapur district).

For this, a platform known as Ushahidi ('testimony' in Swahili) was adapted and linked to an Interactive Voice Response (IVR) system through a toll free number to serve poor, rural women who are largely illiterate. The GPS coordinates (latitudes and longitudes) of all health facilities (primary health centre, community health centre and district hospitals) were collected and assigned codes.

The system was programmed in such a way that whenever community members reported informal payments they had to make at health centres, the connected website displayed the information instantaneously on a map. The IVR also had an emergency option which enabled the caller to directly talk to a CBO partner in their respective districts for a situation which required immediate medical intervention. The two districts, Azamgarh and Mirzapur, were selected for this pilot study based on the presence of strong and active CBOs and their substantial outreach with MSAM in those areas. A number of strategies were used to provide information on women's entitlements and to promote the project and hotline. These included regular campaign planning meetings, printing material giving details about free entitlements and the hotline number, holding community level meetings, distributing pamphlets in market places and fairs, putting up wall paintings in villages and on shops, pasting stickers on vehicles used for

1 Under this scheme, women are provided: free meals while in hospital for 2 days after delivery, free drop back facility 2 days after delivery, free caesarean operations and blood, free referral services, free treatment of postpartum complications until 40 days after delivery, and free treatment for the newborn till 30 days after birth.

2 Monetary or in-kind transactions between a patient and a staff member for services that are officially free of charge in the state sector and erodes the principle of comprehensive free coverage. It is a form of bribery, and victimises the poor and marginalised due to their inability to pay.

Case Story

When Rajmati, 23, a prima gravida, living in a very remote village in Azamgarh district experienced labour pains, she was taken to the CHC where the ANM charged Rs. 500/- for a drip. After the baby was born, she began bleeding very heavily but the ANM said she would get better and it was nothing to worry. Rajmati was discharged and taken home. But soon her condition deteriorated. Rajmati was rushed to the district women's hospital. The doctor there refused to examine Rajmati. She accused the family of delaying, shouted at them and told them to take Rajmati away (it was about 2 am) saying, "*We do not treat patients who deliver elsewhere. They come here to die".* As members of Rajmati's family were aware of the MSMA campaign, they used the emergency option of the helpline and spoke to the CBO partner. The CBO partner in turn called up the chief medical officer who responded immediately and called the district hospital after which she was immediately admitted and her treatment began. The Rs. 800/- charged in lieu of arranging blood was returned when the staff came to know that they had the hotline number.

***"This helpline is very important as it saved the life my daughter-in-law. It helps poor people who cannot afford to pay money to access health services",* says Phoolpatti, who had tears in her eyes while narrating the story.**

local transport, using a health chariot, spreading the messages among students in schools and colleges, meeting with elected representative of local councils, and meeting frontline workers. A total of 3500 posters, 33,000 pamphlets, 1500 brochures, 8000 stickers and 22 banners were printed.

A baseline survey was conducted initially and information on the existence and extent of informal payments was collected. This survey was carried out in 228 revenue villages from 19 blocks of 11 districts of UP in 2012, and 410 women who had given birth in the preceding six months (September 2011- March 2012) were asked about their experiences of seeking free health services in government health facilities. A midterm workshop was conducted in each district for community based organisations, women's groups, government officials and interested citizens to discuss the data collected by the reporting system and formulate evidence-based recommendations and action plans aimed at strengthening accountability mechanisms. Problems using the hotline were also discussed. SAHAYOG maintained a monitoring and evaluation sheet to track the progress of the project. Documentation was done through audio-video recordings, quarterly reports tracking the progress from each of the two districts and detailed minutes of events, workshops and dialogues. At the end, a final workshop was conducted with the implementing team in both the districts to brainstorm and critically analyse the campaign in its entirety to draw out successes, challenges and lessons learnt; recommendations based on their experiences and analysis of the Ushahidi data were also generated. During the project period, 57 meetings were held with district and block level health officials and providers to discuss the Ushahidi maps and data and to advocate for action to stop informal payments.

Discussions with a total of 141 frontline workers, 1380 panchayati raj institution (PRI) members and 102 rogi kalyan samiti (RKS) members were held. An end-term evaluation of the project was also done by a consultant working for AMDD who interviewed the two CBO partners, the SAHAYOG implementing team and the technical consultants who set up the technical part of the project.

