Community of Practitioners on Accountability and Social Action in Health

COPASAH Communiqué

Issue 7, Apr– June 2014

Inside this issue:

Expanding Human Rights Accountability to Private Corporations	1
COPASAH Accountability Lab (India)	3
Lihagule Dispensary: Where Expectant Mothers Bring Their Own Water (Tanzania)	4
Flying COPASAH Flag High in Regional Health Meetings (Uganda)	6
Need to Integrate HIV and TB Programmes in Zimbabwe	7
Demanding Greater Transparency in Health Budgets (Africa)	8
In Conversation with Barbara Kaim...	10
Building Solidarity - COPASAH India's National Meeting	12
Global Symposium in New Delhi to Focus on Men for Gender Justice	14
Members of COPASAH	15

Expanding Human Rights Accountability Framework to Private Corporations

The Universal Declaration of Human Rights and its ensuing instruments envisaged a balance between the rights of the people vis-a-vis the state through the framework of the International Human Rights Law. However, pursuant to the neo-liberal economic policies, private business corporations particularly the transnational corporations (TNCs) have emerged as major players in the abuse of human rights in their pursuit of relentless profiteering in a free market oriented global economic order.

In some countries the budgets of such business enterprises exceed the gross domestic product (GDP) of the country itself. In such skewed power relationship, number of policy changes in sectors such as health care have been effected in favour of such private players. Favourable policies or lack of regulatory policies have promoted their unregulated access to natural resources and their control over basic services hitherto catered to by the state as its constitutional duty. Thus, education, nutrition and water, for instance, are turning into market commodities from being essential entitlements of citizens. The refusal of these corporations to be governed by any law illustrates their power, clout and non-accountability to any government, Constitution or people.

Through the pro-market policies and governmental backing, major global financial institutions have largely redefined health as a private good from being a public good. Health and health-care are being increasingly commodified as market goods. This 'corporatisation' and 'marketisation' of health care is pursued by pharmaceutical, diagnostic, medical equipment and health infrastructure industries. Medical education sector too has attained the character of a private commodity. Needless to say that such an approach has infiltrated the health policies of many nations, resulting in huge malpractices and corruption, as well as human rights violations.[1] The increasing murderous attacks on human rights defenders across the globe, intimidation and threats targeting of whistleblowers, illustrate the violence and human rights violations unleashed on communities who resist.

The Human Rights Council has taken note of such arm-twisting tactics by these powerful entities. The United Nations (UN) working group on Human Rights and Business has repeatedly stressed the need for accountability of business enterprises, particularly of TNCs.[2] In this backdrop the report submitted to the Human Rights Council (HRC) in its 26th session by the 'Working Group on the issue of human rights and transnational corporations and other business enterprises' is a significant development. Subsequent to this report a resolution has been passed, on the 'elaboration of an international legally binding instrument on transnational corporations and other business enterprises

[1] David Berger, Corruption Ruins the Doctor-Patient Relationship in India, BMJ2014;348: g3169doi:10.1136/bmj.g3169(Published8May2014)

[2] http://www.ohchr.org/EN/NewsEvents/Pages/CorporationsMustBeHeldAccountableForHRViolations.aspx (accessed 5 July, 2014)

with respect to human rights.' It offers a ray of hope in making corporations accountable in the future. Drafted by Ecuador and South Africa and signed also by Bolivia, Cuba and Venezuela, the resolution has been adopted with 20 votes in favour, 14 votes against and 13 abstentions[3]. Despite US's threat to withdraw all its investments in Africa and despite strong opposition from the EU and its tactical tricks, a majority of the member states independently expressed their will to see TNCs made liable for violating human rights. The resolution states its decision to establish an open-ended intergovernmental working group for a legally binding instrument on TNCs and other business enterprises with regard to human rights. The chairperson has been authorised to draft such an instrument.

This is a clear step forward towards making corporations accept human rights framework and to ensure their accountability. However, it is likely to be a long drawn struggle to achieve the realisation of a legally binding treaty in the matter. There needs to be a persistent engagement from civil society to press for the rights of human rights defenders, fix accountability for human rights abuses by business entities and defend right to dignity and well being of the most vulnerable populations.

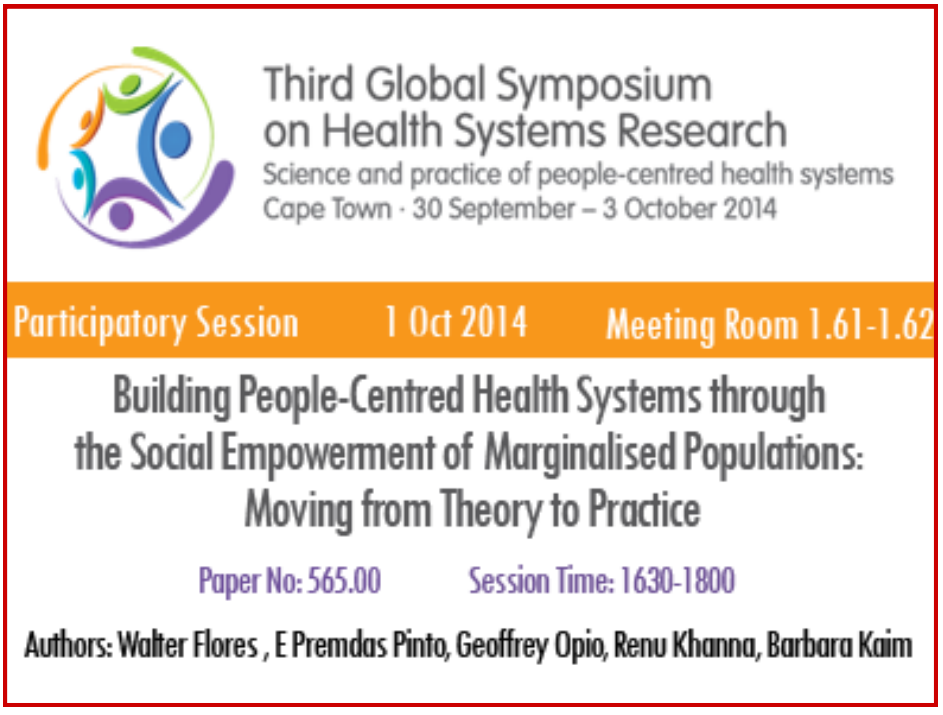
Article by E. Premdas Pinto, South Asia Region Coordinator, COPASAH

E. Premdas Pinto works as the Advocacy and Research Director at Centre for Health and Social Justice (CHSJ), India. He is facilitating the thematic area of community action for health rights with a special focus on processes of community monitoring and accountability in health.

