Practitioners Convening on Community Monitoring for Accountability in Health

CONVENING MINUTES

18th – 20th July 2011

Held at
Indaba Hotel and Conference Centre
Johannesburg
South Africa

Accountability and Monitoring in Health Initiative
Public Health Program

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LIST OF ACRONYMS

AFR	Accountability for Reasonableness
AMHI	Accountability and Monitoring in Health Initiative
CBM	Community Based Monitoring of Health Services
CBR	Community Based Research
CEGAA	Centre for Economic Governance and AIDS in Africa, South Africa
CEGSS	Study of Equity and Governance in Health, Guatemala
CINI	Child in Need Institute, Jharkhand, India
CMP	Community Monitoring Programme
CSA	Centre for Social Accountability, South Africa
CSO	Community Support/Service Organization
EQUINET	Regional Network for Equity in Health in East and Southern Africa
HCC	Health Centre Committee
LDHMT	Lusaka District Health Management Team, Zambia
MUHURI	Muslims for Human Rights, Kenya
NGO	Non-Government Organization
NRHM	National Rural Health Mission
OSF	Open Society Foundation
PAF	Public Affairs Foundation, India
PAR	Participatory Action Research
PETS	Public Expenditure Tracking Surveys
PHC	Primary Health Center
PHM	People's Health Movement
PHP	Public Health Program at Open Society Foundation
PRA	Participatory Reflection and Action
PRMF	Public Resource Management Framework
REACT	Response to Accountable Priority Setting for Trust in Health Systems
SAHAJ	Society for Health Alternatives, India
SAM	Social Accountability Monitoring
SAS	Social Accountability System
SATHI	Support for Advocacy and Training in Health Initiatives, India
TARSC	Training and Research Support Centre, Zimbabwe
TISA	The Institute for Social Accountability, Kenya
UNHCO	Uganda National Health Consumers Organization
VHSC	Village Health and Sanitation Committee
WHRF	Women's Health Rights Forum, India

1.0 Background

This paper documents in detail the minutes of a two and a half day convening of experienced practitioners of community monitoring for accountability in health who met in Johannesburg, South Africa from 18th – 20th July 2011. The meeting was organized by the Accountability and Monitoring in Health Initiative[1] (AMHI) of the Open Society's Public Health Program (PHP), in close collaboration with an advisory group[2] of four experienced practitioners from Guatemala, India and Zimbabwe.

AMHI's internal reflections and a commissioned mapping of existing resources in community monitoring for accountability in health have highlighted that it is an evolving field, with few initiatives across the world. One of the critical gaps identified as hampering the advancement of the field was the absence of spaces and opportunities for practitioners of community monitoring for accountability in health to come together to share, collectively reflect on their experiences and to think creatively about the field and its future. This was confirmed through AMHI's consultations with experienced community monitoring practitioners at the First Global Symposium on Health Systems Research in Montreux, Switzerland in November 2010.

This strategic convening sought to initiate discussions in response to this gap. It brought together 39 participants from 12 countries around the globe with a mandate to review current experiences and begin shaping an agenda for strengthening the field. These practitioners came from a wide range of experiences in community monitoring, health rights, budget monitoring and expenditure tracking.

Two background documents were prepared prior to the convening: a review of the literature and a synthesis of responses to a questionnaire sent out to all the convening participants. Both of these reports are available on the OSF PHP Seminars website (Available Here).A summary report of this meeting is also available on the Seminars website.

2.0 Welcome, Agenda Overview and Participant Introductions

Objectives:

- To set the tone for the workshop.
- To clarify objectives and expectations of the convening from the perspective of organizers.
- To give an overview of the agenda and introduce workshop principles.
- To establish an environment conducive to participation.
- To mutually familiarize participants and their organizations.

2.1 Opening Remarks - Ms. Cynthia Eyakuze, Project Director of the Accountability and Monitoring in Health Initiative (AMHI)

Cynthia Eyakuze gave a warm welcome to all participants attending this 'Indaba' on community monitoring for accountability in health. She noted that it was most appropriate that we had gathered at a place called Indaba, which means "a council or meeting of indigenous peoples of southern Africa to

[1] Combining the former Public Health Watch and Health Budget Monitoring and Advocacy Projects of the Open Society Foundation's Public Health Program

[2] Advisory Group members included Abhijit Das (CHSJ, India), Abhay Shukla (SATHI, India), Rene Loewenson (TARSC, Zimbabwe) and Walter Flores (CEGSS, Guatemala)

discuss an important matter." She felt that this meaning could easily be appropriated to reflect the essence of what this convening hoped to achieve.

In describing the background to the convening, Cynthia noted that AMHI is a project of the Open Society's Public Health Program (PHP) which supports civil society groups to effectively and strategically use budget and community monitoring approaches as mechanisms for promoting greater government accountability and transparency in health care to its citizens. AMHI is one of 10 projects or initiatives within the PHP that works to create health-related policies and practices based on inclusion, human rights, justice, and evidence. The programme works on the assumption that community monitoring is one of a complementary set of approaches to advancing health rights, including those of socially marginalized groups.

This convening brought together experienced practitioners of community monitoring for accountability in health for 3 purposes:

1. To share practical experiences and synthesize lessons about how we are thinking, how we are doing, and what impact we are having
2. To support and enhance the existing practice
3. To establish where we can go from here to better link practice, learning and documentation in mutually reinforcing ways

AMHI hoped that, by the end of the two and a half days, the meeting will have: enhanced the understanding of the current contexts, concepts and designs for and practices of community monitoring for accountability in health; identified gaps for effective practice and use of community monitoring for accountability in health; and begun developing a community of practitioners/learners interested in advancing the field.

Cynthia concluded her opening remarks by noting that AMHI was privileged to have had four experienced practitioners from around the world who advised them through the preparation of this convening. Three of the advisors were then invited to the front to share their interest in this work and to explain how the current process builds on and reinforces past work and links; and the value and innovation it now seeks to add.

Dr. Rene Loewenson, Director of Training and Research Support Centre (TARSC) Zimbabwe, Equity Watch and EQUINET noted that she was happy and privileged to be a part of this process. She explained how the southern and east African region has been involved in generating evidence, knowledge and perspectives on health equity and social justice for over 10 years, especially through the Regional Network for Equity in Health in East and Southern Africa (EQUINET). EQUINET and TARSC have used a multiplicity of processes and approaches, including participatory approaches, monitoring of budgets and looking at social and economic determinants to monitor health equity. There has been a strong focus on creating dialogue across the region, which has been consolidated in a number of reports and fora. In November 2010, EQUINET presented a session on Participatory Reflection and Action as an approach to Health Systems Research at a conference in Montreux. One of the outcomes of this session was to carry on sharing evidence to develop a more global perspective. Rene noted that the second Global Health Systems Research conference will held be in China in November 2012 and she hoped that some of the learning coming out of this meeting will be reflected at the Global Symposium.

Abhay Shukla from Support for Advocacy and Training to Health Initiatives (SATHI) in India emphasized that any health system reform cannot be successful unless people are at its center, not only as objects of the process but as active participants. Citizens need to exercise their agency to make sure all health reforms are to the benefit of ordinary people. He pointed out that this was the unique aspect of the meeting – to share and emphasize this focus.

Walter Flores from Center for the Study of Equity and Governance in Health (CEGSS), Guatemala echoed the other conveners' statements that this meeting was a unique opportunity for colleagues from so many countries and regions around the world to share experiences and ideas. He thanked all participants who completed the questionnaire he sent out prior to the meeting and commented on how impressed he was by the range of experience and knowledge represented in the meeting. He encouraged participants to look at the synthesis document he prepared, based on the participants' response to the questionnaire. He noted this was an important document to review.

2.2 Agenda and Working Principles

Vinay Viswanatha, Program Officer at AMHI, gave a brief overview of the agenda (see Appendix 2) and working principles for this convening. He began by emphasizing the participatory nature of the meeting, allowing for changes in the programme based on participant inputs as new insights arose. Broadly speaking, the 3 days were divided as follows:

Day 1: focused on concepts as a way to develop a shared understanding and language in community monitoring for accountability in health.
Day 2: moved into a more in-depth analysis of practice. What we are doing and how we are doing it, looking at the scope of our work, our challenges and enabling factors.
Day 3: focused on mapping available resources, identifying gaps, and exploring ways to face the challenges and strengthen the capacity of community monitoring work.

Vinay concluded by noting that by the end of the three days he hoped the meeting will have a better understanding of what community monitoring means for each of us and collectively, what other approaches we need to include to deepen our work, and some agreement on how we want to move forward as an active learning community.

THIS CONVENING:

Was truly diverse

- 39 participants
- 12 countries: *Bangladesh, Brazil, Denmark, Guatemala, India, Kenya, Peru, South Africa, Uganda, United States of America, Zambia, Zimbabwe*
- 30 organizations

Had a wide range of rich experiences in

- health rights
- community monitoring
- budget monitoring
- expenditure tracking

2.3 Participant Introductions

After briefly talking in pairs, each participant introduced their partner in the plenary, focusing on a combination of personal and professional details, their expectations of the workshop, and what motivates them in their community monitoring work. It became clear from the introductions that participants' greatest motivation for coming to this convening was to learn more about community monitoring, to draw on each other's diverse experiences to strengthen their ability to create better

conditions for demanding the right to health, and to build a larger community of practice. (See Appendix 2 for a complete list of participants.)

3.0 Sharing community monitoring experiences from the field - Plenary Presentation

Objectives:

- To develop a shared understanding of community monitoring for accountability in health through the presentation of three longstanding community monitoring efforts which use different approaches, carried out in diverse settings.
- To introduce key terms of reference, key elements of community monitoring work and key lessons from a practical standpoint.
- To generate interest and start discussion among participants.

3.1 Engaging citizens and front line health workers to influence health policy and practices in indigenous communities in Guatemala – Dr. Walter Flores, CEGSS, Guatemala

Walter began his presentation with a documentary film (Available Here) about Guatemala and the work of his organization, the Centre for the Study of Equity and Governance in Health (CEGSS). The documentary film emphasized that, although social and economic rights are enshrined in the constitution, there are grave inequities between rich and poor, especially exacerbated by more than three decades of armed conflict. Indigenous people particularly face social exclusion at all levels. The film went on to highlight the main strategies used by CEGSS to improve indigenous people's access to health through citizens' participation in both public services delivery and social auditing, and a strong focus on transforming power relations and access to health resources. CEGSS works at municipal level but has recently started to work at national level, providing technical assistance to the Ministry of Health in the design and implementation of an institutionalized community monitoring programme.

Following the documentary, Walter made the following points:

- *CEGSS' work aims to challenge power dynamics, especially between frontline health workers and the wider community*: CEGSS' work with indigenous populations began in 1995 in very rural areas where people had been affected and traumatized by the civil war. In the beginning, implementation of the project was very difficult due to already asymmetrical power dynamics and confrontations between frontline health care workers and citizens. Early in the programme, CEGSS realized that front line healthcare workers were as much a part of the community as the patients they saw and, if given the opportunity, could contribute to positive change. As a result, CEGSS, in consultation with the community and partners, began to include health care workers in all activities. This was very successful in improving the communication and trust between citizens and front line healthcare workers. So much so, that the Ministry of Health and municipal authorities began to put pressure on the health workers to stop being involved in that work because they were unhappy with the increasing demands from community based organizations. The health care workers refused, saying that they could not ignore the needs of the people.

- *Using participatory approaches throughout the process is the key*: The work CEGSS does with indigenous people is based on participatory research and action (PRA), and is focused on building and generating knowledge that can promote social change. Monitoring starts with a baseline which then allows the community to monitor progress right from the beginning. Community monitoring is seen as important to provide knowledge and evidence that change is happening – not only in relation to equity and access, but also to understand power relationships and the strengthening of democratic practice. Through the use of PRA tools, CEGSS looks at the role of the local elite and explores ways in which they can also be incorporated into the process.

- *There is a need to compliment academic knowledge with information that comes from ordinary citizens*: Advocacy from the ground-up is an important component of CEGSS' work. Citizens communicate to different categories and levels of stakeholders. The PRA work generates information that is then published in peer reviewed papers, journals for international research, policy briefs for policy makers and donors. This same information is also produced in the form of community newsletters and radio programs to spread awareness among the local communities.

- *CEGSS' main challenge was how to scale-up the program without losing the key characteristics of success*, especially the right skills and attitude to working with communities, and the right approach to social change. The work has generated a lot of interest and in order for the organization to expand they need to be able to transfer these skills and knowledge to other organizations, which is very challenging. CEGSS has done several trainings and identified personnel they thought would be able to take this further, with varying degrees of success. Furthermore, CEGSS noted that the Government was now expressing interest in the work and its scale-up that posed a huge challenge for CEGSS as it was challenging to find sufficient people within the formal Government structure with the right skills, values, behavior and overall commitment and sense of solidarity with community, a key ingredient for success of such initiatives.

3.2 Overall structure and design of CBM (Community Based Monitoring of Health Services) under NRHM (National Rural Health Mission) in India – Dr. Abhijit Das, CHSJ, India

Note: Two presentations from India in this session focused on the community-based monitoring of health services programme (CBM) in India. The first, led by Abhijit Das, focuses on the overall structure and design of CBM from a national perspective. This was followed by a presentation by Abhay Shukla who presented on the experiences of CBM, specifically in Maharashtra State.

In a short film presented by Abhijit Das (Available Here), the then Joint Secretary for the Ministry of Health and Family Welfare in the Government of India, Mr.Amarjeet Sinha, stated that "*For me, community monitoring is a platform to hold the state responsible for its obligations*." This statement was further elaborated on during this presentation.

As Abhijit explained, community monitoring for health in India began after a new government came into power in 2005. This government launched the National Rural Health Mission (NRHM) in April

2005 with a view to bring about architectural corrections and strengthening of the rural public health system, expected to improve health services for the rural population. One significant policy initiative under NRHM was in the form of a comprehensive framework for Community Based Monitoring and Planning of health services at various levels of the Public Health System. Community Based Monitoring (CBM) of health services. Under CBM, it was envisaged that with facilitation by civil society organizations, community members will be involved in periodically collecting information about local health services, prepare and display 'report cards' on health services, dialogue with health service providers and officials in various committees, organize 'public hearings' on health services, and raise issues at all levels including at District, State and National levels. Further, the government also developed very clear delivery standards and guidelines that spell out the range of services and minimum human resources, infrastructure, equipment and drugs, and functional standards that should be available at different levels of the public health care system. These guidelines, called Indian Public Health Standards (Available Here), played a key role in facilitating CBM in India.

Figure 1: CBM Conceptual Framework, India

Objectives of the programme: CBM had specific objectives which included the provision of regular and systematic information about community needs, monitoring the functioning of the public health system at various levels, identifying gaps and deficiencies, and enabling the community and CBOs to become equal partners in the planning process.

The CBM conceptual framework was based on two assumptions: that there is an empowered community and clearly articulated service standards. The community experience of public health service delivery gets consolidated through a public forum inquiry where providers and community representatives review score cards implemented by users. This leads to a new plan of service delivery, which is again consolidated and compared to the previous experience. This framework draws on the learning cycle in PRA.

The CBM operational framework was part of the NRHM programme and included structures from the Village Health and Sanitation Committee (VHSC), through to Primary Health Centre (PHC), Block, District and eventually State Planning and Monitoring Committees. Lower levels of the structure fed information upwards, followed by appropriate action and interventions at all levels.

While these looked neat and elaborate on paper, Abhijit pointed out that implementation often does not move beyond the lower levels, with limited ownership at state and district levels. At the same time, while it was recognized that health care providers were the interface of the health system with the community, true decentralization and devolution from the Head Office in New Delhi to the village level was taking a long time.

The scope of the programme had also been controversial. Since it was a government programme and part of its implementation framework, the government wanted this programme to be rolled out throughout the country as quickly as possible. Taking into consideration the vastness of the country and the complexity of the process, the CSOs pushed the Government for an initial pilot phase. Eventually, the pilot programme was rolled out in 9 states, working in a limited number of districts and blocks to include a little more than 1,600 villages. He noted that the general challenge with implementing programs in India was that the Government wants large scale programs that bring results overnight. But then, once the CSOs commit to doing what the Government intends them to do, and then administrative inefficiencies kick in. That the bureaucracies do not follow planned programme cycles was an important lesson from these ongoing CBM efforts in India.

Quality control: In order to roll out a programme across 9 states, care was needed to ensure quality control at all levels. A set of resource material, adapted and translated as appropriate, was used to ensure quality control in the different states. There were manuals for managers, facilitators and trainers at all levels and a manual for the actual monitoring process (Available Here). Community awareness materials on health care entitlements in the form of posters, booklets and other creative mediums were produced and disseminated on a mass scale to increase community awareness and ownership of the program. An elaborate website was also developed where data from each village block and district could be uploaded onto the website and linked to the government website (Available Here).