Analysis of the baseline data showed that the 410 women interviewed spent an average of Rs. 1277/- to access 'free' maternal health services. The total out-of-pocket expenditure came to around Rs. 5,22,000/-. Between January 24, 2012 and May 15, 2013, the hotline recorded a total of 863 reports of informal payments collected from the two district hospitals, and various CHCs and PHCs across Azamgarh and Mirzapur districts. It is interesting to note that 60% of all payments reported to the hotline amounted to over Rs. 500/-.

Evidence generated about the extent, nature and amount of informal payments being asked for supposedly 'free maternal health services' is a reality in these districts. Government officials at all levels also found the evidence generated by the platform useful for their supervision of health facilities. Following a large number of reports from Atraulia CHC in Azamgarh district, a block level event was held on November 16, 2012. Data for the CHC was presented before the Additional Director, Medical Superintendent of Atraulia CHC, the Health Education Officer, deputy chief medical officer, all staff nurses and ANMs of the CHC. Women described the demands that were made for informal payments when they tried to access care for maternal health services in the CHC. The staff in turn were asked for an explanation and reprimanded for their behaviour. This was followed by several positive changes.

The medical uperintendent was transferred and there were improvements in water and electricity supply to the facility, and medicines began to be provided free of cost. The women were treated with respect by the staff and food was provided to them during their

stay in the hospital following delivery. The Additional Director accepted that the act of registering complaints by the women was very important and the Ushahidi data was useful as it made officials realise the enormity of the problem and take appropriate action to stop such practices. Analysis of the reporting patterns showed that the number of reports made about the facility dropped from an average of 18 reports per month before the dialogue (January to November 2012; highest being in the month of September at 56 reports) to three reports per month after the block level dialogue.

Moreover, the use of this technology has been instrumental and there is a visible shift from collection of sensational anecdotes to systematically recorded evidence that informal payments are being demanded. With assistance and training, poor rural women were able to use mobile phones to make confidential complaints about informal payments, thus transforming their role from passive beneficiaries to active agents. Since the reports did not place blame on an individual health worker, women felt that they could safely return to the health facility in the future to seek services without retaliation.

However, mere provision of a toll-free reporting help-line does not ensure that users of health services will feel motivated to report a grievance. It requires a level of 'active citizen engagement' to take the trouble to report informal payments. This was substantiated by the finding that 69% of all reports came from blocks that had strong MSAM and CBO presence, implying the fact reporting was highest in areas that have active, grassroots community groups. The mapped data generated by the platform can be used as a tool to monitor health facilities' performance and to plan a strong follow-up action. Some of the key learnings from this project were:

1. The need to promote active community involvement in the functioning of rogi kalyan samiti through a grievance redressal system in all facilities that provide labour/delivery and emergency obstetric care services (e.g., giving a hotline number, putting in a help desk and a complaint box).
2. Ushahidi based reporting system ensured confidentiality, which protected the witnesses' identity, helped in involvement of the community and the complainant felt safe. There is a need to promote similar innovations and initiatives by the government.
3. Need to focus and minimise informal payment as this leads to a huge trust deficit amongst those community members who have to pay from their pocket for services which are supposed to be freely available. This can be reinforced and undertaken by involving local community groups and other NGOs and by using data generated through Ushahidi-based reporting systems.
4. There is a need to ensure that all pregnant women have information about entitlements at the time of ANC registration, preferably by incorporating it in the Mother and Child Card. Maternal health related entitlements and the grievance redressal toll-free number need to be written prominently on the walls of all government health facilities in a central location and/or outside the maternity ward.

Moreover, the use of this technology has been instrumental and there is a visible shift from collection of sensational anecdotes to systematically recorded evidence that informal payments are being demanded. With assistance and training, poor rural women were able to use mobile phones to make confidential complaints about informal payments, thus transforming their role from passive beneficiaries to active agents.

The pilot project 'Mera Swasthya Meri Aawaz' has successfully demonstrated the power of collective community action in bringing about a positive change in health services. However, the "dual approach" of continuous community awareness about schemes and entitlements, and promoting the complaint mechanism is important and necessary for this change. Involving district-level government officials from the beginning also led to a more positive engagement and instant response that resulted in lives saved.