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

[3] United Nations General Assembly - Human Rights Council http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/26/L.22/Rev.1 (accessed: July 10, 2014)

COPASAH at the 3rd Global Symposium on Health System Research, Cape Town



COPASAH Accountability Lab on Critical Accountability Issues (India)

"People refer to community monitoring with varying terms-social accountability, social audit, community based monitoring and planning. Are these connotations the same or is there anything different around these terms?"

The seminar which was held on April 22, 2014 at Centre for Health and Social Justice (CHSJ), New Delhi was instrumental in providing a contextual understanding to the entire process and intention behind the terms we generally use for social accountability. For most of the community practitioners from across India the seminar was a very effective platform that helped them to connect theory with practice on social accountability.

The session on *Accountability Lab* tried to look at how different organisations and people are looking at community Based monitoring (CBM) and how COPASAH would like to see it. Accountability lab connotes the learning space and process aimed at promoting reflections on social accountability. The theme of the first accountability lab was "Critical Accountability Issues for Practitioners of Accountability in Health" to facilitate a clarity among practitioners on the various perspectives on accountability. It comprised of a lecture on the theme of COPASAH Accountability Lab on critical accountability issues (India) by Dr. Abhijit Das, Director, CHSJ. Clarification on the usage of the various key concepts in social accountability was taken up for discussion during this accountability lab.

Voice and Compact:
In order to understand the meaning of the terms pertaining to community based monitoring (CBM) and planning, social accountability and social audit, there should be clarity on the conceptual framework about the role of community. The two essential conditions of social accountability are 'voice and compact'. Voice is a situation where citizens strongly articulate what they need and what they expect from the public services. Compact is an agreement between the state and subject about their rights and entitlements. Social accountability takes place in the social domain. When the state clearly articulates what they will do in terms of public service delivery, it is easy to measure the public service provision against the intent. Then it becomes a part of social accountability. Social accountability can lead to benefits to all the parameters of the society and not only specific to health through citizenship voice, autonomy and capacity. Not only the individual autonomy, but collective self governance is equally important in accountability process. In COPASAH the vision centres on citizenship paradigm, with the assertion that community centrality is completely non-negotiable in the social accountability process.

Participation:
In order to understand the development of health movement, the notion of citizenship is very important. Participation can vary from passive engagement to self mobilisation and from people being positive beneficiaries to active participants. Political condition of the community in which accountability is implemented is closely allied with active citizenship. It is important to transform subjects to citizens, wherein there is participation in policy formulation and democracy.

Construction of agency-autonomy was highlighted as a vision of COPASAH accountability, in which the agency means to be able to exercise one's desire, and articulate at a public platform. The group's interest is to empower the marginalised to challenge the existing power relation with the state and get the decision making in favour of marginalised people and their autonomy. There are imbalances in health knowledge, as well as power relation between the provider and community and this inequality is further increasing because of the issues of marginalisation and poverty. Therefore, any accountability process has to consider this huge imbalance instead of starting from a normative assumption. It was further emphasised that the trust at lowest level has to increase to meet the demand and supply.

The lecture was followed by a discussion on the challenges of social accountability and the ground reality. This was enriched by sharing of field experiences by the participants. The various political factors never remain constant where a community is involved. Empowering the community through an experience or exposure may ensure sustainability in the long run.

The lecture will be soon uploaded on the website.

Various political factors never remain constant where a community is involved. Empower the community through an experience or exposure, may ensure sustainability in the long run.

Article by COPASAH Secretariat Team, India
To know more about events organised by COPASAH, please **CLICK HERE**.

Lihagule Dispensary: Where Expectant Mothers Bring their Own Water (Tanzania)

The village's water pipes were removed in order to be replaced by a more efficient pipeline system – but in a piquant twist, the new pipes were never put into place. This has left the village literally high and dry.

It's almost a week since Gostake Haule gave birth to a baby girl, Rachel. Though she was lucky to deliver her bundle of joy safely, her experience at the hospital is not something she will soon forget. "When I went into labour I took the normal things women take with them to hospital, but my relatives also had to take a 20 litre bucket of water while accompanying me to Lihagule dispensary for delivery," says Gostake.

While being discharged from the dispensary, she was surprised to hear the nurse asking her relatives to collect her bed sheets and return them after washing. They did so, giving back the cleaned sheets after a few days so that they could be used by other patients. The problem of water shortage is so severe in Lihagule, located in a semi-arid part of Southern Tanzania's Masasi Ward in Ludewa district that patients including expectant mothers, have to carry their own water to the dispensary. In a bid to end the water woes of its residents, the Lihagule village government is urging the central government to help it establish a water project. Pressure from residents has at least prompted Ludewa's current Member of Parliament (MP), Deo Filikunjombe, to address the issue. Filikunjombe says, "I have already shared my responsibility of buying a water tanker for the dispensary. The onus now rests with the village government to get it transported from Njombe to the facility." Unkept promises by the area's previous political representative and bungling by the authorities has brought about a tragic situation in Lihagule. The village's water pipes were removed in order to be replaced by a more efficient pipeline system – but in a piquant twist, the new pipes were never put into place. This has left the village literally high and dry.