Results were documented in the form of traffic lights: scores related to maternal health, quality of care, etc. was divided into red, yellow or green blocks. Red - deemed as poor functioning by the community - dominated the first phase of monitoring; these results ultimately forming the basis for the baseline.

Concerns: India has a federal and a state government, and health fell in the domain of state responsibilities. The CBM activities in the pilot project were sponsored by the federal government but they were not too concerned about the results which fell into the hands of the state. After demonstrating that this project could work it was hoped that the state government would continue to provide financial support to ensure continuity. Unfortunately, few out of the 9 states have continued their support for the CBM program.

3.3 Processes, strategies and impact of CBM in Maharashtra – Dr. Abhay Shukla, SATHI, India

Abhay Shukla deepened the discussion about CBM in India by highlighting what had happened in Maharashtra state since 2007 (Click Here for the presentation). To start with the CBM program was implemented in 5 districts of the state and by 2009, there were 500 Village Health Committees, 78 PHC committees and 23 Block Committees involved in the program. This increased to 13 districts and 750 villages by 2011. He pointed out that, even though the CBM programme is resourced with public funds, bottlenecks at the state committee level resulted in civil society organizations and community-based activists taking a lead within the districts. This was the first time in India where civil society has played such a big role in the CBM programme. Various publications on CBM in Maharashtra can be accessed at SATHI's website (Click Here).

Processes and tools: There have been a number of key processes in implementation of the CBM in Maharashtra. These include: capacity building of VHSCs; data gathering and filling in report cards at village, Primary Health Centre (PHC) and rural hospital levels; dialogues with health functionaries; media coverage and state level conventions.

To support this, the programme used a series of user friendly tools accessible even to the illiterate. The tools are all in pictorial format. For example, the monitoring booklet uses a code where two dots mean the service is fully functional, one dot means it is partly functional and no dot means that it is not functional at all. These dots are then added up and put onto the report card, divided into red, yellow and green. There was also a village health calendar which documents whether the health workers are visiting the community on a regular basis.

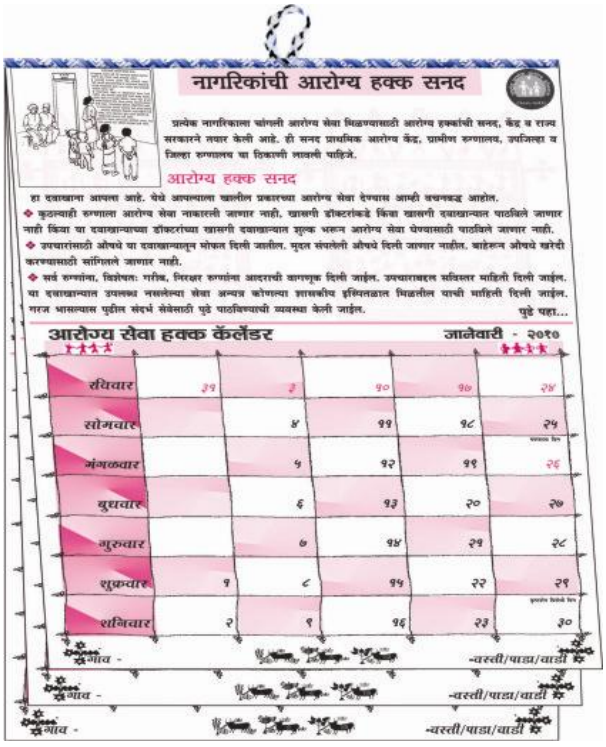

Figure 2. Village Health Calendar that was used as an easy-to-use visual community monitoring tool in Marathi language

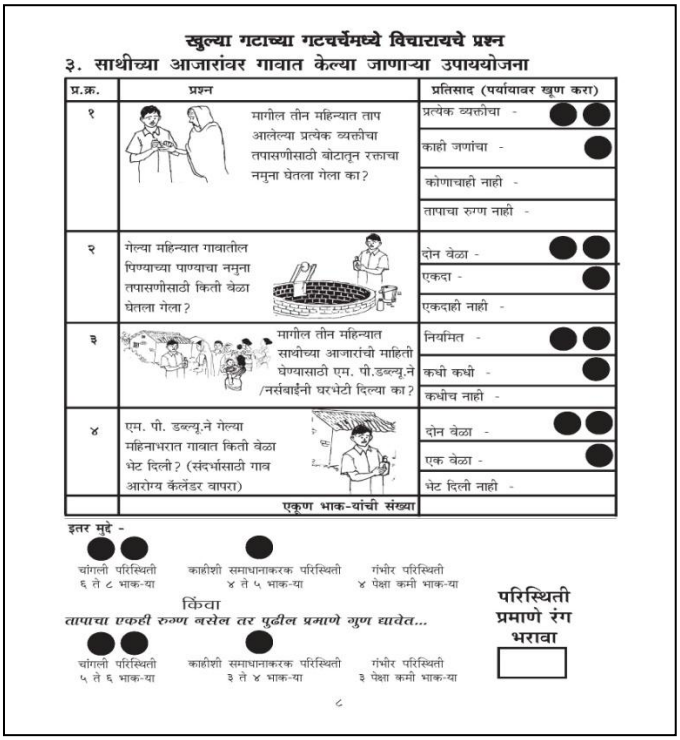

Figure 3. Sample CBM tool for monitoring village level community based health services in Marathi Language

Public hearings, as a forum for dialogue and accountability, were also common. Such meetings were highly interactive and involved many stakeholders. During the meetings, the health officials were expected to respond to the issues raised by the people and the discussions and agreements were then recorded and put up in the form of a poster. Village Health Report Cards and cases of denial were represented such as a woman in labor who was turned away from a health facility and had to be shuttled to a private facility. Nearly 108 public hearings were organized so far, with women, civil society organizations and activists actively participating in them. People had also given testimonies about improvements at their health facilities. The findings were recorded and reported by the media, with over 200 articles published in the media in the last few years. The state CBM newsletter reached out to over 32 states in India and was distributed to PHCs, Rural Hospitals and civil society organizations.

Impact: CBM had contributed to significant improvements in rural health services in Maharashtra. The practice of PHCs prescribing medicine from private shops had shown considerable decline; illegal charging and private practice by some medical officers had been checked; there had been an increase in the number of visits by Multi-Purpose Workers and midwives to the villages and village-level health services such as immunization had improved. Many non-functioning sub-centers were rejuvenated to provide services, and many communities' reported improvement in staff behavior.

Contextual factors: There were some contributing positive and negative contextual factors which affected, and continue to affect, the success of the CBM programme in Maharashtra:

Positively,

- The introduction of the NRHM in 2005 provided an enabling environment and gave a strong message that the government had to respond to the health needs of rural people.
- Maharashtra state's strong civil society, especially under the umbrella of the People's Health Movement (PHM) and the 'Right to Healthcare' campaign, meant that the state was already under pressure to be accountable to a civil body.
- The availability of already developed community monitoring tools and community awareness materials (under 'Right to Healthcare' campaign) was also an enabling factor.

Negatively,

- The state bureaucracy was not very enthusiastic about CBM. Compared to the pilot phases in 2007 and 2008, the Ministry of Health commitment towards CBM had declined.
- Continued systemic problems with: corruption in the purchasing of drugs and other medical equipment; posting and allocation of personnel from top to lower levels; over centralization of decision making; major shortages of medicines; and a lack of transparency in the procurement systems called actions at a higher level that were not easily amenable for community monitoring approach at local levels.

In response to the challenges expressed above, the PHM network is developing a campaign to deal with key systemic issues not being adequately addressed through the CBM programme. Advocacy efforts are underway at state level to strengthen wider social support and political commitment to CBM. On the one hand, the PHM plans to continue to occupy and expand the spaces for community monitoring and, on the other, develop health rights struggles and policy-related campaigns for structural change. The belief is that when people's knowledge and people's organization are combined then change will start to happen.

3.4 Community monitoring programme in Zimbabwe – Dr. Rene Loewenson, TARSC, Zimbabwe

Rene Loewenson began by showing delegates a circle within a triangle as a way of describing conceptually what TARSC and partner organizations in the southern and east African region were doing in relation to community monitoring.

The 'triangle': First of all, there is society, the market and the state. There is a direct and pivotal relationship between these three in terms of health and the strengthening of people-centered health systems. These are described as follows:

- *Society:* level of organization of its citizens, its power and its ability to influence (or not) the state and the market.
- *The market:* its ability to satisfy the resources for health, particularly the extent to which it enables control over those resources within the society as distinct from removing those resources elsewhere.
- *The state:* in terms of how it uses its constitution, policies, laws and organization to create a balance between the market and society.

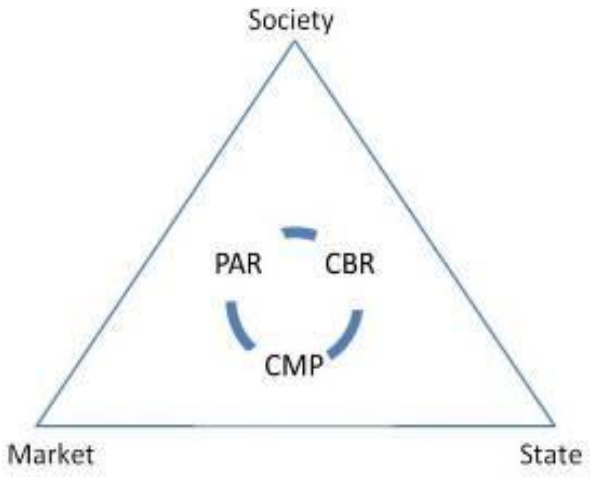

Figure 4. The 'triangle' and the 'circle' concept of TARSC

Rene went on to explain that, in southern and east Africa, organizations were working to address these kinds of interactions. For example: Zimbabwe gained its independence in 1980 after a protracted liberation struggle. The new government came in with strong commitments to address social needs and to manage the relationship between society and the market. There were major improvements in access to health and education. In the 1990s, with the World Bank Economic Structural Adjustment Programs (ESAP) and neo liberal reforms, the state shifted its focus from the local market to the external market. Zimbabwe became driven by the global economy at the cost of society and saw a real decline in health and other social indicators. Currently, many groups in civil society were not only trying to hold the state accountable for what it was presently doing, but actually trying to transform the state to address the negative changes that took place in the 1990s.

The 'circle': Community monitoring was not a singular activity. It existed within the context of how organizations' used ideas and knowledge to transform the state. In the case of TARSC in Zimbabwe, TARSC is involved in 3 different, but related, monitoring programs. These are: the Community Monitoring Programme (CMP), Community Based Research (CBR) and Participatory Reflection and Action (PRA).

Community Monitoring Programme: Zimbabwe had gone through a traumatic period in the past decade that brought to the forefront concerns relating to the abuse of political and economic power. There were massive issues that needed to be addressed such as the question of land distribution and ownership, access to resources, and democratic challenges. Issues of access to food and other resources were also highly politically charged.

As a result of the ensuing violence and mistrust, the structure of the CMP took a different turn from that of Indian experience discussed before- monitors had to be anonymous so they could not be traced. Instead, TARSC worked with and through a network of civil society organizations that became the voice for the evidence gathered by the monitors on the ground. In total, the CMP has 250 monitors working in all 55 districts in the country. They started with monitoring access to food, because food was a problem and was being used as a political weapon. The civil society group brought issues of state corruption around food to Parliament. Monitors then began to address other issues, such as access to health services, drugs, income and employment, raising questions around the costs of health, costs of education and other social determinants of health in order to influence national policy.

Community Based Research: Monitoring, however, needs to have some form of local engagement. Issues arising from the CMP are taken up by the local research teams in the district, working together with other interested civil society groups and health workers in the public health system. The CBR has been used to identify issues related to primary health care, and to influence national dialogues on the allocation of funds to the primary health care level.

Participatory Research and Action: In PRA, community members actively get involved in gathering and using evidence around problems that directly affect them. They reflect on their own experience and then identify specific actions, particularly actions people can take up themselves to produce change. This gives community confidence to create alternatives, to build dialogue between various actors in the health system and to determine how Zimbabwe's health care system should look.

Challenges: In conclusion, Rene noted three basic points of challenge:

1. TARSC's aim is change and transformation and not just monitoring what exists. It is as much a battle for ideas and influence as it is a battle for evidence. It is about creating confidence in society to transform the state so the evidence can be used effectively as a source of power.
2. TARSC has observed that change does not happen in a linear way. When windows of opportunity open up, it is important to be able to build the right conditions for people to jump in and utilize the space that has opened up for them.
3. Finally, TARSC recognizes that change happens at different levels. It is possible to shape ideas but it is difficult to deal with structural determinants. It is important to have ideas that bridge the divide from the local to the national, the national to the region and then up to the international. Each of these levels has a role, while respecting that each also has its limitations. They cannot work in isolation of each other – there is a need to strengthen systems of interaction.

3.5 Plenary Discussion

A number of key issues arose from the discussion, summarized below:

- *Addressing power relations, especially with the state*: There were a number of questions around this issue, and a number of responses. Rene pointed out that the work in Zimbabwe is community owned, not government driven. TARSC develops alliances, for example between health workers and the community and with parliament, so that community-based evidence can be used to help influence state processes. On the other hand, Abhijit noted that in the CBM programme in India, government is a crucial actor and civil society needs to identify and occupy the space that government opens up for CBM. He also pointed out that the practitioners need to be aware that government involvement could lead to program becoming notional. As CBM starts receiving more Government funding, the danger of cooptation becomes real and greater. Hence the great need for practitioners to ensure that their work remains grounded in community organizing and ownership.

- *Engagement with the media*: A participant from Kenya noted that the media reacts mostly to sensational news and that it is not interested in reporting stories about community-based monitoring, so the question arose how to get the media to report on this work. Abhay pointed out that the media is always looking for catchy headlines so, in India; they use events such as public hearings to attract the media. He also shared that at one time, the Maharashtra CBM hired a media consultant to assist and give guidance on the effective use of the media.

- *The importance of including special social groups*, including women, young people, the disabled, and such marginalized groups.

- *The role of health workers* in sustaining change is important. This is especially relevant in a corrupt health system to ensure health workers do not try to undermine the interests of the community.

- *Capacity, time and resource investments in CBM* are usually far greater than anticipated. The need for such an understanding and appreciation by various stakeholders, including implementing organizations and funding partners, is especially relevant for community monitoring initiatives to remain sustainable.

4.0 Building a shared language

Objectives:
- To explore what is meant by key terms used in community monitoring work
- To develop a shared understanding of these terms to inform and facilitate future discussions

Delegates were divided into four groups for this session. Each group was given a list of 4 terms to discuss amongst themselves, focusing on their own experiences as a starting point for defining the terms and elaborating on what the terms meant to them in their work.

The four groups' categories were as follows:

Category 1: Rights, entitlements, social justice, social change
Category 2: Community monitoring, community mobilization, empowerment
Category 3: Power relationships, legitimacy, autonomy, state
Category 4: Information, evidence, knowledge, accountability

Below is a summary of the report back and discussions that took place in plenary after the group work. As acknowledged at the end of this session, there was no clear consensus on the meaning of certain terms, but recognition of the complexity of meanings. This is reflected in the definitions described below.

4.1 Rights, entitlements, social justice, social change

Rights- Rights are universal and need to be defined beyond citizenship, to include non-citizens. The state is obliged to provide certain human rights and civilians need to claim and make use of them. There is a distinction between individual rights and collective rights and sometimes these two may be

at odds with each other. Both civil/political and socio-economic rights need to be addressed. A key question is how, and who, produces these rights in a society.

Entitlements – An entitlement is a right guaranteed by the law. It is something that is resourced by the state. In reality, though, civil society may want more than what the state has guaranteed. Or the entitlement may be in law, but not adequately implemented.

Social justice and social change – These two concepts are intertwined. Social justice needs to be linked in with political and economic justice. Social change is a means to social justice. Social change implies participation and institutional transformation.

Note: During plenary discussion, two more terms were added to this list - *consciousness* and *social class*. These words were more popular in the 1960s and 1970s but have been dropped in favor of a more individualistic interpretation of community relations and a denial of power dynamics. Consciousness is what actually drives all processes. Practitioners do not co-opt consciousness from the community, and it is not our own consciousness that we impose onto the community. At the same time, community consciousness may be limited by the community's own context, so sometimes we have an important role to play in raising their consciousness. This is complex, but important to understand. For example, government will finance entitlements and we could do a lot of work on this to no end if we are not driven by the consciousness of people's rights.