Conclusion

The pilot project 'Mera Swasthya Meri Aawaz' has successfully demonstrated the power of collective community action in bringing about a positive change in health services. However, the 'dual approach' of continuous community awareness about schemes and entitlements, and promoting the complaint mechanism is important and necessary for this change. Involving district-level government officials from the beginning also led to a more positive engagement and instant response that resulted in lives saved. The evidence and learning captured by the hotline system as well as in the workshops and focus group discussions has not only led to positive recourse in some cases but has also helped to generate a practical set of recommendations that can be implemented. With the continued collaboration between the government of Uttar Pradesh, grassroots community groups and civil society, the women can realise their entitlements to utilise free, life-saving maternal health services and to accelerate the reduction of maternal mortality in rural areas of UP. ☐

Original Report: A Brief Report of Findings from the *Mera Swasthya Meri Aawaz* Pilot Project of SAHAYOG, June 2011-2013

Revised for the newsletter by: Dr. Bharti Prabhakar
Bharti Prabhakar is working with Centre for Health and Social Justice, a policy research and advocacy institution around health and human rights and men and gender equality in India, She has done Masters of Public Health (MPH) from BITS Pilani and is a Homeopathy graduate.

To know more about the work of MSMA, please CLICK HERE
To know more about the work of SAHAYOG, please CLICK HERE

Helping Women's Leadership in the Development and Implementation of Women's Human Rights

The profile of The Association for Emancipation, Solidarity and Equality of Women (ESE), Macedonia

The Association for Emancipation, Solidarity and Equality of Women (ESE) was founded as a civil society organisation in 1995 in Macedonia. Since the beginning, ESE has developed and helped women's leadership in the development and implementation of women's human rights and social justice in our society. Over the last 15 years, ESE has been guided by its dedication for seeking solutions to problems. By promoting human rights, it improves social and economic justice, considering these as an indivisible set of standards to be enjoyed by all people.

The main target population groups towards which ESE has focused its work are women in Macedonia and the Roma ethnic minority. Since the beginning, ESE has identified and maintained its work on issues of women's health; protection and prevention of domestic violence as it is one of the prevailing forms of violence against women; and participation of women in decision making bodies. Later on, ESE used the practice of continuous assessments and monitoring of women's human rights in all societal spheres. So far, ESE has prepared and contributed to five reporting processes on UN human rights treaties including shadow reports to four major human rights treaties.

ESE has also continuously worked on improvement of the health status and access to health care services for women and Roma minority. The work on improvement of women's health is mainly focused on advancement of health rights concerning reproductive and sexual health issues and the health of the women in the period of menopause. Since 2010, ESE has been implementing the project: "Human rights in patients care" that aims at raising the level of awareness among general public (patients); legal and health professionals on the importance of respecting and implementing health rights.

The work of improvement of Roma health is mainly focused on obtaining the right to health and access to health care services for the Roma - starting from the access to health insurance, access to reproductive health care services, immunisation coverage of Roma children and access to preventive health care services aimed for Roma women and children. In the last three years, ESE has expanded its work with Roma through provision of paralegal services in the Roma communities on protection of the health rights. At the moment ESE and its Roma partners are implementing the second grant on provision of this type of assistance.

In its overall work, ESE has used different approaches, methods and techniques such as direct services for those in need, conducting different types of researches and analysis for determining the actual conditions, policy reviews, implementation of advocacy strategies for improvement of the situation. ESE has also engaged with governmental institutions, political parties and members of the Parliament.

ESE has so far focused on building partnerships with various stakeholders. At the national level, ESE cooperates with other CSOs on different matters of common interest, especially with CSOs that work in the areas of gender, health and Roma issues. Apart from CSOs, ESE also cooperates with professional associations that enable involvement of the broad professional community in its operation. ESE cooperates with all relevant governmental institutions. ESE also cooperates with the Assembly of the Republic of Macedonia through participation in the operation of different commissions. At the local level, ESE cooperates with the municipalities in all regions of the country.

The main target population groups towards which ESE has focused its work are women in Macedonia and the Roma ethnic minority. Since the beginning, ESE has identified and maintained its work on issues of women's health; protection and prevention of domestic violence as one of the prevailing forms of violence against women; and participation of women in decision making bodies.

Since 2009, ESE started to integrate budget monitoring and advocacy based on it, in the field of improvement of the right to health for Roma minority (specifically for improved immunisation coverage of Roma children).

Since 2009, ESE started to integrate budget monitoring and advocacy based on it, in the field of improvement of the right to health for Roma minority (specifically for improved immunisation coverage of Roma children). Due to the experienced advantages of these approaches, which were lacking in the previous work of ESE, in 2010, ESE decided to integrate budget monitoring and advocacy in its strategic work i.e. the entire scope of work of ESE. Thus, since 2011, ESE started to implement the programme for capacity building of ESE staff regarding the applied budget work supported by Open Society Foundation (OSF). In mid- 2011, the activities for community monitoring work were added to the pre-existing applied budget work regarding monitoring of the activities aimed for immunisation of Roma children in Macedonia.