Rues Lihagule resident Agusta Haule, "I too was asked to bring a bucket of water with me for delivery. Water shortage is a big problem not only at the dispensary but also in the village." Fortunately, it was raining when Gostake was taken to the dispensary. Like others in the village, her family had gathered rainwater from house roofs and also collected rainwater at the dispensary which was quite helpful. The nurse at the dispensary, Maraim Mpangala, confirms, "Water shortage in the area adversely affects the services here." Mpangala, who is the dispensary's only employee, has to walk long distances to fetch water for the facility from the only pond in the village. "The problem is so acute that I am forced to ask expectant mothers to bring water along when coming here for delivery," says the 50-year old nurse. A delivery consumes nearly 20 litres of water. Not just expectant mothers, all patients are bearing the brunt of the water shortage. The dispensary serves Lihagule's 1450 households. The whole exercise of fetching water takes Mpangala nearly eight hours in a day, drastically reducing the time she gets to serve her patients.

Source of the Water Problem

Lack of water consumes a lot of time of the womenfolk who have to go in search of it. Lihagule's Executive Officer, Marko Mituba confirms that women and children walk for almost eight hours to get water from the village's only source in Nyantivilili area. Villagers are even forced to skip bathing for long durations. "It is common for pupils to attend school without bathing, while water to wash their school uniforms is hardly available. The teachers too understand the state of affairs," says villager Avers Augusta. Adds Mituba, "The pond water is not clean enough, putting the villagers' health at risk. During the rainy season the water turns muddy, causing diseases like diarrhoea."

In fact, water was earlier being supplied to a majority of Lihagule's residents through a water project till Ludewa's then MP Prof. Raphael Mwaliosi directed that some changes be made to improve the supply. The water project's nearly 20 year-old six inch water pipe was to be replaced by a more efficient and narrower three-inch pipe which was expected to bring the supply to all the villagers. However, though the old pipes were removed it has been a long wait for the villagers as no new pipes have been installed yet.

"We were promised a new water pipe by the MP but nothing has happened to date," says Mituba. The district water engineer's office too has not provided any answers regarding completion of the project.

Villagers Demand a Water Project

Augusta recalls that Filikunjombe had promised to provide a solution for the water problem after being elected. "He had asked us to give him three years because there was a lot to do…maybe he will do something this year", she hopes. When contacted, Filikunjombe said, "Water shortage is a problem burdening many other parts of my constituency." Expressing his inability to solve the problem alone, he urged the people to work with the village government and councillors to tide over the water problem. "I need everyone's support," he said. On being questioned about the replacement of the old pipes, the MP said the Chancellor would provide answers.

Villagers are disappointed at the way district authorities are handling the matter, with the area not having any infrastructure for water storage either. However, the Lihagule village administration plans to take up the matter again with the district authorities and press for further action. According to the National Water Policy, 2002 and the Water Act 2009, citizens have to establish water projects in their areas through their local governments. The central government assists them only when the cost of the project is too high for the local government to afford on its own. The District Water Engineering department is supposed to work closely with the village government in carrying out feasibility studies on water projects and in providing technical advice.

There is some hope for the dispensary at least, with construction of a rainwater harvesting system underway, even though it is progressing at a snail's pace. With rains in this semi-arid region being erratic and the water harvesting technology being rain-dependent, the system is likely to be functional for only a short interval in the year during the brief rainy season. The Lihagule village administration and residents, nevertheless, are determined to make authorities accountable for the mystery of their missing pipes.

The Lihagule village administration plans to take up the matter again with the district authorities and press for further action. According to the National Water Policy, 2002 and the Water Act 2009, citizens have to establish water projects in their areas through their local governments.

Article by Sauli Giliard

Sauli Giliard works as Programme Officer in Daraja Development, Tanzania.

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

Flying COPASAH Flag High in Regional Health Meetings (Uganda)

Aidspan requested monitoring of the Global Fund by utilising the lessons and experiences gained through COPASAH The meeting provided an opportunity for governments, UN organisations and civil society representatives from four African countries to learn how to implement this approach in sexual, reproductive, maternal, newborn and child health.

Sharing of COPASAH's best practices and its experiences at discussions in two significant workshops is helping to implement a rights' based approach to health in four African countries. It is also shaping the creation of a health watch mechanism in the region through the Global Fund.

The two meetings in which I participated in November 2013, (at Lilongwe in Malawi and at Nairobi in Kenya) in my capacity as Executive Director of the Uganda National Health Users'/ Consumers' Organisation (UNHCO) and as the regional coordinator for COPASAH East and Southern Africa region, turned out to be brainstorming sessions with different stakeholders on board.

Members sharing notes during the workshop in Lilongwe, Malawi

Sharing of Innovations and Best Practices

The Lilongwe regional workshop focussed on the application of a rights' based approach (RBA) for women and children's health. The meeting provided an opportunity for governments, United Nations (UN) organisations and civil society representatives from four African countries to learn how to implement this approach in sexual, reproductive, maternal, newborn and child health. All participants agreed upon the further steps to be taken in the countries, like consensus on baseline in a country and what to do after it.

UNHCO's RBA approach was also recognized in the meeting as an innovation. At UNHCO we plan to further strengthen the 'Patient Charter' to see how the RBA can be used effectively to improve maternal and child health. The best practices and experiences in community monitoring of COPASAH for improved health outcomes were also shared in the meeting.

A Watchdog for the Global Fund

The second meeting in Nairobi was organised by the Kenya-based international Non Government Organisation (NGO) Aidspan. Aidspan's mission is to reinforce the work of the Global Fund to Fight Acquired Immuno Deficiency Syndrome (AIDS), Tuberculosis and Malaria. The meeting focussed on improving the effectiveness of the Global Fund through putting into place a local watchdog mechanism. Aidspan requested the East and South African regions to participate in monitoring of the Global Fund by utilising the lessons and experiences gained through COPASAH. It asked the region to either provide guidance to the Global Fund or conduct the actual monitoring. I volunteered to be in the committee, called Africa Health Watch.