4.2 Community monitoring, community mobilization, empowerment

Community monitoring - The goal of community monitoring is change, and change needs information and organizing. Community monitoring assists with providing the information –it sets the benchmarks and then assesses improvements, for example, in services. Community monitoring has to be accompanied by community awareness of their rights and entitlements.

Community mobilization - is about collective action. This collective action has to include marginalized groups. It should be in line with the community's own priorities. Awareness and information play an important role in community mobilization. Closely linked to community mobilization is *community organization*. Organization is the structure and mobilization is the function. Mobilization cannot be sustained for a long period of time without some level of organization. It ensures that mobilization is not determined by outsiders and that the processes are carried forward. The community's organization helps to define their priorities.

Empowerment - is about changing power relations. There are two kinds of power relations - power relations within a community, and those between the community and the larger system. In order to change these power relations there is a need for information and awareness, as well as collective action. Capacity building and training are often needed here.

Some key questions arose from these: Who is doing the empowering and how is it taking place? Is it an external or internal process? Who defines the change? Is community geographical or issue-based? The group agreed that it is issue-based – if there are shared concerns; then there is potential for shared action.

4.3 Power relationships, legitimacy, autonomy, state

Power relationships - has to do with the asymmetry, or unevenness, of relations. In large part, power relationships are determined by access to information and influence, and this cuts across different types

of relationships affected by social and economic control, as well as access to political structures and the bureaucratic apparatus of the state. These power relations can be changed but this hinges on the type of influence individuals or organizations have and their capacity to transform existing structures.

Two other terms that are key to perpetuating power relationships are 'hierarchy' and 'structure'. The structures of authority may not necessarily represent the interests of society and often people's trust in authority is not very great. Legal frameworks can open up space for marginalized groups and create conditions for hierarchies to interface with others in the public health sector. This may possibly shift power relationships and can affect the realization of people's needs.

The term 'powerlessness**'** is also relevant here, both in terms of the powerlessness of social groups in a community, but also the powerlessness of public officials within the state who may find common interest with communities, but have no influence to create the conditions for transformation. A question then arises as to how we can build alliances between community organizations/ leaders and powerless authorities to create the conditions for change.

Legitimacy - There are two issues here. There is the legitimacy of the state and whether its mandate has been accepted by society; and then there is the legitimacy of civil society in the way we interact with communities. On the first, the legal framework of the state is important because it allows for discussion on ways in which we can transform that mandate, and creates an opportunity for the discussion of rights and the necessary redress that the deprivation of rights entails. The other issue – related to civil society's role in community monitoring – also has to do with the question of mandate. Finally, it is noted that building legitimacy takes time and serious work to build trust and understanding.

Autonomy - has to do with people's capacity to build the conditions which would lead to self-government or self-determination; not only the autonomy of individuals but also of the different levels or spheres of society or government.

State – There are two things to say about the state: 1. the state is diverse. It is divided into different levels of government and institutional structures that communities have to relate to, and 2. There is a tension between identifying how the state in its different forms of authority represents different interests. A state can be based on patronage or it can represent the interests of one group above the interests of the collective whole. If a state is more democratic and responsive to the needs of different groups of people, then there is likely to be more space for community mobilization, community participation and community monitoring. So the question becomes how we can enable community mobilization and community organization within state structures that do not support participation, and whether this will necessitate more direct confrontation.

4.4 Information, evidence, knowledge, accountability

The group saw information, evidence, knowledge and accountability as all linked to each other. We get *information* from the media, workshops, literature, from civil society organizations and, of course, from the community. That information is important to build *evidence* to help generate an advocacy strategy. Then, once the community is empowered with the *knowledge*, they are then able to make government and those responsible *accountable* for what they do or do not do.

Information and knowledge is power. It is important that information is disseminated in a way that is accessible to 'ordinary' people at community level.

We get evidence from case studies, from research, from media, and from personal experiences. Even silence can convey a message. Evidence builds the knowledge to disseminate information to the communities that we work with. In community monitoring, the practitioners help to bring this knowledge to the surface, especially at community level. Knowledge helps communities' confront those in power and demand for their rights.

Good accountability assumes good governance structures. Only then will the political leaders understand that they have to follow certain procedures to be able to respond fully to the communities they have been elected to serve.

4.5 Moderator's summary remarks

The moderator of this session made some important summary remarks, with comments from the floor. He acknowledged that the aim of this session was not to build a common language, but to recognize commonalities and differences when they arise. What connects all of these terms is each practitioner's own individual concept or theory of change. This is not neutral. If there is one key message that comes out of this discussion it is this: how we interpret these concepts determines the way we implement our programs.

5.0 Community monitoring for social accountability – Basic concepts

Objectives:

- To explore the importance of some of the basic concepts that define our work in terms of how they have influenced and continue to influence the contours of our community monitoring work.

Delegates divided into four groups to discuss the following themes in terms of how each theme relates to their work:

Group 1: Ideas about social change based on frameworks of rights and justice
Group 2: Role of community consciousness, mobilization, and empowerment
Group 3: Changing power relations and dealing with the State
Group 4: Role of information and evidence for community conscientization and in demanding accountability from state authorities

Each group was given a set of three questions to guide their discussions. Discussions were followed by group presentations in plenary session, as documented below.

5.1 Group 1 - Ideas about social change based on frameworks of rights and justice

a. How has the framework of rights and notions of social justice influenced your work?
This framework has been very important to us. This framework helps to ensure that the needs of the marginalized social classes are in the forefront. Due to these rights and notions, the state can be made accountable to everyone, even the less privileged. However, monitoring on its own is not enough; we have to create alternative approaches to monitoring to ensure that the process does not end with questions but ends with finding solutions. The community needs to own the whole process. The focus should not only be on the State but also include monitoring of private services in the health system.

b. How has the framework of rights and notions of social justice strengthened your work relating to bringing about the social change you envisage and in engaging with the state authorities?

The fact that there is a framework, based on the constitutional rights in each country, plus the various international conventions, has forced the state to be more accountable and given communities a context in which to demand their rights. It has put pressure on authorities to prioritize, perform and react to real problems at community level. The framework has also clearly made a distinction between individual and collective rights which, although sometimes in conflict with each other, is important.

"When those with authority lack motivation, then those with motivation must begin to exercise authority…"
- A statement from Mr. Amarjeet Sinha, Former Joint Secretary for the Ministry of Health and Family Welfare, Government of India (from the video on CBM in India)

It is important that the community monitoring work makes the link between problems faced at local level and how they are impacted by global policies. This will increase the analysis needed to bring about change.

c. What are the limitations and challenges faced while trying to adapt the framework of rights and notions of social justice into your practice? What strategies have helped you mitigate these challenges and to overcome the limitations?

- Lack of social and economic power at grassroots level to enforce their rights.
- Difficulty proving that the framework of rights and notions to social justice work.
- Lack of support from the governments and reluctance on their part to deal with issues of social justice. Making links between health and unemployment (an important determinant of health along with being an important stand-alone issue of social justice), for example, is threatening to the state.

One strategy to mitigate these problems is to create spaces for government and various stakeholders to meet and discuss issues in an open and transparent manner.

Sometimes the government is more comfortable hearing different perspectives, not just the voice of civil society, including community people themselves, local leaders, researchers and such others. This multi-pronged approach can be very effective in some instances.

5.2 Group 2 - Role of community consciousness, mobilization, empowerment

a. How have you involved the communities in your community monitoring work?

Some examples include:

- Centre for Economic Governance and AIDS in Africa (CEGAA): works within community structures (e.g. formal local governance structures) to ensure sustainability and legitimacy. They analyze the mandate and power of these structures to identify and explore how to address any gaps. For example, some community structures may exist but are not accountable to the community. Or the leadership may be corrupt. These issues are addressed before moving forward.
- TARSC: works with and through a membership-based coalition made up of community-based organizations that are trained to gather evidence. The challenge they face is negotiating and agreeing on priorities among such a diverse group of people.

- Uganda National Health Consumers Organization (UNHCO): strike alliances between the service providers, patients, community members and policy makers. They form a committee and work together to identify and work on solutions that will address the common service delivery issues they face.
- SATHI: works with 'village health and sanitation committees' (VHSC) mandated by the public health system, which include traditional leaders and activist groups to ensure that the community has a voice. CSOs work within these committees to mobilize communities to act.

b. *How can we as practitioners of community monitoring develop really empowering and transforming experiences in the participating communities?*

A number of activities were mentioned, including the use of public hearings and meetings; group visits to health centers to discuss their rights; sharing of information on health rights, entitlements, government programs and policies and such others through people-friendly materials like booklets, newsletters, etc. so people are informed and not afraid of discussing the information since it has been made public.

However, the group recognized three challenges in this regard:

- Documentation of experiences and lessons learnt is a challenge.
- How to ensure that the voice of the community is heard, rather than people imposing their voice onto the community?
- How to build networks that raise community voice and make sure that experiences are shared?

c. What are the larger contextual factors that influence community mobilization and empowerment in your work? How have you worked to influence those factors to facilitate community empowerment and action?

- Personal security
- Conflict between the communities and government
- Culture which can prevent some voices from being heard
- Lack of political will

5.3 Group 3 - Changing power relations and dealing with the State

a. What strategies/processes have worked best for you to engage with and transform power relationships between the state and citizens?

As a starting point, we talked about who represents the state. We have to be aware that there are many branches in the state and that the center of power is usually very distant. Sometimes the power of the state is reproduced in the health workers and is expressed through their relationship with community. In terms of strategies, we need to identify the people we can work with 'inside' the state and build alliances between them and the CSOs. It is also important to build relations between the health providers and community. The media should also be used effectively.

b. What are the most critical challenges you face in your work to transform power relationships?

- Corruption
- Corporate influence- the big pharmacy institutions and private health providers are not properly regulated because of their influence and financial backing
- Building consciousness in the state can be difficult
- Mobilizing people to act in a sustaining manner
- Determining who to listen to/work with in the community; how to deal with power structures at local level

c. *How have you dealt with the conflicts (including push back and back lash from the state) inherent to this work?*
   - Engage with broader social movements
   - Use a variety of strategies
   - Take advantage of opportunities arising
   - Use the media, including the internet, to make sure issues are discussed.

5.4 Group 4 - Role of information and evidence for community conscientization and in demanding accountability from state authorities:

a. *Can information and evidence play a role in community conscientization and empowerment processes?*

Broadly YES, but it depends on the information and evidence. The community has to have access to the information, whether generated within the community or provided by external people doing research. Only then can they generate and use the evidence to their own benefit.

b. *What types and forms of information and evidence are used in your work in demanding accountability from the state authorities? What forms of information and evidence have you found to be more effective to holding state authorities accountable?*

Many types, including policy documents, testimonies, patient surveys, policy briefs, assessment tools, budget information, expenditure monitoring and media coverage. Some of these documents, however, have greater impact at the program manager level and not so much in spaces beyond that. Community generated information is not sufficient on its own to influence dialogue at national policy level, except perhaps for personal cases that too only to a small extent.

c. *How have you used the information and evidence from local level to influence larger policy processes and practice? What are the main challenges associated with this?*

There are some people from the civil society who sit on national and other public committees where such community generated information/evidence to influence larger policy processes and practice. Strategic partnerships with state and para-state structures can also be very helpful in this process. For instance, state level public hearings on 'denial of right to health care' was organized by PHM-India in strategic collaboration with National Human Rights Commission (NHRC), an autonomous statutory body, that 'forced' high ranking state officials to participate in the hearings as respondents, and to listen and respond to specific cases of denial of health rights raised by the victims themselves. The involvement of the NHRC had wider ramifications in terms of their recommendations and report being taken seriously by the state and national governments while designing health policy and programs. Other venues for dissemination of the community generated information/evidence to influence larger policy processes and practice include: radio, and media in its various forms, meetings with parliamentarians, use of health committees and such others.

The group reported that they were not able to discuss challenges due time constraints.

Conclusion

One important issue arising from this discussion was a point made by a participant who expressed concern that the group was not taking into account the role of the private sector in the provision of healthcare, and implications for the state and ordinary people. It also reflected on the role of the global economy in pushing for privatization and the rolling back of the state.

The convening participants also called for community monitoring practitioners to explore ways of monitoring private sector activities to make them more accountable.

6.0 Community monitoring for accountability – The road map for change

Objectives:

- To understand how organizations define the change they want and the pathways they follow to achieve the desired change.
- To understand the assumptions and belief systems that underlie the road map for change, as well as the context and processes needed to reach our destination
- To develop a shared understanding of the value of having a conceptual framework to plan and execute a successful transformational strategy.

This session focused on the different conceptual frameworks people use in their practices of community monitoring. The session began with Walter Flores giving an overview of the different frameworks identified during the literature review he undertook in preparation for this convening. This was followed by 3 other presentations from participants who were using community monitoring approaches with relatively well-developed conceptual frameworks.

6.1 Overview of the topic and synthesis from participants' responses – Dr. Walter Flores

This presentation was based on the literature review produced by Walter and his team at CEGSS in preparation for this meeting. He summarized his findings on four different conceptual frameworks.

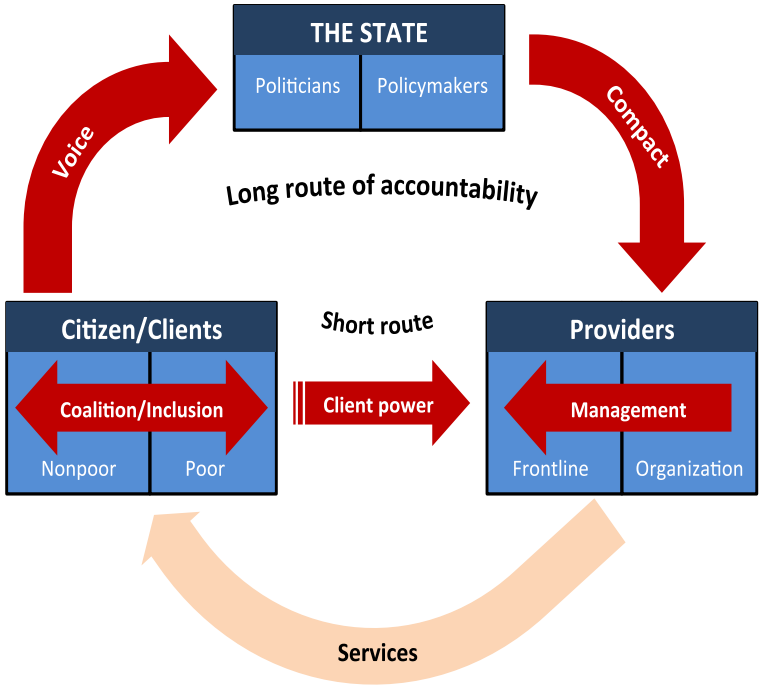

Figure 5. Framework for Public Accountability

Framework for Public Accountability

This framework was initiated by the World Bank. It argues that there are two routes to public accountability: the long route in which beneficiaries have to deal with the state in order to reach service providers, and the short route which is a direct line from beneficiaries to providers. The long route is problematic in that beneficiaries have to deal with an often inefficient and corrupt bureaucracy in order to get their needs met. The short route, the World Bank argues, allows for the development of 'client power', putting citizens as clients in direct communication with service providers and especially those at the front line.

- Strengths of this model:
  - It recognizes the demands of the poor population.
  - It emphasizes the need to have mechanisms to enforce a response from providers, authorities and politicians.
- Limitations:
  - No analysis of contextual factors.
  - May generate technocratic responses to complex political, social and economic issues.
  - Over-emphasis on supervision and demands on frontline providers who, in many contexts, are another victim of social exclusion and may be disempowered to respond to demands.

Generic Framework for Social Accountability

This model was developed by the National Institute of Administrative Research in India and is an adaptation of the World Bank framework for public accountability. The adaptations have two main characteristics – the model is simpler, and it puts emphasis on voice and compact. 'Strong voice' refers to facilitating and strengthening citizens' voice; and 'strong compact' refers to the use of traditional state-centered mechanisms to improve delegation of tasks and the creation of adequate incentives to ensure providers deliver services properly.

The framework makes explicit that the two components must work together to deliver effective accountability.