Considering the lack of transparency and accountability of the government, ESE now plans to focus on improved transparency and accountability of the government using the approaches of budget monitoring and community monitoring.

Article by: Dr. Borjan Pavlovski
Dr. Borjan Pavlovski is a medical doctor and is currently pursuing his Masters of Public Health at the Medical faculty in Skopje. Dr. Pavlovski works in Association for Emancipation, Solidarity and Equality of women in Macedonia – ESE, as Programme Coordinator of the programme for public health and women's health.

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

"Gaon Swasthya Samikhya"[1]- A Process to Foster Community Action in Odisha, India

Introduction

Public health is the practice of preventing disease and promoting good health among the people, from small communities to the entire country. The public health system in India comprises a set of state funded and managed health care facilities. Community participation is expected to be a key component of the public health system. The declaration of Alma-Ata states: *"Primary health care… requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate" (Para VII (5), Alma Ata Declaration, 1978).*

The vision statement of the National Rural Health Mission (NRHM)[2] has stated one of its goals as "*To set up a platform for involving the Panchayati Raj Institutions[3] and community in the management of primary health programmes and infrastructure".* The section on the core strategy of the mission of the NRHM states, "*If the mission of health for all is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters".* Therefore, the participation of PRI members, service providers and community is essential for community based monitoring or community based action in NRHM as a rights platform.

NRHM has emphasised on community based monitoring which includes not only engaging community in monitoring of health services but also planning and implementation of the schemes that promote good health of the people. This process is not considered as a fault finding but a fact finding mechanism and promotes good understanding between community and service providers for better outcome of the health care services. Community monitoring is also a mechanism for ensuring greater government accountability and transparency in health care to its citizens at the local, regional and national levels. The community based monitoring (CBM) process was first initiated as a pilot in nine states of the country including Odisha.

Background and Perspectives on Community Action in Odisha

Drawing the mandate from the NRHM framework, Odisha was one of the nine states to implement the first phase of community monitoring in four districts (namely Bolangir, Kendrapada, Mayurbhanj and Nabrangpur) in the year 2006-08.

After successful completion of the first phase of community action in Odisha it was planned that the state government will take the ownership of the process and upscale/ further expand the programme from its own budget supported under this programme implementation plan (PIP) with the support of State Advisory Group on Community Action (SAGCA). Proposals were submitted to the Mission Director in 2008 to extend the community action programme covering all villages and blocks in the four districts where the process has been initiated in the first phase. However, the state government felt that there was a need for a change in the community monitoring tools considering the complexities and level of literacy among the members of the community in the state giving the process a setback.

The initial enthusiasm during the phase one among the key stakeholders and the SAGCA was lost as it was felt that the process may not be sustainable without government ownership and support. However, with the change of leadership at the Mission Directorate level in 2010, the efforts of SAGCA regained momentum.

Community monitoring of health services is the "systematic documentation and review of the availability, accessibility and quality of health services against specific government commitments or standards by actual beneficiaries of services, for the purpose of doing advocacy with service providers and policy makers to improve the services.

1. Gaon Swashtya Samikhya is an expression in the Odiya language which loosely translates to Village Health Review.
2. NRHM is a common platform for delivery of public health services in rural India.
3. The Panchayati Raj Institutions or PRI are the local self government institutions at the village, subdistrict and district levels comprising of locally elected representatives.

The term community monitoring had been changed to community action during the course of implementation of Phase-I project to involve all stakeholders and for imbibing a shared perspective of *fact finding rather than fault finding* for improved planning and implementation of the health programmes in the community.