Participants brainstorming during the Aidspan meeting in Nairobi, Kenya

The participants took keen interest in the Agurulude Health Centre case study which has been published by COPASAH. They also wanted to know more about UNHCO's experience in budget advocacy using text messages for replication.

Article by Robinah Kitungi

Robinah Kitungi is COPASAH regional coordinator-COPASAH East and Southern Africa Region and is working with Uganda National Health Consumers' Organisation (UNHCO), Uganda.

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

Need to Integrate HIV and TB Programmes in Zimbabwe

Looking at Zimbabwe's challenges in eliminating tuberculosis (TB), health experts are calling for greater integration of the Human Immunodeficiency Virus (HIV) and TB programmes within the country's healthcare system. UNAIDS country director Michael Bartos says, "Tremendous progress has been made in minimising the spread of HIV while the TB program has been relatively weak."

Strengthen Coordination Systems

At a recent workshop, Bartos highlighted the urgent need to strengthen coordination between the health systems of HIV, TB and malaria respectively. The workshop with Zimbabwe's civil society organisations was organised by Acquired Immuno Deficiency Syndrome (AIDS) Accountability International, Southern Africa AIDS Trust and Zimbabwe AIDS network. "As civil society, we need to enhance HIV mobilisation to support TB, as mobilisation is quite weak in communities where it matters. The issue of lack of resources also needs to be addressed to eliminate the spread of TB," pointed Bartos.

Senior researcher, Dr Gemma Oberth of AIDS Accountability International added, "The top priority is creating a coordinating mechanism for HIV and TB. HIV coordinating structures are disproportionately strong in comparison to the civil society networks built around tackling of TB." Representatives of HIV groups created a priorities charter at the workshop, stressing upon an 'advocacy road map' for the Global Fund to fight AIDS, TB and malaria. Identified priorities included prevention, treatment, advocacy, care and support, mitigation and stigma reduction.

Increase in New TB Cases

A WHO-commissioned research project ranks Zimbabwe 17th among the 22 countries in the world worst-affected by TB. Victoria James, Director of New Dimension Consulting which conducted the research, brought out the trend of growth in the disease saying, "The estimated incidence of new TB cases was 633 per 100,000

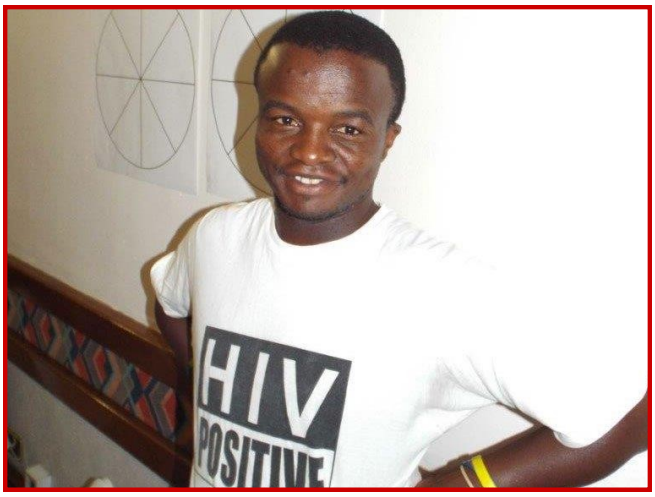
She said, "75 percent of adult TB cases are reported to be co-infected with HIV. The rate of HIV testing in TB is 97 percent." She expressed concern that over the very low treatment rates and exhorted the civil society to take on a more active role in addressing the issue.

Challenges in Health System

Dr Charles Sandy, deputy director of the AIDS and TB programmes at the Ministry of Health and Child Care said, "TB is managed through the routine health system. Despite collaborating with local and international partners, we are facing paucity of resources."

Although some progress had been made in addressing the disease. Dr Sandy said, "we are dependent on the healthcare delivery system which faces issues such as lack of motivation among health workers, low community awareness on TB and a resource-crunch." He pointed that the government is working with civil society organisations through the Country Coordinating Mechanism and he also invited NGOs to offer suggestions regarding how to increase their involvement.

75 percent of adult TB cases were reported to be co-infected with HIV. There is need to enhance HIV mobilisation to support the relatively weaker TB programme.



Emmanuel Gasa is a young HIV/AIDS activist working within the civil society in Zimbabwe

Article by Wallace Mawire

Wallace Mawire is a Freelance Writer and award winning photojournalist based in Zimbabwe and regularly writes on health and development issues. He is also a key Correspondent for the Key Correspondents Programme supported by the International HIV/AIDS Alliance.

To know more about the work done by Key Correspondents, please **CLICK HERE**.

Demanding Greater Transparency in Health Budgets (Africa)

This call to action marks the launch of an African-led network demanding better use of existing funds for women and children's health as well as a greater allocation in national budgets for mothers' and babies' survival.

Role of Africa Health Budget Network

The Africa Health Budget Network (AHBN) is a group of African and global organisations and individuals using budget advocacy as a tool to improve health service delivery in Africa. AHBN concentrates on three strands of work: connecting members to formal training opportunities, events and tools; promoting learning and sharing within the network and applying coordinated and focused pressure on African leaders on their health financing commitments.