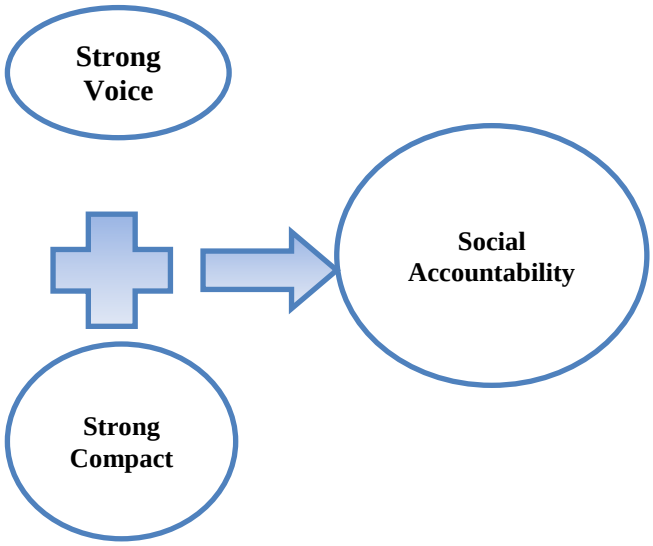

Figure 6. Generic Framework Social Accountability

- Strengths
  - Very practical, with detailed tools on how to generate strong voice and strong impact.
  - It identifies the preconditions for strong voice.
- Limitations
  - There's an over-emphasis on voice as the main mechanism to demand accountability without addressing the complexities of 'voice' for poor or marginalized population groups.

Right to Health Accountability Framework

The emphasis in this framework is on rights and obligations. It was developed by Helen Potts while she was at the Human Rights Centre at the University of Essex, UK. The framework accepts that monitoring can be carried out by the government itself, by civil society, or by both.

- Strengths:
  - Relevance of monitoring mechanisms, remedies and participation.

- Limitations:
  - There is an over-emphasis on legal mechanisms. In many contexts, legal provisions are not sufficient to generate a responsive state.

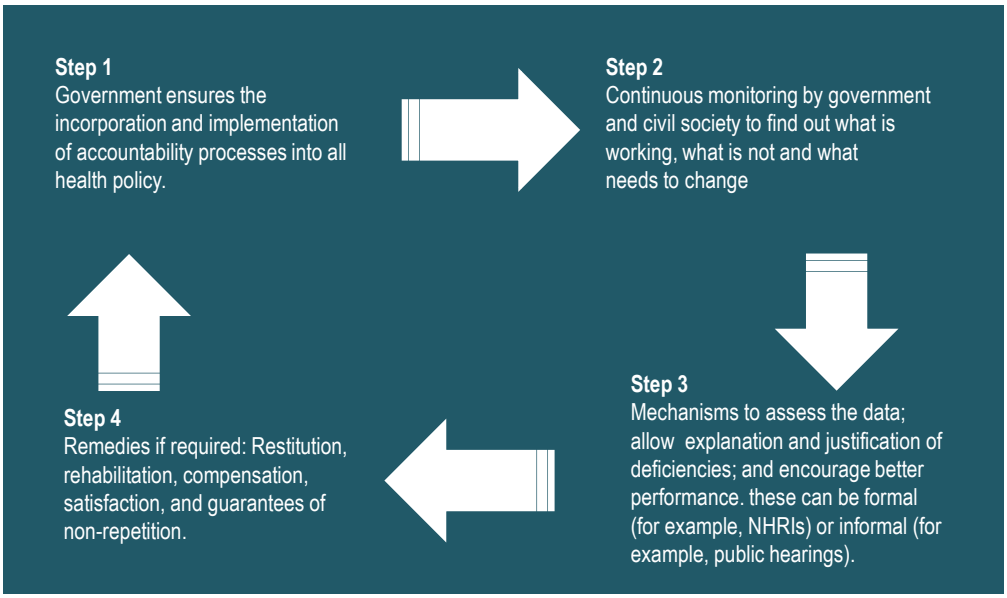

Figure 7: Right to health accountability process

Relationship between Rights, Resources and Accountability

This framework was developed by researchers at the Institute of Development Studies, Sussex University, UK. The framework has an emphasis on the analysis of relationships, rather than prescriptive causalities. It addresses the relationship between rights, resources and accountability. Citizenship is placed in the center of the framework because it confers material and political rights and access to resources as a key component to an accountable system.

- Strengths:
  - Challenges the development of simple frameworks for highly complex issues.
  - Makes explicit power relations as the key issue around accountability, access to resources and rights.
  - Citizenship is at the center of rights, resources and accountability.

- Limitations:
  - This is analytical rather than implementing framework.
  - Not specific for community monitoring.

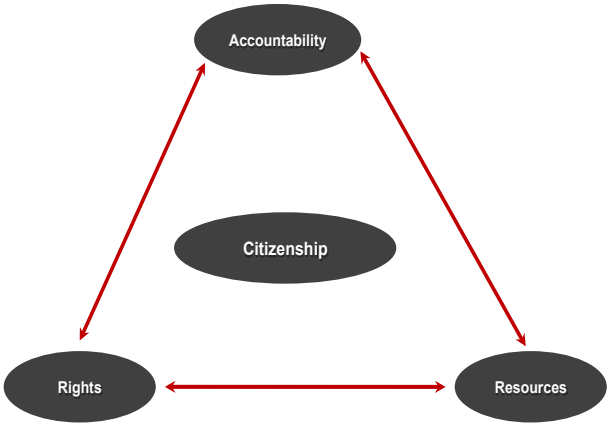

Figure 8: Relationship between rights, resources, accountability and citizenship

Information from questionnaires:

Finally, Walter summarized findings arising from the filled questionnaires that delegates submitted to him prior to the start of the convening.

- Most organizations said that they had not developed or adapted a specific framework
- Two organizations were using available/adapted frameworks for citizen participation and participatory priority-setting
- Some made reference to principles and concepts in other known frameworks, such as popular education, rights based approaches, PAR, etc.

- Few others presented the statements of their organizations, project purposes, objectives, goals and outcomes as their conceptual framework.

6.2 Accountability for Reasonableness (AFR): A priority setting concept – Dr. Jens Byskov, Centre for Health Research and Development, Denmark

Accountability for Reasonableness is an ethically-based framework that is best used in resource-constrained environments. The focus is on achieving legitimacy and fairness in decision making in health systems. Legitimacy here is defined as the acceptable moral authority of decision-makers; decisions are morally acceptable and fair if the decision-making process is morally acceptable.

The argument is that, if there is no legitimacy and fairness in the health system, this will lead to unclear and unrealistic priority-setting, demotivation, distrust and a waste of resources resulting in reduced health care.

Accountability for reasonableness operationalizes the concept of fairness within a specific context. It rests on four conditions, developed by analyzing health care organizations and what makes them work well:

- Decisions are based on reasons which stakeholders can agree,
- The reasons are publicly accessible and transparent,
- There is a quality improvement mechanism for challenging/revising the reasons, and
- There is a leadership enforcement provision to ensure that all the above conditions are met leading to public accountability, and the monitoring of service outputs, health outcomes and trust.

AFR has been implemented in three African countries - Kenya, Tanzania and Zambia. In all three countries, the focus is on evaluating the effect of improved priority setting of indicators in relation to quality, equity and trust. After 5 years, all the districts involved in the three countries wanted to continue using the framework. The common thread running through all three countries is that community and district officials realize national priorities are not serving them optimally, and that the national level was not committed to community consultation. In all three countries, the districts are trying to take charge of their own processes through use of AFR framework.

Finally, Jens addressed the question of power. He noted that the meeting talked a lot about power and argued that the AFR framework is power blind which, he claimed, is not so wrong because it allows people to go into a community and say everyone will benefit, irrespective of the power situation. He concluded that one of the best ways to address power, maybe, was by ignoring it.

6.3 Holding a mirror to the government! Experiences with Citizen Report Cards (CRCs) – Dr. Sita Sekhar, Public Affairs Foundation, India

The Context: Why citizen report cards?
There are three reasons for developing citizen report cards. In all instances it relates to the inadequate role of the government who:

- Are not accountable to anyone since they hold a monopoly over all health care services provision.
- Do not respond to the demands of users of the service.

- Lack incentives from within the health system which serves to block demand-driven improvements.

The Concept: What is a citizen report card?
A CRC is similar to a school report card: it allows users of health care services to assess the health services' performance in relation to a set of clearly defined criteria. The CRCs allow for comparison between different aspects of a service (e.g. accessibility of the service, reliability and quality, responsiveness of the service provider, etc.), gives opportunities for reflection and, most importantly, triggers change and improvements in the health service. The framework is described in the diagram below:

Preliminary Work:	Identify the issues, ascertain feasibility of CRC, define scope of action, design survey, and frame the sample
Implementation of CRC:	Collect user feedback, engage with service providers, rate services, analyze and interpret data, and produce reports
Setting an Agenda for Reform:	Actively engage all stakeholders (users, citizens, service providers, policymakers, etc.), disseminate findings, and promote advocacy (civil society, media, etc.)
Benchmarking and Reform:	Affect citizen-driven reform and maintain a continuous benchmarking process through periodic review
Self-Monitoring Institutions:	Encourage service providers to be accountable and monitor their own effectiveness without requiring external impetus

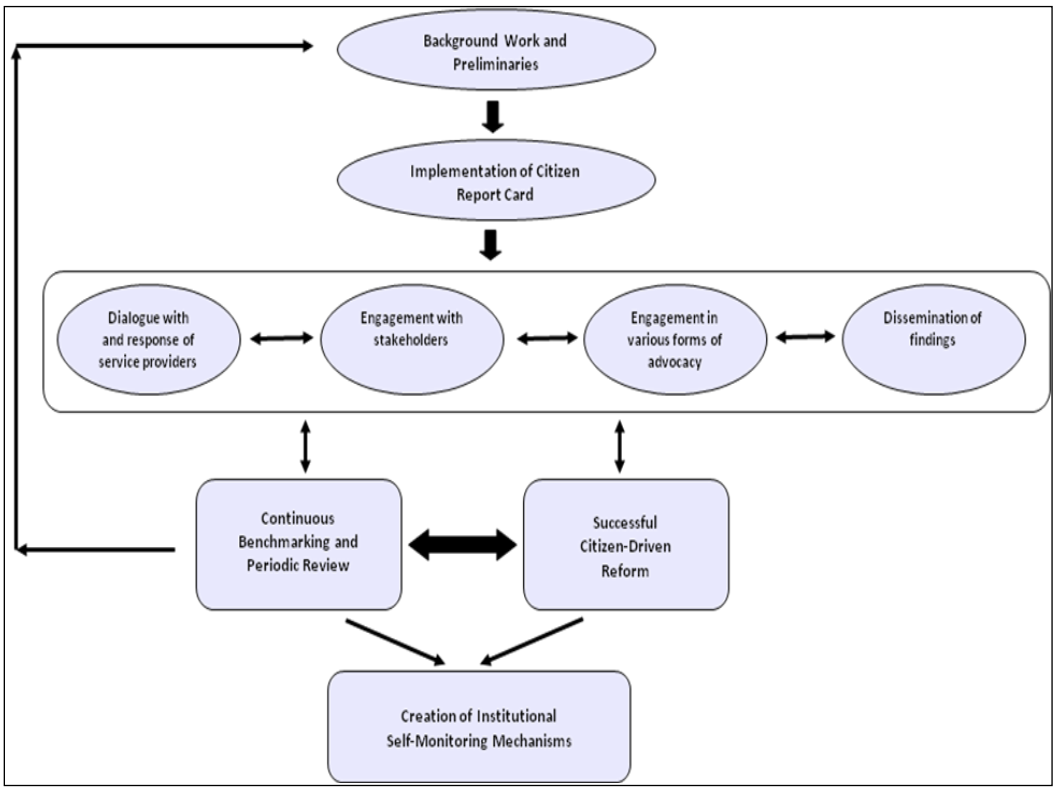

Figure 9: Conceptual framework for use of Citizen Report Cards

Who can implement a CRC?
CRC has been used by various actors in many different parts of the world. For example:

- Individual civic society organizations (e.g. Transparency International and many other organizations).
- Civic society partnerships (e.g. People's Voice Project, Ukraine).
- Independent Multi-Stakeholder Consortiums with representatives of government, civic society or even citizens directly (e.g. Water and Sanitation in Kenya).
- Governments for internal review (e.g. Vietnam).

Impact: points of influence
The major impact of CRCs as sited by Sita was that the cards give communities and other stakeholders in the health system a concrete, measurable tool to compare clearly defined issues both over time, and between different areas in the health care service. The cards present both strengths and weaknesses of health care services, making the information more objective and acceptable to service providers. It enables policy makers to set policy priorities, assists health centers improve their services, provides a bridge for civil society to dialogue on citizens' priorities, and transmits the voice of the poor without any intermediary.

6.4 Social Accountability Monitoring (SAM) – Ms.Gertrude Mugizi, Centre for Social Accountability (CSA), South Africa

The CSA has been involved in monitoring in the Eastern Cape, South Africa, since 1999. The organization believes that everyone has the fundamental right to obtain justifications and explanations for the allocation and use of public resources and, conversely, duty bearers have the duty to provide so. An *explanation* is when the government says "this is what we are going to do and this is why we are going to do it." *Justification* goes a step beyond this, and says "this is why what we say we are going to do is the best thing that we can do, given all the other choices that we have".

The CSA uses a rights-based approach in SAM processes, believing that:

- Citizens are not passive users of public services, but active holders of fundamental rights,
- The state has an obligation to deliver public services effectively,
- Failure to deliver services is a violation of people's rights, and
- In order to deliver services efficiently and effectively the states must transform into a social accountability system.

Whether a state is a dictatorship or a democracy, it has to operate through five basic processes in order to be effective:

- Planning and resource allocation – what public funds are available and how do the state plans to use them?
- Expenditure management – how effectively are public funds spent?
- Performance management – how do service providers perform in implementing their plans?
- Public integrity – what mechanisms exist to prevent, or take action against, abuse of public funds?
- Oversight - are officials or service providers called to account by oversight bodies?

Figure 10. The Social Accountability System framework of Centre for Social Accountability

This is what CSA calls the Public Resource Management Framework (PRMF) and there are multiple tools that can be used to measure its success, such as budget analyses, expenditure tracking reports, scorecards, etc. In order to transform the PRMF into a Social Accountability System (SAS) it must deliver on all the rights promised in South Africa's human rights framework that includes economic and cultural rights. CSA's social accountability model sees all five processes as inter-related. If one process doesn't work the whole system doesn't work.

Also important was the fact that the problems do not necessarily manifest where they originate. For example, a problem may manifest itself in terms of lack of access to drugs but it may actually be an expenditure management problem. Thus, SAM looks at the whole system, not just one component, putting the onus squarely in the hands of government whose mandate and responsibility is to deliver services.

Finally, the key elements to the CSA's social accountability model are:

- It defines Social Accountability as a fundamental human right.
- It defines the state as a Social Accountability System.
- It is most useful in tracking systemic reasons for service delivery failures.
- It is a continuous process, not a one-off event. This is often a challenge since it is difficult to keep the community motivated once their initial needs have been met.
- It can be used to monitor issues that span across multiple levels of government, including community level.
- It demonstrates how civic actors can conduct evidence-based advocacy by monitoring the public resource management framework, demanding explanations and justifications for any systemic issues, and following up consistently to ensure corrective action is taken.

6.5 Plenary Discussion

- *Who is 'we' in community monitoring?* There seemed to be a mix of players – the community (in all its diversity), practitioners, and others – referred interchangeably while using the term 'we' in community monitoring. This was questioned by the convening delegates who called for clarity in understanding while referring to 'we' in the community monitoring work. Questions were also raised about who defines 'moral acceptability', 'standard of reasonableness' and such other value-laden terms?

- *Challenging the status quo:* Concerns were also raised about the frameworks that shied away from challenging existing structures but, instead, were complicit in accepting the way things are, despite their inequities. For example, accepting unfair allocation of funds. It was felt that that such restrictive frameworks may not be as helpful since challenging status-quo was an important component of social justice work including community monitoring.

- *Sign posts on the road to change*: The practitioners need to be reflective and speak about the conceptual framework they are using when they present their work, instead of just focusing on the methods. There is a need to make explicit, the assumptions they make while conceptualizing their approaches and how they think about how and why the change occurs.

Tuesday, July 19
DAY 2

7.0 Community monitoring tools, methods and practical approaches

Objectives:
- To lay the foundations of a shared understanding of the work we do, its basis, scope and limitations.
- To develop awareness about of the broad diversity of approaches, and the tools used by different approaches for enabling community monitoring.
- To explore common challenges and strategic responses.

In this session, four self-selected groups discussed a set of questions related to practical approaches to community monitoring, and then reported back to plenary. The four approaches discussed were:

1. Community-based data collection and score cards
2. Health facility surveys
3. Social audits
4. Budget and Social Accountability Monitoring

7.1 Group report back: Community-based data collection and score cards

Q1: Role of the community and how, if at all, community empowerment is enabled:
- Involved in problem-identification: the extent of this role is often affected by the length of the relationship of the NGO/mediator with the community they work in/with.
- Specially marginalized groups in a community require specific attention and inclusion (single women, disabled, and such other groups).
- In some cases, the community is part of designing the community monitoring exercise; in others, mediators go in to do a scoping exercise at the start of the process.
- Community is part of the data collection process, where they are respondents, but also at times investigators (though this may induce some bias).