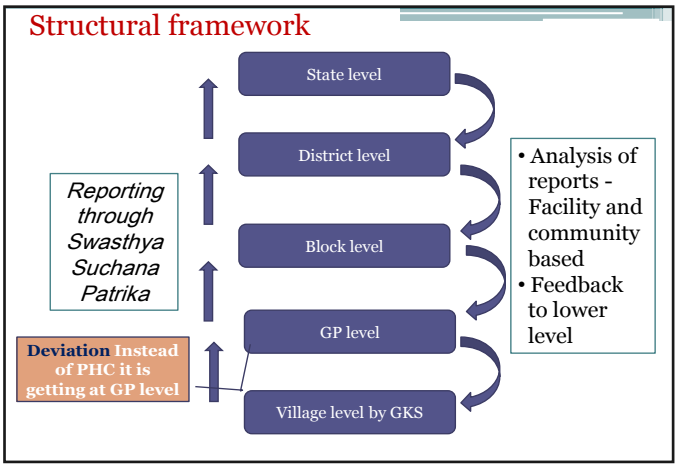
Gaon Swasthya Samikhya-(Community Action –Phase-II)

The term community monitoring had been changed to community action during the course of implementation of Phase-I project to involve all stakeholders and for imbibing a shared perspective of *fact finding rather than fault finding* for improved planning and implementation of the health programmes in the community. To bring in further innovations the programme is proposed to be renamed as *Gaon Swasthya Samikhya (GSS)*. A concept note on the modified operational guideline was presented before the SAGCA on 10th June 2010 with the chairmanship of Dr. Pramod Meherda, IAS, Mission Director, NRHM. To bring in improvement in the draft operational guideline different committees were constituted. The SAGCA was also restructured and formed.

The Advisory Group for Community Action (AGCA) was constituted under the chairmanship of Mission Director, NRHM, to provide technical support for the implementation of community monitoring during the pilot phase. The same group was notified to provide technical support for the implementation of GSS. The group is headed by Mission Director, NRHM and consists of directors from health, women and child development, panchayati raj and rural development departments and members from civil society organisations.

Roles and responsibilities of AGCA

- To provide required technical support to NRHM, Odisha for the implementation of GSS programme in the state.
- To support preparation of required module and materials; including providing support as resource person for conducting meeting and capacity building programmes.



District	Total Blocks	Total GPs
Mayurbhanj	26	382
Kendrapada	09	230
Ganjam	22	475
Bolangir	14	285
Rayagada	11	171
Total	82	1543

- To undertake field visit to districts and blocks to provide supportive supervision at different levels for the effective implementation of programmes.
- To coordinate among different departments and other stakeholders to strengthen inter-sectoral convergence.
- To develop criteria for selection of nodal agencies at the district and block level. In addition, provide required support to the nodal agencies for field implementation of the programme.
- To provide support for the analysis of the overall output of the intervention and suggest policy recommendations.

Process of formulating *Gaon Swasthya Samikhya* programme

The process is to start from the village where gaon kalyan samitis (GKS) have been formed at the revenue village level to be a platform to address the health issues and promote community level action. GKS members meet every month to discuss the health issues of the village. It is proposed to use this opportunity to integrate the discussion on birth and death in the meeting, leading to further analysis of causes, service availability and utilisation, and identify action points at different levels that could prevent such deaths. This will be linked to reporting and analysis on the delivery, quality, availability, and reach of the services at the village/gram panchayat (GP), block and district level and taking appropriate actions for required service delivery. Focus being fact finding not fault finding and moving from event to service and evidence based analysis and reporting.

Current status of implementation of Gaon Swasthya Samikhya in Odisha

The implementation process of GSS programme in the state of Odisha has been robustly planned and started from 2012. With the proactive role by AGCA Odisha, the process has been rolled out with the support of NRHM. Five districts, 82 blocks and 1543 villages have been taken to carry out GSS programme in the state.

To implement the entire process, Human Development Foundation (HDF), Bhubaneswar a state level civil society organisation has been assigned as nodal agency to carry out the "Swasthya Samikhya" in the state.

Progress at a glance of Gaon Swasthya Samikhya programme implementation in Odisha

- Based on the learning of the first phase of community monitoring activity implementation, subsequent discussions and consultations, a detailed operational guideline, posters, brochure and information booklets (Suchana Patrika) have been prepared. The Suchana Patrika has been developed based on several indicators like infant death, maternal death, their cause, steps taken by GKS, immunisation status and sanitation, etc.

- For the effective implementation of the programme, review committees (Swasthya Samikhya Samitis) have been constituted at the village, block, district and state level. At the state level, a review committee has been constituted comprising different government functionaries as its members.

- To strengthen GSS, the district level advocacy workshops on GSS have been organised. The prime objectives for organising the workshop was to sensitise the participants about the programme.

- To carry out "Swasthya Samikhya" (community monitoring) process at the block and district level, NGO selection process is underway. A training manual has been developed and designed to operationalise the modus operandi for implementation of GSS at the grassroots level.