Need to Revise Health Budgets in Africa

Accessing acceptable, high quality healthcare is a fundamental right of every human being.[1] Although Sub-Saharan African countries have succeeded in decreasing the ratio of maternal mortality by 49 percent between 1990 to 2013, 179,000 women still die due to pregnancy and childbirth related causes every year, largely due to lack of access to quality care. [2]

Adequate investment in health systems, including health workers, drugs and infrastructure could stop these preventable deaths and bring economic and social benefits worth nine times as much required[3]. Despite this evidence, less than half of African Union governments currently spend $54 per person on health, which is the minimum requirement to cover basic health services.[4] Accelerating the coverage of RMNCH (Reproductive, Maternal, Neonatal and Child Health) interventions at a rate to match that of the best performing countries in Africa would imply spending only $9.05 more per person per year, on average.[5]

While many service delivery and health financing commitments have been made in the context of the Global Strategy for Women and Children's Health, and there are other regional initiatives (see Table), few of these commitments have been met. Ensuring that commitments made by African Governments are delivered and implemented, requires a concerted focus on accountability. Budget advocacy is a useful tool to strengthen accountability as it enables those outside (or even within) government to measure the amount of resources allocated to and spent on particular commitments.

Activists Demand Accountability in Health

Civil society organisations in Africa are calling for greater accountability and transparency from their leaders on the use of public funds for the survival of mothers and babies. At a World Health Organisation (WHO) international conference held in Johannesburg on July 1, activists of the Partner's Forum pressurised senior government officials from across the continent on the issue.

This call to action marks the launch of an African-led network demanding better use of existing funds for women and children's health as well as a greater allocation in national budgets for mothers and babies' survival.

The AHBN believes it needs to get specific about the promises made on these issues, and to track whether these promises have been kept. Its first priority, however, is to make sure African Governments are transparent about what they spend on health. While most governments are committed to improve healthcare, like through greater spending, however it is difficult to check whether the promises are being kept if the budget is not publicly available or if the information in the budget is not clearly presented.

The AHBN has compiled a scorecard[6] on the level of openness by governments on their health spending. Out of 26 African countries profiled, only one i.e. South Africa scores as being sufficiently transparent. Dr Aminu Magashi Garbain,

[1] United Nations Committee on Economic Social and Cultural Rights. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) [Internet]. United Nations; 2000. Available from: http://www.unhcr.org/refworld/pdfid/4538838d0.pdf

[2] World Health Organisation, UNICEF, UNFPA, The World Bank & the United Nations Population Division. (2014). Trends in Maternal Mortality: 1990 – 2013.Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: WHO.

[3] Stenberg, K. et al (2014) Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework, The Lancet, 383: 1333-54.

[4] World Health Organisation, Global Health Expenditure database, "General government expenditure on health / cap Purchasing Power Parity (NCU per US$), 2012", accessed 23rd May 2014.

[5] Table 2, p. 1343, Stenberg, K. et al (2014) Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework, The Lancet, 383: 1333-54.

[6] http://www.mamaye.org/en/evidence/africa-health-budget-network-transparency-scorecard The scorecard uses data from the Open Budget Index 2012, http://survey.internationalbudget.org/#download

Table : Budgetary allocations in various commitments to improve women and children's health in Africa

Initiative	Promise Made
Commission on Information and Accountability (2010)	Track and report (i) total health expenditure (ii) total reproductive, maternal, newborn and child health expenditure
	Create "compacts" between country governments and all major development partners to enable predictable commitments
	Relate spending to commitments, human rights, gender and other equity goals and results
Abuja Declaration (2001)	Allocate at least 15% of annual budget to improving the health sector
Maputo Programme of Action (2007)	Institutionalise National Health Accounts (NHA)
	Allocate a higher proportion of national health budgets to SRH (sexual and reproductive health)
African Union Plan of Action to end preventable maternal, newborn and child mortality (2013)	Increase resources for CARMMA/MNCH (Existence of CARMMA trust fund)
	Implement health financing policies and strategies to promote universal health coverage
	Reduce proportion of out-of-pocket expenditure to total health expenditure

a practitioner said, "African activists are now using the internet and social media to discover more about their government's priorities. We note that our governments are shy about sharing public expenditure on health. We want to know more. This matters to the women and children of my country, Nigeria. At an international conference in Johannesburg we will be calling for greater transparency in health spending and demand increased expenditure on the health of women and children which is critical to Africa's progress."

Dr Mohamed Yilla, Country Director for the Mamaye Campaign in Sierra Leone added, "Countries like ours with poor survival rates for mothers and babies are also often plagued with under-investment in the health sector. For a couple of years now civil society organisations in Sierra Leone have been advocating for increased and more transparent health financing. This has led to an increase in the health budget. It is vital they continue to pressure the government to meet its commitments. The African network will help us share our experiences and the lessons learnt to improve our advocacy."

Budget advocacy is a useful tool to strengthen accountability as it enables those outside (or even within) government to measure the amount of resources allocated to and spent on particular commitments.

Article by Dr Aminu Magashi Garba

Dr Aminu Magashi Garba is a medical graduate and holds a masters degree in Public Health from the London School of Hygiene and Tropical Medicine. He was Executive Director of the Nigeria-based NGO Community Health and Research Initiative from April 2002 to December 2009.

He currently works with a DFID-funded project *"Evidence for Action in Nigeria on Maternal and Newborn Health"* and also coordinates a national coalition of civil society organisations and media, *'Accountability for MNCH in Nigeria,'* that strives to promote accountability and transparency in improving services via advocacy, use of annual scorecards for MNCH and budget-tracking. He is also the regional lead of the Africa Health Advocacy Network (AHBN) comprising committed individuals, media and organisations in Africa, which promotes health budget accountability, participation and transparency.

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

In Conversation with Barbara Kaim

Barbara Kaim is the Global Steering Committee member of COPASAH and is a key affiliate of East and Southern African region of COPASAH. E Premdas Pinto from the editorial team had the following email interview with her.

How have you been involved in COPASAH in the recent past?

I was fortunate to witness the birth of COPASAH. I was a participant in the historic meeting held at Johannesburg in July 2011, where COPASAH came into being. The meeting brought together 39 practitioners from across 12 countries. All the practitioners had experience in health rights, community monitoring, budget monitoring and expenditure tracking. The meet was an exciting space to share our knowledge and experiences in the field of accountability and community monitoring in health. This enabled us to think creatively about the future and one of the outcomes was formation of this network.