How is community empowerment enabled?
- Community representatives take part in the analysis of the trends and presentation of findings to decision makers.

- Communities also, at times, develop strategies to scale up activities.
- Communities can shape the debate.
- Through participation, community members realize that it is a collective problem, a way of feeling empowered.

Q2: How information is gathered, and how evidence is organized and communicated:
- Many methods, such as check lists, pictorial methods for the non-literate, participatory and interactive tools, participatory action research, stories as case studies to capture people's experience, direct observation.
- Mediator group may be needed to do compilation of information, particularly in large, geographical areas.
- Mediator group plays an important role in triangulating the information coming out of community experience with information from other sources like public authority reports and surveys.

Q3: How authorities are engaged, at which level(s), and for what purpose:
- Again, there are many methods, such as: report cards, newsletters, films, media briefings, public hearings, presentation by community members' at large events or with key officials in meetings, radio, petitions/ letters to key policy makers, etc.
- People get included in various committees as a way of engaging with public officials.
- Securing the passage of government orders is a way to engage authorities.
- Some confrontational methods can also be used: demonstrations, protests, marches, litigations, etc.
- In order to improve dialogue with the authorities and create less of an antagonistic atmosphere, it may be important to share the findings with authorities before going public, so they can prepare their responses.
- Include front line providers and relevant government officials in the monitoring process so they also have a voice to express their concerns.

Challenges:
- Literacy level of a community – need to make the tools simple while keeping them rigorous.
- How to make the data credible for officials?
- Sustainability – how is the community on its own going to continue with the monitoring activities?
- Should the onus for mobilizing resources for monitoring be on the community? Or is it a responsibility of the system itself?
- Difficulty of creating a non-adversarial space, while also ensuring that the community is still empowered.
- The role of the private sector in the provision of health services and how that impacts on community monitoring work.

7.2 Group report back: Health facility surveys

Q1: Role of the community and how, if at all, community empowerment is enabled:
- It is important to differentiate the role of the community, and the role of the facilitating organizations.
- Communities contribute to the collection of information (surveys, focus groups, observation, etc.).
- Community members participate as members in government mandated Health Center Committees (HCCs), which should be elected through community processes.

- Communities contribute to analyzing results, negotiating for changes to be made, and in ensuring implementation.
- NGOs can assist in training and the provision of technical support to communities and HCC members.

Q2: How information is gathered, and how evidence is organized and communicated:
- Questionnaires, checklists, key informants interviews, exit interviews, making minutes of Health Facility meetings transparent, etc.
- Patients are trained on the treatment they should receive and on government protocols so they can monitor the quality of health services.
- Focus groups are used to triangulate information with particular attention to the marginalized groups.
- Generation of case studies.
- Involvement of communities in case reviews (e.g. maternal case death studies).

Q3: How authorities are engaged, at which level(s), and for what purpose:
- Structures may not exist for engagement, in which case, they may need to be created.
- Presentation of findings is an important way of engaging with the authorities, both through policy briefs and direct presentations to the authorities by community members.
- General meetings, such as Annual General Meetings, offer another opportunity to engage with officials, especially higher level Ministry of Health representatives.
- Parliamentary committees can be engaged around health budgeting issues.
- The Ministries of Finance and Women's Affairs are also key ministries in which to engage.
- May need to build alliances and coalitions to strengthen community voice when addressing decision makers.

Challenges:
- Weaknesses of HCCs. Many of them have no legal status; members lack an understanding of their role, and lack the necessary skills, confidence and power to assert their authority.
- HCCs usually play more of a consultative role, rather than as a decision making body.
- HCCs at times are plagued by political domination reproducing local power asymmetries.
- There is a general lack of understanding as to where power and decision making authority is located - HCC members often don't understand how to use their collective strength.
- Limited power of health facility managers to act on problems identified.
- Action following the results of health facility surveys can be undermined by international agencies that have their own agendas and indicators of success e.g. focusing on numbers and immediate results, rather than the process itself.
- Monitoring, especially in large hospitals, takes time and resources.

7.3 Group report back: Social audits

The group began by reporting on 4 experiences of social auditing, from Brazil, Kenya and two from India, looking particularly at the processes involved in each. Thereafter, the group drew out common features and challenges, based on the three questions given to them by the facilitators:

Brazil –Social Councils of Health are present at multiple levels, and are used as a municipal mechanism for social auditing. These Councils were set up by law during and after the transition from

a military to a democratic state. Council membership consists of community users (50%), trained to interrogate health planning and expenditure processes, and public and private providers, including government representatives (the other 50%). Here, the social auditing component encourages the active participation of trained users in discussions around planning, budgeting and expenditure on health.

Kenya – Social auditing processes in Kenya are not limited to health, but include the auditing of the Constituency Development Fund, focusing on how social services are planned and whether they meet the needs of the intended beneficiaries. Representatives from community-based organizations are trained over 5 days in both the theory and practice of social auditing, and they then go out and audit expenditures and assess the impact of the economic development funds on communities. Findings are presented to the government authorities for verification, and then publicly shared. An important component of this process is the role civil society plays in the verification and validation of official government plans. This model is based on the Indian example, and is now recognized as a legally-backed process.

India – Initially, social audits were set up to audit the National Rural Employment Guarantee Act. It was also piloted to audit the Integrated Child Development Services programme. These social audits were located within the local government council using citizen audit groups who were trained to check whether individual beneficiaries were receiving their benefits. The citizen audit groups were provided with a list of the names of intended beneficiaries and, using oral, physical and documentary verification, produced reports that were then shared with the relevant authorities. As is the case in Kenya, these social audits included validation and verification by citizen groups. The second Indian example was similar, except that its focus was on auditing health care facilities.

Q1: Role of the community and how, if at all, community empowerment is enabled:

- The investigation process is community-led.
- In both India and Brazil, social auditing was born out of strong civil society demands for access to information and the demystifying of government data.

Q2: How information is gathered, and how evidence is organized and communicated:

- Government documentation has to be accessible; otherwise it is not possible for local audit teams to verify the information.
- There is a need for rigorous training in information gathering.
- In all cases, information is shared at a platform or forum – in Brazil the forum is built in as a Council, the impetus in Kenya came from civil society but is now slowly becoming legally constituted, and in India it is primarily the Village Development Council.

Q3: How authorities are engaged, at which level(s), and for what purpose:

- The state provides the information, arranges logistics, provides wages for the audit teams and is responsible for ensuring that action is taken to rectify problems arising from the audits.
- Higher level government officials usually endorse the social auditing process more readily than those working at local level. This is not surprising, since social audits tend to look at specific entitlements at the lowest level of service delivery, without questioning policy design. This leaves lower level officials more vulnerable to criticism.
- The entire social auditing process needs a strong civil society to act as a pressure group to ensure decisions and actions adopted by the Forum are followed up.
- Social auditing does not have to be state sanctioned, but it is desirable.

Challenges:

- Cases of corruption can surface during a social audit which may lead to violent action on the part of the accused. In Brazil, a number of people were murdered because of what they unearthed and knew.
- Funds from the national level can be blocked by local municipal authorities or due to bottlenecks in the bureaucracy.

The difference between community-based monitoring and social audits:
While there are many similarities in terms of methodology and goals between the two processes, the differences are stark:

- The starting points are different: in social auditing the starting point is the validation of official documents by community representatives; community-based monitoring starts with the experiences of the community.
- Since social auditing is scrutinizing official documents, it involves higher levels of training to ensure the accuracy of information gathered.
- Triangulation may or may not occur in community monitoring, but it has to be done in social auditing.
- Social auditing is about opening up to public scrutiny information which is usually the monopoly of the state.

7.4 Group report back: Social Accountability and Budget Monitoring

This group drew on the experiences from 3 case studies: CSA model of Social Accountability Monitoring in Tanzania, and budget monitoring in Mexico and Kenya.

Q1: Role of the community and how, if at all, community empowerment is enabled:

- The starting point for these processes is the national plan or budget. Because the nature of the information is strategic and complex in character, the community sets the priorities and then a mediator is brought in to undertake the budget monitoring exercise. Once the information has been collated, the community gets involved again to debate the findings through public hearings, meetings with the local councils, etc. and to plan for social action. The middle part of the loop is, therefore, delegated and, as a result, the community's role is more distant. The mediator usually comes from a local or national level organization.
- In Tanzania, a civil society network mediates the process; in Mexico, this is done by a local organization. In Kenya, the process is more open with 40-50 people carrying out the investigation in a more public manner.

Q2: How information is gathered, and how evidence is organized and communicated:

- In some cases, there are legal provisions to allow access to information; in other situations, it may be more difficult to get documents from the authorities.
- In Kenya, officials are asked to bring the necessary documents to a meeting where the information is discussed and analyzed. These meetings take place on a weekly basis.
- In Tanzania, a specialized team scores the materials by grading the government action and through the use of score cards

Q3: How authorities are engaged, at which level(s), and for what purpose:

- Authorities are responsible for providing the information.

- They are engaged through small meetings, larger public hearing, through use of the media and such other avenues. In some cases, national anti-corruption and human rights commissions, or parliamentary committees, are involved.
- It is important to involve multiple structures, both governmental and non-governmental, to ensure that the onus to keep the issue on the agenda is not only on the community.
- In Kenya, if the authorities do not meet agreed deadlines, the civil society groups follow up with law suits, court cases, and civil actions (such as dumping garbage in front of a local office).

Challenges:

- Access to information is a challenge - what information is given to you, when, and whether it is understandable.
- Sustainability: how to keep the community involved over time, especially when the issue is systemic in nature. If the problem is solved at the local level, or if the issue moves into national level processes, the community easily loses interest.
- Security issue for researchers when officials put pressure on them to stop the work.
- The link between national NGOs, mediators and community is complex. The community often does not feel engaged.
- How do we move from discrete social accountability and budget monitoring actions to systemic change? Such as, how money is allocated, and addressing issues of equity and power.
- There is a global tension about the relationship between representatives and those they represent. In our case, how do we ensure that the mediator is accountable to the community?

The difference between community monitoring and SAM and budget monitoring processes:

- Social accountability and budgeting processes start with policy. Community monitoring focuses on implementation.

7.5 Plenary discussion

The plenary discussion reflected on two issues: how can we learn across methodologies, and are there any ideas on how to meet some of the challenges expressed in all of the above mentioned approaches. Some of the key points that came out of the discussion follow:

- *Complementarity of all approaches*: There was general agreement that all these approaches would be more effective if seen working together in a circular relationship, rather than as finite processes. Community monitoring and health facility surveys can be used to identify and push for changes at local level; social audits or budget monitoring would then monitor implementation and/or policy changes to ensure gains are realized and maintained. This involves a more strategic way of thinking. It would also most certainly be a longer, more sustained process. It also assumes that one organization cannot do it all – organizations need to build alliances with complementary approaches (please see figure 13 below).

- *Solving systemic problems*: There are two important underlying questions: what are we trying to achieve? And, what do we do once we have the evidence in hand? In all the approaches, it may be possible to expose inequities in the health system, or degrees of corruption, but appears that monitoring cannot solve wider systemic problems. However, these approaches have the potential to generate critical gains in realizing the importance of citizenship (i.e. establishing the groundwork for mobilization, empowerment, etc.) and that these gains, in turn, contribute to systemic change. This also involves a more conscious understanding of the linkages from micro to macro level, from community to larger policy issues to international trends.

Table No. 1. Essential features, uses and challenges of different community monitoring approaches

Method	Essential Features	Uses	Challenges
Community-based data collection and score cards	Compiles information on community experiences and needs through use of a range of participatory approaches and tools; local advocacy begins with interface meetings with local service providers to agree on changes needed and ways to implement the change.	Gather community perceptions on accessibility, availability and quality of services to identify gaps and promote accountability of local service providers; identify local solutions.	Literacy level of a community; monitoring private health sector; ensuring participation of marginalized groups in a community.
Health facility surveys	Community visits to health facilities to assess and verify type of service, adequacy of health human resources, medicines and equipment, and functionality of infrastructure; information is collected through questionnaires, checklists, key informant interviews, exit interviews and critical review of health facility documents/records.	Identify gaps in service delivery, health human resources, medicines, equipment, and infrastructure at health facilities; identify solutions at local level; findings can also be used as an advocacy tool at district or national level.	Weak relations or limited power/authority of local health governance structures can make communication and shared problem solving between community representatives and health facility personnel challenging.
Social audits	Community assessment of public records to assess the allocation and use of public resources; findings presented to public officials in public forums to reinforce the rights of citizens to scrutinize effective use of public resources and receive stated government services and hold public authorities accountable for their decisions and actions.	Scrutiny of public authorities' decision making and use of resources by communities; monitor individual case studies with regard to receiving services or supplies (e.g. medication); document negative impact of current policies and practices; reveal corruption and unfulfilled obligations.	Access to government/public documents and information; social audits look at specific entitlements at lowest level of service delivery, leaving lower levels of authority vulnerable to criticism and often critical of the process; Needs involvement of strong civil society groups to ensure decisions and follow-up actions.
Budget and Social Accountability Monitoring	Tool to understand the intent and impact of government budgets; skilled mediator undertakes the analysis, while community representatives set priorities, review findings, and plan for action; facts are compared with government commitments and standards.	Assess Government's compliance with its own stated policies and commitments; assesses how equitably and efficiently government's resources are being used; identifies funding gaps.	Access to relevant government documents and information; sustaining community involvement over time.

8.0 Unresolved issues from Day One

Objectives:

- To reflect back on some of the key conceptual dilemmas which arose during our discussions on Day One
- To develop a common language, while also acknowledging the complexity and diversity of our group
- To identify issues that are still troubling us that need to be developed further

Four issues were discussed during this session:

- How do we (as community monitoring practitioners) understand community consciousness, empowerment and latent power in community monitoring work?
- How do we understand and deal with the role of markets and the private sector in community monitoring work?
- How do we understand and make local-national-global connections in community monitoring work?
- Who is the 'we' and what is the role and ethics of facilitators of community monitoring?

The notes below summarize the main points arising out of these discussions.

8.1 How do we understand community consciousness, empowerment and latent power?

- An understanding of the community and its own processes is a critical first step to making sure that the mediating organizations/facilitators are following community's agenda and not forcing communities to fit into mediator's agenda and thinking.
- Consciousness is not just the consciousness of the community but it is also the consciousness of the facilitators. It is a two way process: to be an activist is not an imposition of consciousness but a dialogue.
- We need to understand the multiple layers of community consciousness. For example, women may be empowered by being involved in the community monitoring process in public spaces, but they still may be disempowered in their home environment.
- One of the roles of community monitoring facilitators is to build a community understanding of people's rights and to help them activate their latent power.
- Power starts from the consciousness within an individual, but is facilitated by collective action.
- 'Community' needs to be seen as an organizing phenomenon rather than as a geographical phenomenon. This brings to question whether community monitoring can be carried out when a community is not organized. Further to this, are we talking about first establishing a community in order to monitor, or are we talking about drawing on existing communities, or representatives of a community, to participate in the monitoring process?
- We need to be very careful that we don't compartmentalize people into 'communities' and thereby ignore the common struggles faced by people across class, race, gender or geographic distance. There are larger solidarity struggles and, if we want to change systems, we need to make sure we don't atomize or fragment communities and the problems they face.
- Issue for further discussion: Relationship of marginalized groups to larger community processes and the risk involved in further marginalizing vulnerable groups during monitoring.

8.2 How do we deal with issues of the market and private sector?

There was a general consensus that privatization of health is a common issue faced by most countries, that it brings up a number of complex issues related to the relationship between the private and public health systems, and needs much more discussion to address implications in our monitoring work. Specific issues arising from the discussions include:

- In all our countries, we are dealing with mixed health systems. We cannot focus only on the public health system, especially since communities are interfacing with both private and public health facilities.
- We need to understand that private includes private for profit and private for non-profit.
- We need to debunk our theories of privatization and look at the private sector through a community lens to understand how it is or is not meeting community health needs.
- We need to explore the role of the state in this complex environment and review how the state is being co-opted or impacted by private interests and the private system.
- We need to view community not just as users of either system but as active citizens with expectations and rights.
- Monitoring of the private and public sectors is not sufficient; we also have to think about building alliances across many levels in both public and private spaces to ensure the interests of communities and their rights to health are not abused.
- We work on the assumption that the state is strong enough to counter the interests of the private sector, but this is often not true. We may be risking the situation by putting additional burden on a weak state, thus undermining rather than strengthening their role.
- There is also a risk of legitimizing the idea that choice is important. If we put too much pressure on the state, then it sends a signal that privatization is a better option thus further undermining the state.
- Can private systems be made accountable? If so, it will require different strategies and techniques.
- Uganda case study on private-public mix and health insurance initiatives: brought together private providers, civil society and private public health management systems which looked at the role of the state in regulating the private sector and ensuring consumer protection.