The state training of trainers for the GSS programme was organised for key stakeholders to discuss about relevance, need and perspective of community monitoring, role of GKS promoting the Swasthya Samikhya programme, health and social determinants of health, formation and role of swasthya samikhya samitis at district, block and GP Level. GSS programme was launched by the Chief Minister of Odisha Shri. Naveen Patnaik at Karanjia, Mayurbhanj on 2nd March, 2013

Conclusion and Way Forward

Involvement of community in public health care is a critical task as it needs to interlink convergence and involve key stakeholders from all related fields of health. Though the policy document of NRHM lays emphasis upon community involvement and participation in health care but achievement is very poor. Health for all will be dream for all as long as community ownership will not be impulsively sprouted. The community based monitoring has initiated the process of empowering the community in Odisha, but still, all districts have not been covered under the CBM process. Currently under GSS, five districts, 82 blocks and 1543 GPs have been taken as initial implementation of activities. However, there is a felt need of transforming community action in more number of districts. The year 2013-14 will be targeted to 10 districts, 169 blocks, 15,000 GPs and 27,000 villages for GSS programme implementation. To organise activities from village level to state level is hard task but with proper proactive planning from divergent levels, the goal of NRHM "A community led health care system where community will plan, manage and utilise the health services" can be achieved. □

Currently under GSS, five districts, 82 blocks and 1543 GPs have been taken as initial implementation of activities. However, there is a felt need of transforming community action in more number of districts. The year 2013-14 will be targeted to 10 districts, 169 blocks, 15,000 GPs and 27,000 villages for GSS programme implementation.

Article by: Sudarshan Das
Sudarsan Das is a development thinker, columnist, leader and institution builder. He started his career as a lecturer in sociology and has more than a decade of research and academic experience. Mr. Das has held various positions of responsibility including Director, Centre for Social Development; Dean, Student Welfare; and Registrar at KIIT University. He has been associated in various capacities in many civil society organisations in the country. Mr. Das is a regular columnist in the daily Oriya newspapers, The Samband and The Pragatibadi and many other journals and periodicals.

Updates for March to June from COPASAH East and Southern African Region

Community of Practitioners in Accountability and Social Action in Health (COPASAH) is steadily growing in the East and Southern African region. The growing number of members will be a resource in fostering social accountability. The new members from different thematic areas of the health sector will add value to COPASAH due to the different strengths, expertise and experiences they will bring on board.

Community of Practitioners on Accountability and Social Action in Health (COPASAH) is steadily growing in the east and southern African region. The growing number of members will be a resource in fostering social accountability. The new members from different thematic areas of the health sector will add value to COPASAH due to the different strengths, expertise and experiences they will bring on board. In Uganda alone, eight new members were recruited to join COPASAH and other organisations have also indicated an interest in joining. The East and Central African region COPASAH secretariat is also in the final stages of signing an agreement with Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (GEGSS) for a project fostering sharing and learning between COPASAH members for improved social accountability in health funded by Accountability and Monitoring in Health Initiative (AMHI) of the Open Society Foundations. The proposal was discussed and approved by COPASAH during the steering committee meeting held in Beijing, China, in September 2012. The project aims to consolidate COPASAH as a knowledge-generation and sharing community through the implementation of innovative capacity building strategies for its members and increasing the visibility of COPASAH at regional and global level. The above project is designed to meet the needs of the members identified during the needs assessment conducted in Kampala before the project design. In addition, it also meets capacity needs of members though knowledge and experience sharing. Uganda National Health Users/Consumers Organisation (UNHCO) and Training and Research Support Centre (TARSC) will be the implementing partners.

To further support social accountability initiatives, UNHCO submitted a concept on voice and accountability to Demographic Governance Facility (DGF) which has succeeded to the concept note stage and UNHCO has been given a go ahead to write a full proposal, which was submitted and now awaits final appraisal by DGF. The proposal was submitted in partnership with two COPASAH members- Kapchorwa NGO Forum and Pallisa Civil Society Organisation Network. The project will further strengthen social accountability in health through strengthening capacity of community structures (civil society organisations, health unit management committees, and community leaders) and citizens for increased transparency and accountability in health sector in Uganda.