Since then I have represented my organisation, the Training and Research Support Centre (TARSC) in the COPASAH global steering committee, in association with TARSC colleagues and especially Rene Loewenson, also a COPASAH founder. In addition, I've taken the lead in certain aspects of work that we are carrying out in the East and Southern African regions, with the Uganda National Health Consumers Organisation (UNHCO) as regional coordinators.

Can you mention some key activities that helped in getting people involved in COPASAH in Eastern and Southern Africa?

Over the last year, TARSC has been working with COPASAH and the Regional Network on Equity in Health in East and Southern Africa (EQUINET) to strengthen the use of participatory approaches in building community roles in accountability and action. EQUINET has been involved in this area for over a decade. Its work highlighted the importance of access to resources, especially in ensuring that meaningful resources reach the primary care and community level. Given the wide social inequalities in our region, we wanted to explore ways to strengthen people's voices and roles in decision-making in the health systems, and in the access and use of health services.

These issues motivated us to hold a regional meeting at Zimbabwe in October, 2013. The meeting was hosted by TARSC in association with COPASAH and EQUINET. There were 30 participants from Kenya, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. Many participants were hearing about COPASAH for the first time.

Given the wide social inequalities in our region we wanted to explore ways to strengthen people's voices and roles in decision-making in the health systems.

Community members in Cassa Banana, Zimbabwe discussing their roles in the newly formed Community Health Committee

The training focused on the use of an approach called Participatory Reflection and Action (PRA). In this, community members affected by problems actively participate in gathering, organising and reflecting on their own experience and generate evidences to identify actions, particularly those actions which people can take themselves' to produce change.

Following the regional meeting, TARSC has been providing technical support to organisations in Zimbabwe and Tanzania in exploring how PRA approaches can position the discussion on accountability and initiate a dialogue between communities, frontline health workers and local authorities. The organisations involved – Zimbabwe Association of Doctors for Human Rights, Zimbabwe National Network of People Living with HIV, Health Promotion Tanzania and Ifakara Health Institute (IHI) – and these have been reporting regularly about their work on the copasahconnect e-list.

What was the response from practitioners on the initiatives and idea of COPASAH?

There's been a great response. Our regional membership has increased to 81 and the geographic spread too has widened. It has led to deepening of the debate on the link between social accountability and community empowerment in our region. The discussions have focused on the need to view community monitoring as part of a larger process

That starts with building an informed health-literate community which is able to interact with health service personnel to jointly design, implement and monitor plans and budgets for the health system at the primary care level.

This in turn potentially allows for improved transparency, better dialogue between rights holders and duty bearers, and the establishment of platforms for feedback and consultation. We hope these discussions will be taken up at a wider level throughout COPASAH globally.

Could you summarise key achievements and challenges as COPASAH in your region?

In addition to what I've mentioned earlier, I would say the socio-economic and political environment in our region presents powerful contextual factors to motivate both community monitoring and social accountability work and also makes it more difficult, especially where there are resource constraints and a lack of political will on the part of duty bearers to engage with community concerns.

Despite these challenges, we are fortunate to have in East and Southern Africa a strong civil society with a wide range of experiences in interacting with public officials which is trying to build more people-centred health systems. COPASAH is already working with a number of such groups, especially through the EQUINET family, serving to broaden and strengthen our work.

How can we increase solidarity through COPASAH?

Well, one, this newsletter is a good way to share stories, experiences and build a sense of community. I'd encourage everyone to visit the COPASAH website and source the interesting publications available there.

Information-sharing is just one way of building solidarity. Ultimately, our commitment is to those at the community level who do not have a voice and whose rights are being ignored or abused. Despite differences in the ways which various regional groups are working in COPASAH and differing cultural contexts, we are linked by the similar struggle to make those in power – whether state or private sector – more accountable to the majority. We need to work more on developing strategies to achieve this. Our membership should be used to support community voices and to play roles in shaping, implementing and monitoring the policies and performance of the state, and in shaping perspectives on the options for change.

We also need to build alliances with other organised groups around the world not only in the field of health but also in related sectors like environment and gender. This would create a stronger movement committed to ensure that the states' promises of meeting the needs of its citizens are fulfilled.

This is a challenging set of targets for COPASAH. I look forward to being a part of this challenge, in solidarity with other members of our Community.... and beyond.

Despite differences in the way various regional groups are working in COPASAH and differing cultural contexts, we are linked by the similar struggle to make those in power – whether state or private sector – more accountable to the majority.

Barbara Kaim

She is a Programme Manager at the Training and Research Support Centre (TARSC), Zimbabwe and also a member of the COPASAH Global Steering Committee. She is actively involved in strengthening COPASAH activities in the East and Southern African region.

To know more about the TARSC , please CLICK HERE.

Building Solidarity - COPASAH India's National Meeting

Thirteen participants from six Indian states deliberated on some of the critical areas of perspectives among COPASAH members, deciding on pathways to strengthen COPASAH and come up with ideas on how to increase the contribution as well as participation of members.

The community of practitioners in health accountability in India has grown in strength and solidarity under the mantle of Community of Practitioners on Accountability and Social Action in Health (COPASAH) with significant insights and constant support from steering committee members. This solidarity has gained momentum with two international workshops on accountability and health (Mumbai workshop in February 2013 and Delhi workshop in September 2013), a regional workshop in Gujarat, and two learning exchange visits facilitated by the South Asia region.

The need for consistent support to sustain this group with continued inputs, opportunities for exchanges and growth has been expressed in several ways. Keeping this objective in view, a one-day meeting of COPASAH members who had earlier participated in the Mumbai and Delhi COPASAH workshops, was organised at the office of the Centre for Health and Social Justice (CHSJ) at Saket in New Delhi on April 22, 2014.