8.3 How do we understand the connection between local, national and global?

- Discussions highlighted four interrelated issues:
  - Bridge the spaces between the local and national level and to some extent at the international level if we want to effectively drive systemic change.
  - Bring pressure to bear on the donor and international community to adjust international priority setting on development goals.
  - Recuperate the emphasis on rights which take into account the citizenship and power of communities.
  - Strengthen the voice of local communities by forming alliances across the spectrum that can take the interests of local communities up to the international level.

- In order to achieve these goals, we need to:
  - Connect the three levels, especially the local to the national. We need to reflect critically on our modes of engagement with the authorities and not allow the authorities to continue 'passing the buck' from local to national to international level. Each level has to be responsible and accountable.

- Identify stories of change expressed through the voice of empowered people at local level and disseminate the same for positive reinforcement of the work.

- This discussion made it clear that the practitioners have to build consciousness and power at all levels, not just as empowerment for the marginalized. There is a need for empowerment at all levels to bring about change (for example, the Minister of Health to challenge the Minister of Finance, or a Head of State challenging the international status quo).

8.4 Who is the 'we' and what is the role and ethics of facilitators?

- The discussion focused on 'us' as the community of practitioners, and facilitators of the community monitoring process. Irrespective as to whether we call ourselves facilitators, mediators or activists, there are some key questions we need to ask ourselves in terms of the role we play:
  - What are our intentions in this process? To what extent do our interests influence the way we work with community?
  - Who are our allies (within the state, coalitions, etc.)?
  - How can we ensure our monitoring work represents the voice of marginalized groups and highlights a broad cross section of community concerns?
  - As representatives of civil society, do we stand in front, behind or with the community?
  - Who owns the community monitoring data and who is responsible for taking action on the findings?
- There are numerous ethical issues that need to be taken into account, including the possible backlash on frontline providers for example.
- There are different power dynamics within the 'we' - this needs to be acknowledged and dealt with.
- In terms of our future direction: We need to be transparent about who we are and our role in the community, giving space for communities to make their own choices and to demand accountability from us.
- Future issues for discussion: Developing a list of questions for discussing the 'we' and elaborating on role and ethics of community monitoring facilitators.

9.0 Context matters: Understanding how context influences strategy and how successful implementation strategies can challenge contexts

Objectives:
- To explore how contextual factors affect community work, and
- To develop a shared understanding of how organizations develop and adjust their strategy in challenging environments, on the basis of their diverse and distinct experiences.

This session involved all delegates placing themselves physically on two axes to represent the context in which they work. In the first round, the axes were:

Repressive state -------- Democratic state

Poorly-functioning public health services -------- Well-functioning public health services

Once participants had located themselves on the floor, the facilitator asked questions to understand how organizations cope with their different situations and how it impacts on the way they implement their community monitoring programs.

In the second round, the two axes were:

Low levels of community organization -------- High levels of community organization

Weak CSOs working on health rights -------- Strong CSOs working on health rights

9.1 Repressive/democratic states …. Poorly-functioning/well-functioning health services

As shown in the Figure 11 on the following page, participants were spread out in all four quadrants, with Denmark, Switzerland and Canada at one extreme of the spectrum, and Zimbabwe, Uganda and Uttar Pradesh state in India at the other. There were a number of countries where, even though the states were relatively democratic, public health services were nevertheless still poorly functioning. In most cases, there was consensus that there was more room to maneuver if community monitoring work remained in the 'safe' domain of health without tackling issues of political and economic power and inequity.

Repressive state and poorly-functioning public health services:
Delegates standing in this quadrant recognized that, even though they are working in a repressive environment, there was still some space to organize at community level. The space is narrowly defined and more difficult if they move into addressing political or socially sensitive issues (e.g. homosexuality in Uganda), but it is still possible to make some progress in strengthening community health structures. Some suggestions on how deal with this situation in terms of community monitoring:

- Build community voice and organize people's power for health (Zimbabwe)
- Work at district level
- Revive local health structures

Other extreme –repressive state but well-functioning public health services:
Gujarat State in India, for example, is one of the richest states in India. It has a reasonably well functioning public health system but the government is intolerant of sexual and religious minorities and has been responsible for instigating violence against these groups. Organizations working in this state have dealt with this situation by

- Creating solidarity links with human rights organizations across the country and internationally
- Adopting a strategy of shaming the state government on their poor human development indicators. This works relatively well because the state government is conscious of their reputation.

Referring to Guerrero State in Mexico: The formal government is reasonably well functioning, but it does not easily allow communities to engage in monitoring exercises. Health workers have been imprisoned for mobilizing communities to question state services. Nevertheless, there have been some reforms in the last 5 years which have enabled greater debate with health authorities.

Largest group –reasonably open democratic spaces but health system not functioning well:
Kenya enjoys political rights but not social and economic rights. Women and other vulnerable groups cannot afford health care and, if treated, receive poor service. The power still lies with the state (where

the Minister of Health goes to Europe to receive cancer treatment). People need to be organized to demand improvements in their health services.

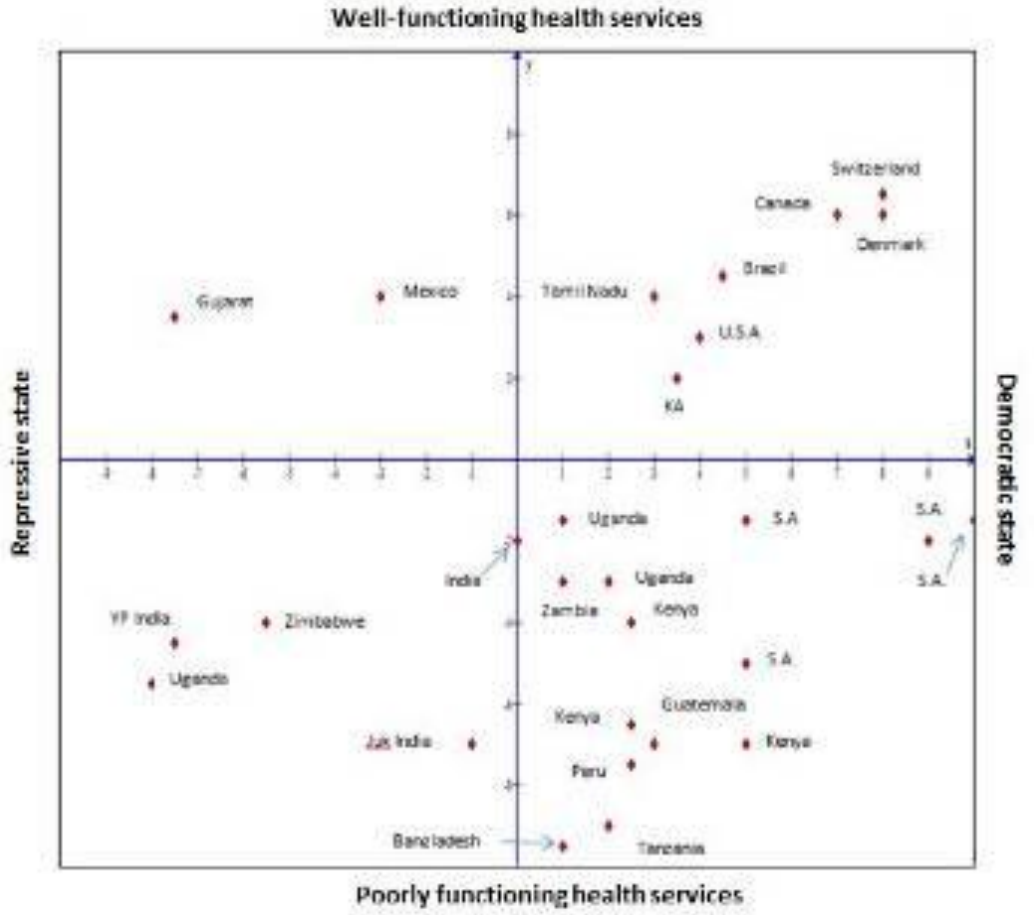

Figure 11. Repressive/democratic states… Poorly-functioning/well-functioning health services

Bangladesh is in a similar situation. They enjoy reasonably good health indicators, but the public health service is still poorly functioning. Outwardly, the state appears to be democratic, and in terms of health and community monitoring work, there are few obstacles. However, as an activist, there is little space. If health workers restrict themselves to dealing with health issues without challenging the power structures, then all goes smoothly. But if they move away from this mandate, problems surface very quickly.

Well-functioning health system and reasonably open democratic space:
The participants in this quadrant noted that, even though their countries have a well-functioning health system, there is still the question of equity and this is what motivates people to continue participating in community monitoring for health activities. In Tamil Nadu, for example, there is a shortage of doctors in some areas, corruption, and discrimination against lower castes. Privatization of health services is impacting on the availability of health services at community or rural levels. There is also the issue that, in some cases like in Greece or Spain, people are seeing their services being withdrawn as the role of the state shrinks.

9.2 Low/high levels of community organization …. Weak/strong civil society organization

The figure 12 below shows that the majority of participants saw their countries as having strong civil society groups with varying degrees of community organization and awareness.

Weak civil society organization and low levels of community organization:
Uganda, Kenya and Uttar Pradesh state of India all fit into this quadrant. They deal with this situation by:

- Trying to strengthen the capacity of the existing CSOs.
- Using the media to inform and mobilize communities.
- Finding entry points, such as through the trade union movement in Kenya, to create room for discussions on health issues.

Smallest group - Weak civil society organization and high levels of community organization
There are many CSOs in Guatemala working on land issues. Even though there could be a connection between land and health rights, it is a challenge to work together. The solution is to work directly with communities, bypassing the more formalized civil society organizations. Alliance-building is key.

Strong civil society organization and high level community awareness
The situation in Brazil is historically grounded in the Paulo Frierian tradition of mobilizing communities to demand their rights. Communities work through numerous community structures, such as forums and councils. Health services are uneven – primary health care is available to everyone and people have access to medicine. But specialist services are not as good and, overall the health system is underfunded. This is why grassroots groups continue to put pressure on the state.

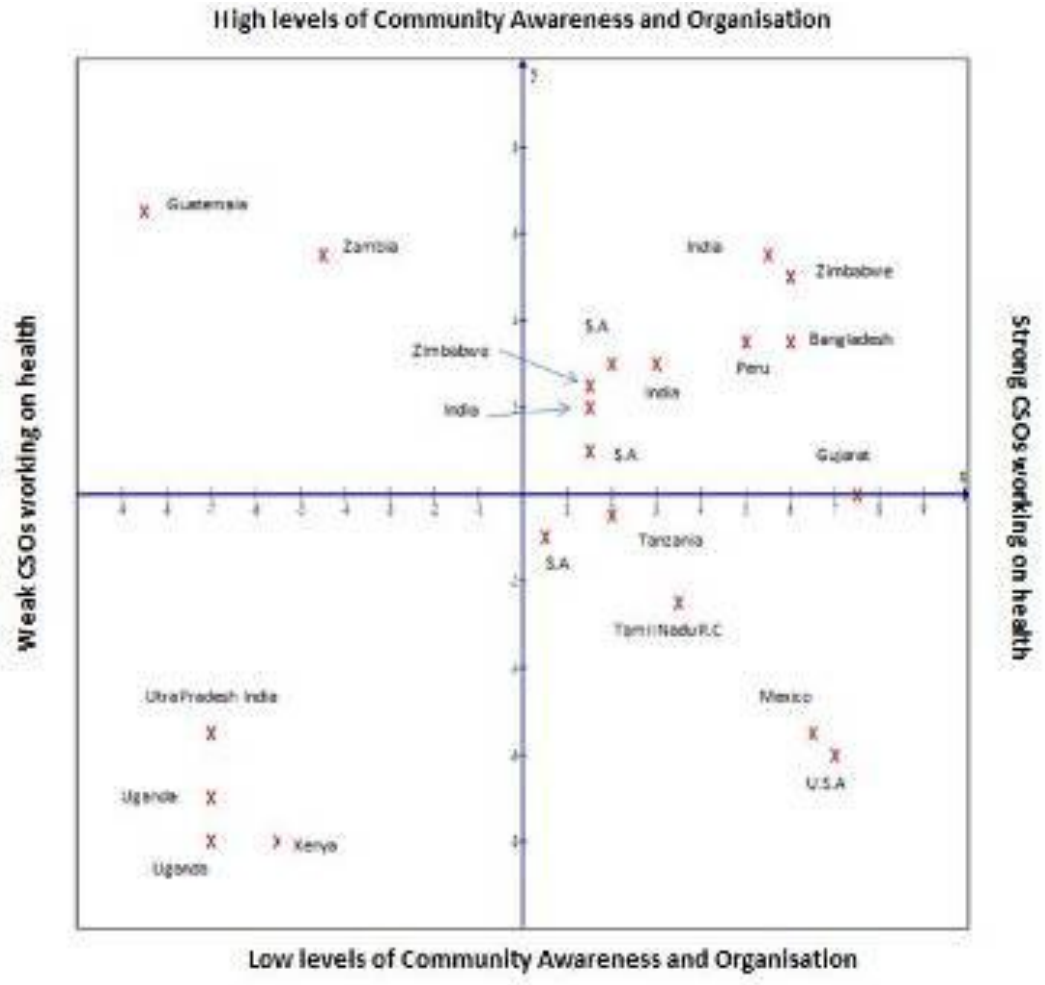

Figure 12. Low/high levels of community organization …Weak/strong civil society organization

10.0 Measuring success: Identifying results and tracking progress in community monitoring strategies

Objectives:

- To explore how participants understand success, how they assess progress, and how they adjust to track it, and learn to monitor institutionally.
- To understand how experienced and successful practitioners monitor results and track progress in different contexts, facing diverse challenges.
- To explore what value, if any, institutional learning processes, monitoring and evaluation schemes add to community monitoring work.

This session was modeled on a TV-type panel discussion with four participants as respondents, Rene Loewenson as the presenter, and Walter Flores as a 'key informant'. The respondents came from a diverse array of institutions:

- One participant with a strong **methods focus** on thinking and documenting changes/impact *(Rakhal Gaitonde from SOCHARA in South India – see Appendix 3)*
- One participant who has been part of a **large scale evaluation effort** *(Renu Khanna from SAHAJ in Gujarat, India who works with urban Muslim minorities in promoting citizenship and the right to health, and has also been involved in reviewing national and sub national community based monitoring program under NRHM in India.)*
- One who has stories of **community mobilization and action** *(Artwell Kadungure, TARSC Zimbabwe – see Session 3.4)*
- A fourth who has worked with a specific group of **marginalized communities** *(Ariel Frisancho, CARE Peru, who works with indigenous women from grassroots organizations in Peru.)*

A summary of the learning coming out of this session is documented below.

What has 'success' meant in your community monitoring activities? How do we know we are making progress?

Rakhal: Community monitoring is merely a means to creating hope. And this can mean different things to different people. For some it is about creating a forum for dialogue, for others it is the mere success of accessing rights, or being able to look a doctor in the face. For those of us who are working with the communities, the mere fact that community members are able to attend monthly meetings and spend a significant amount of time away from their other commitments is a signal of success.

How we define 'success'?

"Community monitoring is about creating hope…"
"We are promoting citizenship …"
"Our focus is on promoting social justice…"
"We promote empowerment and agency…"

Renu: We are promoting citizenship so individual empowerment and agency is important. The first sign of success is when women and marginalized groups become aware of their rights and entitlements, and they begin to demand their rights at an individual level. Then, we move on to the collective process. It is a continuum – from the individual, to collective empowerment, to action.

Other indicators include whether our health system is becoming more responsive, or whether youth are engaged in the process.

Artwell : The focus at TARSC is on promoting social justice. We view success as taking place on all levels, from community to national. We focus on four measures of success:

1. Are communities able to articulate their needs?
2. Are they able to present their issues to local authorities and then, through their community based organizations, to influence debate at a national level?
3. Can they negotiate for resources to improve their lives? and
4. Are they able to monitor delivery of state commitments?

Ariel: Our work with indigenous women aims to promote empowerment and agency at a personal level, as well as in the public domain. It involves building a consciousness of their own processes and a clear analysis of the issues they need to address.