UNHCO and TARSC mobilised CSOs in the region to implement the health literacy programme. TARSC organised a workshop to train staff of health sector CSOs working with communities on health on literacy modules in 2012. One key action point from the meeting was; the participant organisations organise a community meeting and facilitate using module two of the health literacy manual and come up with community action plan. UNHCO organised a health literacy meeting in Kamuli distict in Balawoli subcounty selected after a consultation with district health officer of Kamuli in early March. Using module two of the health literacy manual the communities identified different health challenges in the community and access to safe water was identified as the major challenge which needed to be acted on by duty bearers. UNHCO again took the same community through module four on the healthy environments. Through careful facilitation using module four, the communities were able to identify both healthy and unhealthy practices in relation to healthy environment. The community members made an action plan to change the unhealthy practices.

Article by: Robinah Kaitiritimba
Robinah Kaitiritimba is the Executive Director of United National Health Consumers Organisation in Kampala.

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

To know more about COPASAH Africa and other members from the region, please CLICK HERE

To become a member of COPASAH, please CLICK HERE

Regional COPASAH Workshop for Latin America

On July 15 and 16, steering committee members of COPASAH met in Quito, Ecuador, with members of the Ecuadorian Public Health Forum - a civil society organisation of academicians, practitioners and activitists - to exchange analysis and experiences around the development of public policies in the region and to learn about COPASAH.

The opportunity of holding this meeting in Ecuador was very important to understand what have been the changes in the country as the result of almost a decade of progressive public polices led by a leftist government. As an outsider, the news and perception one usually gets is that the public policies are effective in promoting equity and social inclusion. However, since I do have very close Ecuadoreans friends and during my travels to the country, I have got to learn about essential contradictions within a government that is internationally known to be democratic, radical, progressive and that seeks to strenghtening citizen's participation. Below is a very brief account of such contradictions as I have been informed about by Ecuadorean colleagues.

Since the current presidential elections, public social expenditure has dramatically increased. Public infrastructure, particularly access to roads have largely expanded. Moreover, a new political constitution has been enacted, which is the first one in the world that recognises specific rights to the environment and mother nature. While on the one hand such important policies have been put in place, on the other, public pólices that are rapidally expanding extractive industries - particularly mining have also been encouraged generating in strong opposition from communities and environmental activitists. In addition, there is evidence of a reduced tolerance from authorities towards voices and social movements opposing government policies.

Within the above context, over 25 representatives met for two days. The first day was devoted to analyse the current situation with the health sector public policies and issues around equity, inclusion and public policies. The conclusions of the first day were that although there is a progressive legal framework, the reality of the health system still reflects social exclusion and barriers towards universal access. The increase in the public budget has not translated in any significant expansion or strengthening of public health but rather on the acquisition of highly expensive medical technology, overpriced medicines and medical supplies. Corruption is present and sometimes even gives the impression of being on the rise.

During the second day, Ariel Frisancho presented the experience of Peru in relation to citizens' vigilance of maternal health, particularly those serving indigenous population. Walter Flores presented the experience of Guatemala working with community based indigenous organisations to demand accountablity from authorities and actions to reduce discrimination and disrespect toward indigenous population seeking health care. Collegues from Ecuador also presented their experience as community organisations overseeing the implementation of the healthy motherhood law in Ecuador.

In the final part of the second day, Ariel and Walter introduced COPASAH to participants and described the specific activities that will be implemented in the Latin American región for the period 2013-2014. One of the most relevant conclusions of the second day was the agreement that there is a strong case for active participation of citizens in demanding accountability from authorities, particulary when the legal framework recognises explicit benefits and entitlements for the population. The workshop finalised with concrete actions that included a) the identification of additional organisations that have been working on citizens' vigilance of public polices b) the systhematisation of their experiences and c) active communication between the regional coordination of COPASAH and the Ecuadorean colleagues to promote and participate in the forth-coming COPASAH regional training workshop.

Since the current presidential elections, public social expenditure has dramatically increased. Public infrastructure, particularly access to roads have largely expanded. Moreover, a new political constitution has been enacted, which is the first one in the world that recognises specific rights to the environment and mother nature.

Article by: Walter Flores
Walter Flores is a Steering Committee member of COPASAH and also, Director of CEGSS, Guatemala.

To know about the work of CEGSS, please CLICK HERE

Announcement– East and Southern Africa Regional Training Workshop

The Call

The workshop will explore how to raise community voice in strengthening the resourcing and functioning of primary health care (PHC) systems through the use of participatory approaches to build community roles in accountability and action.