Thirteen participants from six Indian states i.e. Bihar, Delhi, Karnataka, Madhya Pradesh, Odisha and Rajasthan participated in it. The key objectives of the workshop were: to facilitate discussions on some of the critical areas of perspectives among COPASAH members, decide on pathways to strengthen COPASAH and come up with ideas on how to increase the contribution as well as participation of members.

After a round of introductions, E. Premdas of CHSJ gave a brief overview of COPASAH and its process in South Asia. He noted that COPASAH is a global learning platform for practitioners of accountability in health. The members are from three regions - Latin America, South Asia and Sub Saharan Africa. The group aims to promote people -centric and health rights' oriented practices. The platform provides for coming together and sharing experiences, knowledge and skills.

There is a gap in the exchange of knowledge between the academic researchers and practitioners. Significantly, thus one of the priorities of COPASAH is to document the field experiences of practitioners and make these available for learning and sharing, he said. Premdas informed about the data and resources available on the COPASAH website, blogs, listserv, newsletter, case studies and documented experiences of the practitioners and encouraged participants and practitioners to document their experiences and share them through these channels. "Efforts are being made to translate these resources from English into other local languages also," he added.
The challenge however, is to let the group grow on its own as it is not getting funds from anywhere, said Premdas. He further introduced the theme of the proceeding lecture of Dr Abhijit in the seminar and said, that the lecture aimed to lay out the theoretical issues and perspectives of citizen-centric accountability.

Different Perspectives of Accountability in Health
A seminar titled, '*Critical Accountability Issues for Practitioners of Accountability in Health'* was organised during the meeting. This learning space and process, termed as the '*Accountability Lab'* aimed at facilitating clarity among practitioners on the various perspectives on accountability such as those promoted by the World Bank, international donor agencies and the like, vis-a-vis those promoted by COPASAH.

The seminar further laid out the theoretical issues and perspectives on accountability and this session comprised of a lecture by Dr Abhijit Das, Director, CHSJ followed by discussions. It brought forth various perspectives about accountability in health and the different expectations and experiences around community monitoring, which has become an essential tool for the health and social sector. It was analysed in the seminar, how various organisations and individuals are looking at community monitoring and how COPASAH would like to see it implemented. It was also pointed out that COPASAH's vision focused on a citizenship paradigm, and community centrality was absolutely non-negotiable in this social accountability process.

Participants discussing their future plans for strengthening the network

The lecture was followed by a clarification of terms and concepts. The challenges of social accountability and its ground reality were discussed thereafter and This was enriched by sharing of field experiences by participants.

Using Technology to Support Practitioners

A session introducing the COPASAH website and blog was conducted by Dr Bharti Prabhakar. She demonstrated the different resources and learning materials, presentations and lectures delivered at other COPASAH meetings, and global and Indian news updates, available on the COPASAH website. The COPASAH website, blog, e-mail group, Facebook page and quarterly newsletter were also screened.

An innovative online learning platform- the Resource Pack - was also introduced. She outlined that the platform has several concepts, manuals and tools to support the learning of community monitoring practitioners. The Resource Pack can also be used for training purposes. It was suggested that participants can share any tools, case studies, experiences etc for wider use and to enable exchange of knowledge.

Strengthening the Forum

Discussions ensued on how to strengthen the COPASAH learning network and platform. Virtual meeting was proposed as one of the methods of staying connected. It was suggested that regular Skype or Google Hangout meetings could be held every month, on a fixed day depending on the convenience and availability of members. In each session there could be two presentations of 10 minutes each related to field experiences of community monitoring, followed by discussions.

Lavanya Mehra of CHSJ introduced the Skype and Google Hangout as a medium to conduct meetings and discussions among members. With a view to formalise this effort of promoting sharing, reflection and learning, the following methodology was developed for implementing over the next six months:

- Skype meetings to be conducted once in two months, and to comprise seminars on practice of accountability and community monitoring
- The fourth Saturday of every second month, starting from May 2014 , has been fixed for this meeting

V R Syam Prasad, Aneka sharing the community monitoring practices

- The process entails :10 minute presentation, 15 minutes of discussion and note sharing at the end of each Skype meeting
- Moderator's responsibility - Ensure that notification for participating in the meeting is sent out at least 15 days in advance and a summary note with presentations is sent to all those participating. Moderating sessions and giving directions to the discussions as well as building on them was also laid out as an important responsibility

The last session of the day focussed on strengthening of the forum of young practitioners through a practice session on use of technology and social media. Discussion and demonstration on the technical know-how and practice of Google Hangouts and Skype was also undertaken. The one-day meeting concluded with participants agreeing to stay connected and share their experiences for mutual learning. Participants were also urged to contribute through articles in the COPASAH blogs, listserv and newsletter.

Virtual meetings were proposed as one of the methods of staying connected. It was suggested that regular Skype or Google Hangout meetings could be held every month on a fixed day depending on the convenience and availability of members.

Article by Dr Bharti Prabhakar

Dr Bharti Prabhakar works as Programme Officer in Centre for Health and Social Justice (CHSJ), India.

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

Global Symposium in New Delhi to Focus on Men for Gender Justice

The symposium encompasses a holistic approach to understanding the implications of masculinities in different domains and disciplines.