What about the use of process and outcome indicators? What tracking and reviewing tools enable community monitoring projects to be more effective?

These questions were opened up to the floor for general discussion. A number of points surfaced:

- Success is as much about process as it is about outcomes. We need to guard against confining ourselves to written deliverables, often determined by outsiders. Individual stories of success, garnered through listening and observation, are as important as quantitative definitions of change.
- We need to develop our own language of success while still engaging with the dominant paradigms of measurement. Scientific collation of data and rigorous monitoring is also important, as long as the voice of the community is not lost in the process.
- Moving from process to impact indicators takes time. One programme in India starts by looking at 3 process indicators:
    1. Is the community getting organized and gaining a consciousness about its entitlements?
    2. Is the community getting to understand how their health system functions, and what they see as the gaps in the health system? and
    3. Is the community beginning to dialogue with the health system?

  This will need to be measured over a time period of few years. Only then do they move on to impact indicators, specifically looking at qualitative and quantitative changes in the health system, and changes in use of the health system.
- Others noted that all we can expect in the first 1-2 years is a greater responsiveness of the health system. For example, new health facilities opening up or an increase in the quality of care, or less health worker absenteeism.
- When measuring impact, we also need to look at issues such as power shifts, engagement with authorities, strengthening of the collective voice and other dimensions.
- There are a number of tools which can be used to track progress, including progress markers, wheel charts, outcome mapping and others. Adah Zulu from Lusaka District Health Management Team (LDHMT) explained how they use progress markers and wheel charts to measure change from the perspective of both community representatives and health workers. The wheel chart looks at four areas: community involvement, information sharing, resource allocation, and planning.

How can we package our evidence in such a way that it becomes acceptable to others who might need to be convinced by the results and processes we are engaged in?

There were a number of varying responses to this question:

- This depends on the audience we are trying to address. When trying to convince higher government levels to change budgets or policies, we need to package our evidence in the form of tables and diagrams. The evidence needs to be triangulated. This is not about replacing some of the community-based monitoring approaches, but about finding ways of documenting the evidence more strategically, and using persuasion and negotiating skills to create the change.
- Some organizations maintain that they are more inward looking, and less concerned about persuading others. So the focus is on self-reflection and the documenting of successes and obstacles to help communities understand what they are doing and where they need to go.
- Rigorous self –reflection of our own practices is also important so we can become more effective in our work.

Summary of session:

- There is a strategic path to measuring success. Community monitoring, at the very least, must achieve awareness and inclusion of the local population. But it is also possible to identify success at various other stages along the path –including increased community organizing, to articulating and negotiating demands, through to the power of producing change, whether personal (a patient is more assertive in demanding her right to health), social (community demands are met) or structural (government resources allocated more equitably).
- Mapping and tracking successes is an internal part of the community monitoring process. This session has shown that practitioners have a number of approaches to doing this, for example: outcome mapping, sign posts, wheel charts, and progress markers. It is important to embed these approaches in existing structures (e.g. in health center committees or health literacy programs) to ensure continuity and community ownership.
- In terms of outcomes: there are a number of domains for measuring outcomes, not only in relation to health. These outcomes range from the way norms, values and issues of solidarity are changing, through to changes in health services and health outcomes, through to actions in various processes e.g. Community engagement with parliamentary committees and other formal structures.
- Evidence needs to be carefully documented to suit a variety of audiences. Communities need to have easy access to the information, but it is equally important to reshape the community findings to make them accessible and persuasive to higher level authorities. This necessitates a variety of approaches, from the more established ways of documenting findings such as formal quantitative reports, to the use of case studies, oral histories, and participatory tools.

Wednesday, July 20
DAY 3

11.0 Mapping of available resources

Objectives:

- To explore what resources are available to participants, and develop an initial reference list
- To assess needs and gaps met by existing resources
- To jointly explore the value of support for learning and assistance, and discuss approaches for creating a learning community.

This session began with a discussion, using index cards, on what resources participants need to take this work forward. Needs were summarized under the following headings:

- Documentation, including case studies, successes and challenges.
- Training/capacity building, sharing of experiences, exchange visits.
- Guidelines on community monitoring and how to use specific methods such as CRCs, social audits.
- Time!

Following this discussion, delegates reviewed the range of resources that they had collectively put up on the wall under specific headings. These headings included:

- Conceptual resources
- Community monitoring approaches
- Tools, methods and guidelines
- Communicating with communities
- Resources for engaging the state
- Resources for peer exchange
- Resources for reviewing progress
- Capacity building resources

11.1 Conceptual resources:

Commentary: Very few resources were listed that included Paulo Freire's 'Pedagogy of the Oppressed' and some generic frameworks on social accountability.

Recommendation: The participants make a reading list of materials that have influenced their thinking and practice and share it electronically with all the participants.

11.2 Community monitoring approaches:

- Compiled report of community-based monitoring of health services under NRHM in Maharashtra-SATHI, India (Click here)
- Annual report of the community health cell extension unit (CHC, India)
- CWGH Annual Report and website (Click Here)
- CINI—Compiled report of CBM in Jharkhand (Click Here)
- Report of pilot phase of community monitoring in India. Available at www.chsj.org, www.nrhmcommunityaction.org
- Public Resource Management Framework – CSA (Click Here)
- Participatory Voices Project final report (Citizen Oversight of Health Services Quality)-Spanish, CARE Peru 2011
- Governance Action Research Initiative final report CARE UK, to be published in September 2011 (Click Here)
- Book on successful experiences of community monitoring (in Hindi) - SAHAYOG
- "Ask Your Government" radio series, International Budget Partnership (Click Here)
- Children count radio stories
- Community Health Cell- Systems diagrams and draft framework of work produced by NGOs in Tamil Nadu

Commentary: This list is a mix of annual reports, websites, a few books, and some radio productions, but may not capture the entire picture especially due to lack of case studies.

11.3 Tools, methods, guidance

- TISA/OSIEA - Constituency Development Fund Social Audit Guide, Kenya (Click Here)
- TARSC - Community monitoring program report form; and Training resources for CBR
- CEGAA - Budget monitoring and expenditure tracking tools and training; Country Assessment Reports; Country situational analysis tool; and Community and health facility survey tool. (Click Here)
- CINI - Panchayat health report card; Village health monitoring tool – Jharkhand (Click Here); Social audit tools; and Report card and Social Audit reports
- CHC - Village level planning worksheet, Tamil Nadu (Click Here)
- SAHAYOG - Pictorial tools and simple formats for community monitoring
- CBM, India - Community based monitoring toolkit under NRHM (Click Here)
- UDN - CBMES source book (Click Here)
- IPPF (South Asia) - Social Audit Guide/Manual (Click Here)
- PAF - Tools and method guide, e-learning course (Click Here)

Commentary: Most of these materials need to be contextualized. They have limited value because of language problems, problems accessing the material, and relevance in a wider context.
The group agreed that a deeper discussion was needed on how to address the documentation of tools and approaches to make them more useful to a wider range of readers.

11.4 Communicating with communities

- CEGSS radio programs
- Tools for community data collection, report cards at village and facility levels, awareness posters and leaflets – SATHI (Click Here)
- UDN newsletter
- Materials for entitlement awareness based on policy analysis - briefing kit, pamphlets (Click Here)
- Radio story-telling and audio slideshows - OSF Health Media Initiative (Click Here)
- PAF - Engagement with Communities: Advisory sources provided on focus group discussion, CRCs, community score cards and public meetings
- Community theater, in PAR process - EQUINET
- Community radio programs in Spanish, Quechan and Asmara on health rights, health service users, entitlements etc. - CARE Peru
- UDN radio talk shows
- Picture Cards - raising awareness about rights and entitlements (SAHAYOG)
- SATHI - appointed media fellows
- Community photography “Eye on Equity” and exhibit - EQUINET
- CINI - Poster, street plays, songs
- CHC - Permanent boards with report cards printed on them at central locations
- Continuously updated website (in development)—Tamil Nadu (Click Here)

Commentary: There are some wonderfully innovative ideas in this list – from photography to radio shows, community theatre, storytelling, etc. This is clearly where our strength lies; in using a wide range of participatory approaches when working with communities. These approaches are critical, usually context specific, and seldom documented in a systematic way.

These resources are also about ideas. It was noted that collective change, shared learning and learning for action was more prevalent 20 years ago but is now on the decline. A more recent trend is to focus on individual agency for individual change. This tendency needs to be countered whenever possible.

11.5 Resources for engaging the state

- Policy recommendations for citizen participation under county governments
- Appointed state media consultant - SATHI
- CWGH - National Conference and Annual General Body Meeting
- UDN - Policy Review newsletters
- CINI - The final reports and action taken by government
- CBM Maharashtra list of 'Issues to be resolved!' at state level for policy makers - SATHI
- Community research reports - TARSC
- Joint paper by NGOs and government on community monitoring - CHC
- Policy and parliamentary briefs - TARSC
- Social audit findings book - Muhuri
- Film: Reviving Hopes, Realizing Rights—film explaining the process of community monitoring in India
- National policy guidelines to promote citizen surveillance of health services quality—Peruvian MoH (Spanish)
- CBM—Maharashtra state level conventions to discuss and address systemic issues
- National Conference for Health—FORASALUD
- PAF - Engagement with State using publications and serving in various advisory committees

Commentary: Included in this list are a range of resources for engaging with the state including research reports, briefs, meetings and conference reports. The documents exist, but they say very little about the strategies underlying the various approaches. What are the intended and real outcomes of engaging with the state? More strategic reflection is needed to address this question. Case studies could help in systematizing experiences and to draw lessons.

11.6 Resources for Peer Exchange

- EQUINET newsletter (Click Here)
- Power point presentations from DBL - Centre for Health Research and Development
- Participation and the right to health – A Case Study by Helen Potts, Essex University, Human Rights Centre (2008) (Click Here)
- Peer-review proposals, articles, etc.
- Pra4equity mailing list
- Accountability and the Right to Health – A Case Study by Helen Potts, Essex University, Human Rights Centre (2008) (Click Here)
- PAF Peer Exchange
    - Publication list available at www.pafglobal.org or www.pacindia.org
    - 20 min film on CRC, 20 min film on ACC, and 16 min film on electoral reform

- Social Audit Short Film (15 minutes) - Muhuri
- TAC mailing list
- Dawandi quarterly newsletter—SATHI
- TISA - Local Development Monitor (magazine)
- TAW newsletter
- Quarterly newsletter on community monitoring in Maharashtra - SITHA
- Paper on results of community monitoring on peripheral service delivery in a book "Reaching the Unreachable" (Click Here)
- Reports on CBM of education - CINI
- Meeting reports on synthesis of learning from PAR EQUINET. See www.equinetafrica.org

11.7 Resources for reviewing progress

- Performance assessment tools - LDHMT
- Governance Action Research Initiative - Care UK 2011
- Likert scales on change - EQUINET
- Compiled action reports showing change - CINI
- Progress markers and wheel charts - LDHMT
- PAR Embeds reflection on outcomes - EQUINET
- Pawson article and guide to realist evaluation
- "Ten Steps" to realist evaluation—uses Pawson's realist evaluation
- Soft systems methodology
- IDRC's outcome mapping

Commentary: Again, case studies could help deepen the discussion on how to understand and review progress.

11.8 Capacity building resources

- Centre for Social Accountability (CSA) training entitled 'Fundamentals of Social Accountability Monitoring' - CSA, South Africa (Click Here)
- Guide book for community monitoring facilitators - SATHI
- Community newsletters
- PAF/PAC
    - Custom designed workshops on social accountability tools
    - Customized workshops on citizen report card approach
- Film on community empowerment -Voices from the Ground, 7 minutes and 27 minutes - SAHAYOG
- Modules for orientation, monitoring, planning (in Tamil) - CHC
- Manual on Community monitoring under NRHM (India) (Click Here)
- Training toolkit in PRA approaches - EQUINET
- Capacity building modules to train volunteers on citizen surveillance of health services quality (Spanish) - CARE Peru, 2010
- Health literacy training materials - TARSC, CWGH, Botswana Network on Ethics, Law and HIV/AIDS (BONELA), Malawi Health Equity Network (MHEN)
- Manual for Capacity Building of local Community Monitoring groups (Gujarati)
- Social audit training manual - Muhuri

- Accountability for Reasonableness district guide and trainee and facilitator guides (Tanzania)
- Manual for conducting social audits (India) (Click Here)
- Book: Training for Transformation by Sally Hope and Anne Timmel
- Book: Helping Health Workers Learn
- Workshops - value of using media, understanding the media, getting your stories into the media - OSF Health Media Imitative
- Training manual on social audits - CINI
- E-learning course on CSC - PAF
- We are also a resource – every one of us, either on a one-to-one basis or in a collective process

Commentary: This list includes a wide range of training manuals, courses – both e-learning courses and workshops - audio visual materials and books. The question to ask is who is the audience for capacity building? This is not clear from the list.

Recommendations arising from the discussion: A number of people expressed an interest in documenting their experiences in a more systematic way. But this would need time, which is in short supply. The group discussed the option of contracting someone to help with this process.

12.0 Summary of collective experience, strengths, weaknesses and gaps: Synthesis of learning

Objectives:
- To take stock of our discussions in the last two days and assess its usefulness for practice
- To deepen our shared understanding regarding the features, commonalities, strengths and gaps
- To draw out key common lessons to inform and strengthen our practice, and
- To help generate discussion and debate as we move into the final phase of the meeting, especially in relation to building a platform of sharing.

The synthesis team, consisting of Barbara Kaim, Jens Byskov and Renu Khanna, gave a brief summary of the key issues that emerged from the first two days. The summary addressed the following:

- An overview of the features, commonalities, and differences of different community monitoring approaches presented (Jens)
- Lessons emerging that added to the knowledge and practice of community monitoring (Renu)
- An assessment of where we stand currently in our community monitoring practice and identification of gaps that need to be worked out further (Barbara)

12.1 Overview of different community monitoring approaches - Jens Byskov

The table below is a summary of a subjective review of 11 projects that were discussed during the last two days. These findings reflect what presenters focused on during their presentations, and were done without reviewing project documents or holding discussions with the delegates.

Table 2. Summary of different Community Monitoring approaches presented in the convening

Presented project features	Number projects
Total projects presented	11
Community/civil society focus	10
Main focus on single methods and tools	10
Continuous monitoring of the program	8
Monitoring government focus	7
Mainly action focused	7
Clearly expressed aims	6
Concept or methodology explicitly referred to	5
Some internal evaluation of own program	4
Comprehensive or research-based evaluation with triangulation of methods	4

In taking these limitations into account, the table shows that:

- Almost all presentations had a community/civil society focus, with a strong emphasis on tools and methods
- Programme management issues were less frequently included, if at all.

The results indicate a need to make sure activities are based on well planned, managed and monitored programs to ensure optimum learning and success, and to better assess the feasibility of scaling up. The impression is that some projects were fairly small and would not have sufficient clout to counter the large well-resourced top-down programs and services.

12.2 Lessons emerging: Renu Khanna

Renu listed a number of lessons she had identified over the last two days. She emphasized that this list was not exhaustive, but did highlight some of the key issues that had arisen, many of which need further discussion:

Define and be clear about what change we want to see:

- Have a clear idea of what changes we expect in the various domains in which we work; useful to identify milestones in our roadmap.

Contextual issues:

- Need to clarify our own context – this will determine what we do and how we do it.
- Have to address global forces, and make a conscious link from local to national to global. We need to forge and strengthen alliances and solidarity at all levels.
- The role of the private sector in health has to be addressed.
- There are multiple players in any community monitoring program – their different roles (including ours) need to be clarified and revisited constantly.
- It is important that we state the world view/ philosophy/values/assumptions within which we root our community monitoring work.

Concepts, approaches and methods:

- Community monitoring is one of several other methods, such as social auditing, budget analysis, etc. to promote health system changes.

- We need to understand the interrelationship between all the terms we use – e.g. power, community mobilization, change, etc.
- We need to constantly define what our terms mean, especially since they can be co-opted or distorted in many different ways.
- 'Community' is a nonspecific term and needs to be clearly defined contextually.
- Power relations are central – the asymmetry of power directly affects the potential for change for various reasons. Empowerment of citizens is one issue, but we also have to recognize that within the health system, health workers also need to be empowered.
- Hope and trust are important at various levels. Trust between the community and the health system is important to cultivate.

Citizenship and good governance

- Community monitoring is a powerful method for promoting citizenship, good governance and improving health care delivery at community level.
- Need to bring in conscientization and consciousness raising as central to citizenship promotion.

Documentation:

- It is important to document both the positive and negative aspects of the community monitoring process.