Training and Research Support Centre (TARSC) Zimbabwe through the Community of Practitioners in Accountability and Social Action in Health (COPASAH) and the regional network for Equity in Health in east and southern Africa (EQUINET), are planning to hold a regional workshop on Participatory Approaches to Strengthening People Centred Health Systems in the east and southern African region, focusing on ways of improving public involvement, social action and accountability in health for local action and advocacy. The workshop will explore how to raise community voice in strengthening the resourcing and functioning of primary health care (PHC) systems through the use of participatory approaches to build community roles in accountability and action. It seeks to support work at national, district and local level with health systems and communities in health, with a major focus on the interactions at primary health care level.

The training draws on the learning coming out of COPASAH – a global network of practitioners who share an interest and passion for the field of community monitoring for accountability in health - and EQUINET – a consortium network that aims to promote and realise shared values of equity and social justice in health in east and southern Africa. It will be facilitated by TARSC, Uganda National Health Consumers/Users Organisation (UNHCO) and the Lusaka District Community Health Management Team (LDCHMT). The training will use experience coming out of the pra4equity network in EQUINET, including a toolkit which outlines practical ways to build understanding of participatory reflection and action (PRA) methods and their use in strengthening people centred health systems.

Please note that only COPASAH members will be shortlisted for this training workshop. The workshop will be held 60kms outside Harare, Zimbabwe. For more information, please visit the COPASAH website.

We look forward to your support, solidarity and membership.

Announcement– South Asian Training Workshop

Announcement

The Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a network of practitioners from all around the world with a common interest in community monitoring for accountability in health. Over the next one year COPASAH seeks to undertake the following key activities through its network: a) capacity building; b) technical assistance; c) facilitated learning exposure visits; d) documentation and audio-visual support. COPASAH will be offering regional training programmes in South Asia, Latin America and Africa in the coming months.

Keeping the above in view, COPASAH is organising a five days training workshop, from 21st - 25th September 2013, in Delhi, India. The workshop is for the South Asian region and is being organised for capacity building of civil society organisations (CSOs) on accountability and transparency with a view to strengthening the field of community monitoring for accountability in health in South Asia. Further, we aim to provide small grants to selected organisations to support the incorporation of the newly acquired skills.

Please note that only COPASAH members will be shortlisted for this training workshop. For more information, please visit the COPASAH website.

The details of workshop and the grant proposal will be made available on the COPASAH website.

We look forward to your support, solidarity and membership. ☐

The workshop is for the South Asian region and is being organised for capacity building of Civil Society Organisations (CSOs) on accountability and transparency with a view to strengthening the field of community monitoring for accountability in health in South Asia.

Growing list of members of COPASAH (till 30 June 2013)

Africa
Budget and Expenditure Monitoring Forum
Centre for Economic Governance and AIDS in Africa- CEGAA
Community Working Group on Health- CWGH
DBL- Centre for Health Research and Development
Lusaka District Health Management Team - LDHMT
Management Systems and Economic Consultants Ltd
National Taxpayers Association
The Institute of Social Accountability- TISA
Training and Research Support Centre- TARSC
Treatment Action Campaign- TAC
Uganda Debt Network
Uganda National Health Users/ Consumers Organization

Europe
Immpact, University of Aberdeen

South Asia
Centre for Health and Social Justice
Child in Need Institute- CINI
Deepak Foundation
ICDDR,B
Public Affairs Foundation
SAHAJ- Society for Health Alternatives
SAHAYOG
Sankalp Sanskritik Samiti
SATHI- Support for Training and Advocacy to Health Initiatives
Shikhar Prashikshan Sansthan
Society for Community Health Awareness Research and Action- SOCHARA
The YP Foundation
Village Health Committee - Sahiyya Resource Centre

Latin America
Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud- CEGSS
Foro Salud- Foro de la Sociedad Civil en Salud
Universidade Federal do Rio Grande do Sul

Individual Members
Caroline Othim– National Taxpayers Association
Manka Martin Kway– German Foundation for World Population, Tanzania
Masuma Mamdani - Ifkara Health Institute, Tanzania
Naresh Kumar - Community Health Cell, Tamil Nadu, India
Neetu Singh - Gramya Sansthan, Madhya Pradesh, India
P. Chandra - D. Arul Selvi Community Based Rehabilitation, Tamil Nadu, India
Shahidul Hoque - ICDDR,B, Bangladesh
Sohail Amir Ali Bawani - Aga Khan University, Pakistan
Sunita Singh, Madhya Pradesh

www.copasah.net

Like Us On facebook

WordPress