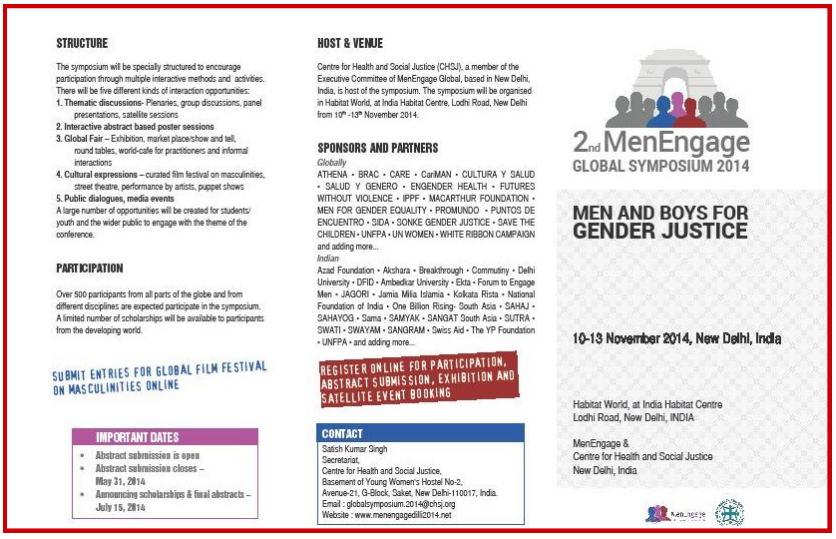
As the work with men and boys for gender equality matures, MenEngage, a global alliance of organisations working with men and boys is organising the 2nd MenEngage Global Symposium in New Delhi from 10-13 November 2014 in India Habitat Centre, New Delhi. The overall theme of the symposium is Men and Boys for Gender Justice. There is deepening realisation that while men and boys are implicated in violence and discrimination against women and girls, many men and boys are themselves victims of violence and risks associated with narrow views of masculinity. 'Masculinities' is emerging as an important lens to understand the influences and compulsions men face. The symposium encompasses a holistic approach to understanding the implications of masculinities in different domains and disciplines. Its purpose is to find ways to engage men and boys for gender equality so that society becomes more caring and non-violent and gender relations become more harmonious.

Building on First Symposium

The first Global Symposium on Engaging Men and Boys for Gender Equality, held in Rio de Janeiro in March 2009 with the theme 'Going to Scale' had marked a major advance by MenEngage in articulating and operationalising work to involve men in gender equality. Today, there is an increasing social consciousness that the issue of women's empowerment and gender equality cannot be for women alone. Thus, five years after the Rio symposium the four-day symposium in New Delhi will promote dialogue with those engaged in women's rights work in order to seek directions on how men and boys can creatively contribute to gender equality.

It will bring together researchers and practitioners, advocates and activists, government representatives and the donor community to share experiences and evidence, reflections and insights, and gain from interactions with global experts. The conference host MenEngage Alliance Global comprises over 400 NGOs and United Nations (UN) partners, all of whom work individually and collectively with men and boys for gender equality. Alliance members include EngenderHealth, International Centre for Research on Women (ICRW), International Planned Parenthood Federation (IPPF), Men's Resources International, Promundo, Salud y Genero, SONKE Gender Justice Network and The White Ribbon Campaign. The New Delhi based Centre for Health and Social Justice (CHSJ), a founder member of MenEngage, is hosting the secretariat for the global symposium.

The conference will see a mix of formal and informal events at the conference venue India Habitat Centre. Speakers will present their ideas or key concepts around the themes of the symposium through oral or poster presentations. There will also be round table or 'chaupal' discussions, exhibition booths where participants can showcase their work, satellite sessions and a host of other planned programmes. The preparatory process includes a series of country level events to engage the public organised across South Asia and the globe around the core tracks of the symposium, which will build up to the event in New Delhi. The preparatory process is being rolled out with cultural events, talks, debates and similar programmes promoting the symposium and the issues it will raise. Student engagement programmes like talks and panel discussions in colleges and universities are being planned. In particular, a specially curated film festival on masculinities is expected to be an eye-grabber at the symposium.



Article by Global Symposium Secretariat Team, India

To know more about 2nd MenEngage Global Symposium 2014 – Men and Boys for Gender Justice, please **CLICK HERE**.

Members of COPASAH

New Editorial Team Member

Opio Geoffrey Atim, is a development practitioner with 6 years of progressively responsible experience in designing, managing and implementing participatory (demand-side) social accountability programmes. He has hands on experience in employing various social accountability methodologies in the field. He is currently the Senior Accountability Manager, GOAL, Uganda and was involved in research and designing and is currently managing a large scale Pilot health accountability project, Accountability Can Transform Health (ACT Health). With support from Department for International Development (DFID), GOAL has formed a partnership with Innovations for Poverty Action (IPA), to significantly scale up this approach across 16 districts of Uganda, for considerable research and impact evaluation component of this programme. Geoffrey loves programmes, especially those that create conditions for positive and systematic change and believes that accountability can transform health outcomes.

Steering Committee Members

The COPASAH Steering Committee (SC) includes representatives, from each of the three geographical regions represented in the convening (Africa, India and Latin America) and a representative from Accountability and Monitoring in Health Initiative (AMHI). The SC is composed of the following members:

Abhay Shukla
Support for Advocacy and Training to Health Initiatives (SATHI), India

Abhijit Das
Centre for Health and Social Justice (CHSJ), India

Ariel Frisancho Arroyo
CARE, Peru

Barbara Kaim
Programme Manager, Training and Research Support Centre (TARSC), Zimbabwe

E. Premdas Pinto
South Asia Region Coordinator, COPASAH

Renu Khanna
Founder Member, SAHAJ Society for Health Alternatives, India

Robinah Kaitiritimba
National Health Users/Consumers Organisation (UNHCO), Uganda

Walter Flores
Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud-CEGSS (Center for the Study of Equity and Governance in Health Systems), Guatemala

Vinay Vishwanatha
Accountability and Monitoring in Health Initiative (AMHI), USA

Editorial Team

Ariel Frisancho Arroyo
CARE Peru

E. Premdas Pinto
South Asia Region Coordinator COPASAH

Vinay Viswanatha
Open Society Foundation

Walter Flores
Global Coordinator, COPASAH

Opio Geoffrey Atim
Senior Accountability Manager GOAL, Uganda

Growing list of members of COPASAH

Africa—40

Europe—8

Latin America—3

South Asia—68

Individual members—77

www.copasah.net