Strategic reviews:

- All of the above implies the need for self-reflection at all stages of the monitoring process.
- We need to be flexible to respond to windows of opportunity.
- There are a number of methods for measuring change and it is good to use a variety.
- It is useful to measure change rigorously, irrespective of the method used.
- Standards, or indicators of change, need to be based on technical parameters, the community's perspective, and focus on the issue of rights.

Finally:

- Community monitoring is a very intense process - in terms of vision and values, and also in terms of time, patience and resources

12.3 Looking ahead and identification of gaps: Barbara Kaim and follow up plenary discussions

Looking ahead:

- An important question to ask is how do we see the future of community monitoring? What is our vision of community monitoring, 3–5 years from now? It is a reasonably powerful tool, but it has its limitations. It needs to be contextualized and combined with other approaches – so if there is a future, what does it look like? And what role do we want to play in building towards that future?

Differing perspectives:

- It is clear from this meeting that there is no single terminology or framework on community monitoring work. There are some commonalities but also distinct differences in terms of approach. Our challenge is to continue working together, despite and perhaps because of our similarities and differences, in a kind of coherent pluralism where the breadth of our experiences can assist in deepening and clarifying each of our programs.

More work is needed on:

- The ethics of community monitoring practitioners and our relationship with community.
- Exploring ways in which our work can include monitoring of the private sector to make them more accountable.
- Exploring ways to bridge the gap between the local, national and global levels.
- Looking at how change at individual to community to structural transformation (cycle of change) happens and ways in which other complementary approaches can deepen this process.
- Good practice on how to track process and outcomes, and how to reshape evidence to make it more accessible to those we want to influence.
- Looking at what sustainability in community monitoring looks like.

Documentation and Platform for Exchange:

- Strong need identified at this meeting for documenting what we are doing and to create an easily accessible repository of information.
- Need for a larger platform for the sharing of ideas and resources, to assist in analyzing /critiquing /deepening our work in community monitoring.

13.0 Strengthening community monitoring practice – World Café

Objectives:

- To identify actions that can strengthen the practice
- To develop a shared understanding of the value of learning processes for improving our work
- To explore the value of participating in a horizontal community of practice

Five thematic tables were set up for a World Café discussion in which participants could choose to sit at one table for 20 minutes, and then a second, to discuss ways of strengthening the theory and practice of community monitoring. The topics covered were:

1. Putting people center-stage
2. Strengthening our practice - Manuals and materials, tools and instruments, practitioners and resource person etc.
3. Evolving new methods and innovations
4. Documenting change
5. Learning from and supporting each other

The groups charted out gaps and discussed actions that could be implemented to strengthen the field of community monitoring for social accountability and advancing collective learning.

Below is a summary of discussions, as reported back in plenary.

13.1 Putting People Center-stage (Participation, mobilization and empowerment focused)

Putting people at center stage is an approach, not simply a method:

- Any serious attempt to put people center stage requires the commitment of the implementing institution to develop a conceptual framework that supports this notion and is willing to review its own organizational agenda in order to make it happen. If this is not achieved, then there is likely to be a conflict between the way the organization works and the way it interacts with the community. We need to become familiar with the literature on this topic, for example Paulo Freire, Robert Chambers and the bibliography at the Institute of Development Studies at Sussex University.

Relationship with the community:

- We can be outsiders, but we have to have strong links with the community based institutions and leadership, and a clear understanding of the dynamics and power structures of the various social groups within that community, including the role of women and other vulnerable groups.
- We need to be accountable to the communities with/in which we work. We can assist in strengthening their institutions, providing them with technical support in the monitoring process, or contribute to setting the conditions and sustaining community mobilization BUT we cannot do the mobilizing ourselves or set community priorities.
- Putting people at center stage also assumes that we have a more long-term commitment to the community and their processes. It is not a one-action intervention, but a cycle of events that take place over a period of time.
- Donors will also need to change their modus operandi if they are to be responsive to peoples' needs and time frames at grassroots level. They need to learn to be more flexible in their approach to working with communities, less bureaucratic and more open to letting communities dictate the terms of the partnership. This is a huge challenge for donors and one that confronts higher layers of power and control.

13.2 Strengthening our Practice - Manuals and materials, tools and instruments, practitioners and resource persons

What 'we' need:

- Capacity building to strengthen our communication skills, especially in the production of story-telling.
- A web-based resource center or repository of documents:
    - To make manuals, guidelines and other community monitoring materials more accessible
    - Containing some kind of an analysis of the context and usefulness of the material (there is a need to develop a set of criteria for this analysis)
    - A resource person or organization to manage the resource center and the links to the different organizations' websites
    - With links to other institutions and materials outside of our own network
- Guidelines on the ethics of community monitoring practitioners
- Build a network of knowledge: Identify a pool of resource persons or groups who can handle specific issues like communications and advocacy, and who could provide information or technical assistance to community monitoring practitioners
- Facilitate greater south-south cooperation
- Organize follow-up meetings and exchange visits
- Develop or source information in creative formats – e.g. videos, case studies – to address lessons learnt, challenges faced, etc.
- Identify and train people from all sectors in order to widen the scope of our resource persons; develop partnerships with universities to organize short courses on community monitoring on the basis of our tools and experience

13.3 Developing new and complementary approaches

Why we need complementary approaches to monitoring*? – Phases and tools in community monitoring:*

- It's not just a question of identifying new approaches but about using or adapting already existing approaches to further deepen the work we are doing in community monitoring.
- While community monitoring has its strengths, there are distinct limitations to what it can achieve, especially in relation to structural or systemic change. Community monitoring is good at identifying issues, but there is the question of how to convert that information into change. As we can see in the diagram below, we need to engage in the entire cycle – from becoming informed/ aware, to demanding rights, to improved services, to structural change. We need to be able to respond to invested interests and power dynamics. This now links up with a whole other range of strategies, such as budget tracking to ensure the allocation of resources, to social auditing or citizen report cards to monitor the proper use of those resources, to changes in quality of life through household surveys, etc. So here we see that all the tools are equally important. They simply work at different levels for different purposes.

Core elements in all the approaches:
There are four core elements in all the approaches mentioned:

- Community input and engagement
- The approach is anchored in a public framework, whether it be a policy or an act or budget line item
- The information is used in different ways to influence strategy
- The presence of a facilitator to implement the process

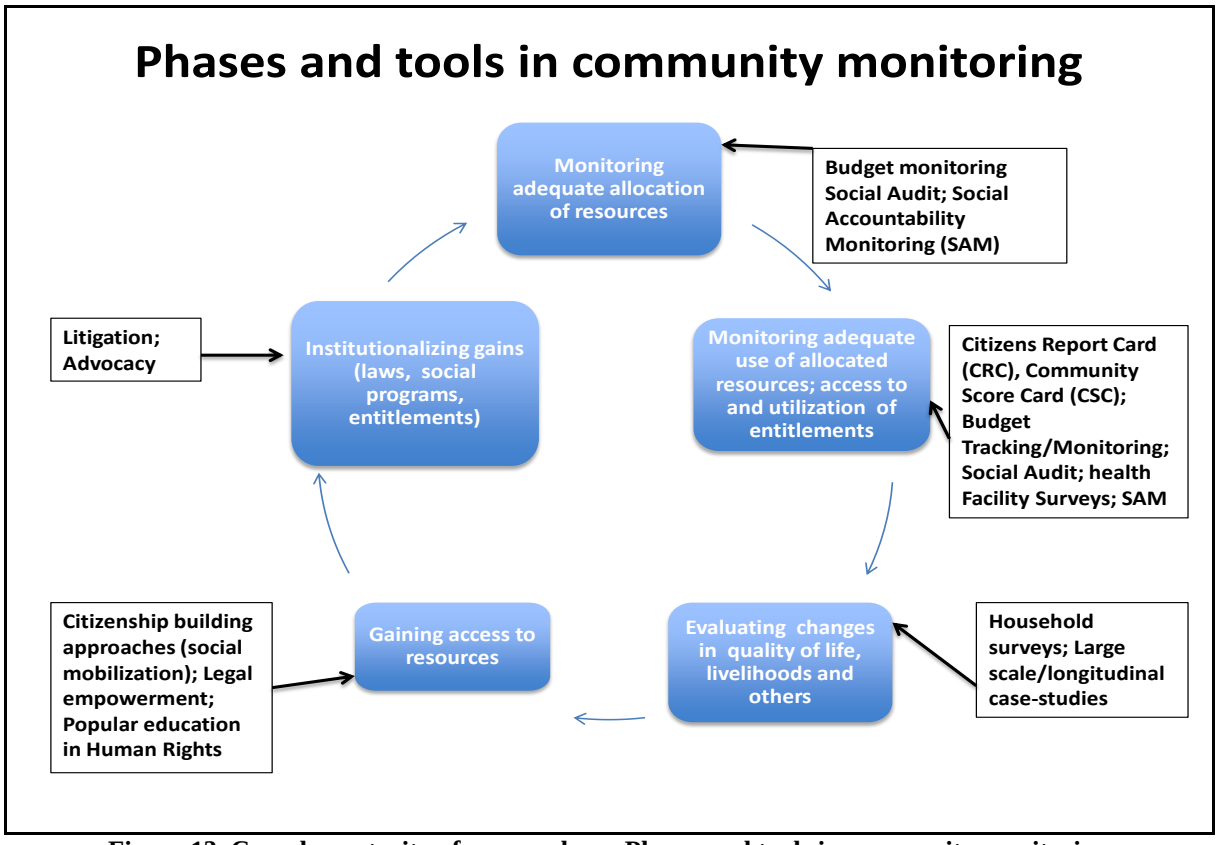

Figure 13. Complementarity of approaches – Phases and tools in community monitoring

Alliance building:

- There has to be a conscious building of alliances across different approaches and different actors, especially with health workers, and discussion on how to collate the broader approach in a cogent and accessible way.
- Included in this is the issue of documenting change, with a specific focus on influencing national and international attitudes to community based monitoring and action.

13.4 Documenting Change

The domains of change that we want to see:

- Empowerment of communities by giving them more information, more confidence to articulate issues, to assist in leveling power relations.
- Improvement of health services i.e. quality and responsiveness of the health services, a reduction in corruption levels.
- Deepening of the discussions and debates on change.

Documentation:

- Documentation is important for learning and empowerment
- There is need to have a shared framework on how we document this diversity, and also how we track changes.
- Evidence needs to be documented in a systematic way to be most useful
- Documentation has to be done at all levels using a range of tools including PRA, triangulation, videos, story-telling, case studies, etc.
- As much as possible, documentation needs to be done by the communities themselves or with technical support from outsiders.
- We need to share the success stories, challenges, ethical dilemmas, intended and unintended consequences, and the limitations of the community monitoring methodologies.
- Need to look at literature in other fields and engage a wider audience.
- We need to make links between practitioners and academics to deepen our learning.

13.5 Learning from and supporting each other

(See section 13.2 for other, interrelated recommendations)

- Use a number of different forums and tools for learning and support. These include: web communication, peer review of publications, exchange visits, regional and international meetings.
- Develop a regional resource center and promote in-country learning so that groups from the same country or region can share ideas and resources.
- Open up our learning community to others who are doing community monitoring, especially women's groups.

14.0 Next steps and concluding remarks

Objectives:

- To identify next steps to strengthen our work and develop a community of practice
- To identify how convening participants can work together in this effort

Cynthia Eyakuze began by referring back to the objectives of the meeting as outlined on Day One. She expressed gratitude to all participants for such rich sharing of experiences and lessons learnt (objective

1), and hoped that the meeting had provided opportunities for enhancing knowledge and critical thinking of our practice (objective 2). She also felt the meeting had made good progress in defining strategies and priorities on how to move forward as a community of learning (objective 3).

At this stage, Cynthia referred back to her role as Director of the Accountability and Monitoring in Health Initiative (AMHI) to propose ways in which her team could contribute to taking this work forward. Based on discussions over the last two years with a range of players in the monitoring field, and especially learning that has come out of this meeting, AMHI identified a number of gaps where they can assist:

Documentation and the Setting up of a Resource Centre:

- Assisting in the documentation of experiences and different community monitoring for accountability in health approaches.
- Support the process of writing up case studies, issue briefs, fact sheets, etc.
- Support the creation of a resource center for easier access to materials on community monitoring.
- AMHI will upload all relevant information and resources related to this convening on the PHP Seminars website (Click Here); including participants' contact information, background documents, presentations, films, etc.

Creating spaces for further learning and sharing:

- Assist in organizing more meetings to deepen learning on various aspects of community monitoring, for example on community monitoring of the private sector. The content of these meetings would be informed by the priorities and needs of practitioners.

Advocacy and support:

- Engage with other donors on the concept of community monitoring for accountability in health to leverage additional resources.
- Create spaces for practitioners to have direct conversations with these donors.
- AMHI is one of 10 projects in the Public Health Program at OSF and will work with colleagues in the other projects to complement and support ideas arising out of the convening, such as health policy issues, health and legal frameworks and strategic use of the media to advance community monitoring and health rights.

Cynthia concluded this discussion by noting that ultimately it would not be appropriate for AMHI, as a donor agency, to manage these processes. However, in the short term, her team is privileged to assist in setting up this platform and creating the spaces in which to do this.

Finally, Cynthia took time to thank the many people who made this meeting possible: the four ad-hoc advisors who challenged and broadened AMHI's thinking on community monitoring in general and the convening in particular; to Vinay, Kandice, Erin and Jorge in AMHI; to the senior leadership of the PHP; to those who assisted with logistical and travel arrangements, and others.

15.0 Formation of Community of Practice on Community Monitoring for Accountability in Health (COPCOM)

Following the convening participants' expressed need for establishing a Community of Practice (CoP) and a call to join the four convening advisors in actualizing the idea; three participants[3] (one each from

[3] Ariel Frisancho Arroyo (Peru), Renu Khanna (India) and Robinah Kaitiritimba (Uganda)

Africa, Asia and Latin America) volunteered to join the advisory group. This group of seven practitioners along with a representative from AMHI decided to form an interim Steering Committee to take forward the work, and adopted the name of COPCOM for the proposed CoP with an agreed mandate to strengthen the field of community monitoring for accountability in health through the collation, production and dissemination of conceptual, methodological and practical experience outputs and by sharing these resources, capacities and approaches among member organizations and other interested stakeholders.

Appendix 1: Concept Note for the convening

Background: The Accountability and Monitoring in Health Initiative[4] (AMHI) of the Open Society Foundations' Public Health Program (PHP) supports civil society groups to effectively and strategically use community and budget monitoring approaches as mechanisms for promoting greater government accountability and transparency in health care to its citizens at the local, national, regional and global levels.

AMHI's internal reflections and commissioned mapping of existing resources in community monitoring for accountability in health have highlighted that it is an evolving field with few initiatives across the world. The absence of spaces and opportunities for practitioners of community monitoring for accountability in health to come together to share and collectively reflect on their experiences and to think creatively about the field and its future was identified as one of the critical gaps hampering the advancement of the field. This was confirmed through AMHI's consultations with experienced community monitoring practitioners at the First Global Symposium on Health Systems Research conference in Montreux, Switzerland in November 2010.

AMHI, with a mandate for contributing to strengthening the field of community monitoring for accountability in health, is interested in exploring how to begin filling this gap. Towards this end, we are organizing a strategic convening that will bring together experienced practitioners in the field to review current experiences and begin shaping an agenda for strengthening the field. We will follow the principle of sharing and using experiences to stimulate reflection on common issues and differences as a basis for general learning.

Convening Objectives:

1. **To share field experiences and synthesize key lessons:** To share and synthesize learning on the contexts for, purpose, methods, reporting and use of different approaches for generation and use of community based evidence for social accountability in health with a focus on the following sub-themes:
    a. *How are we thinking?* Conceptual frameworks and design of community monitoring for accountability in health. What are the essential features (contexts, methods, actors and processes) of current initiatives on community monitoring for accountability in health? What issues arise in applying the different approaches, conceptual frameworks and designs that are being used by different community monitoring for accountability in health initiatives and what implication does this have for our design and approaches?
    b. *How are we doing?* Operational issues of community monitoring for accountability in health approaches. What are the mechanisms, capacities, technical and other support by which communities are empowered/activated to participate in monitoring their health services and demand accountability? How is evidence gathered, organized, communicated/ reported and used for engagement? How are the outputs tracked? What are the critical factors that ensure action following the processes of and using the evidence collected through community monitoring?
    c. *What impact are we having?* How do we understand impact in community monitoring for accountability? What types of impact are practitioners looking at while using community

[4] Combining the former Public Health Watch and Health Budget Monitoring and Advocacy Projects of the Open Society Foundation's Public Health Program.

monitoring for accountability in health approaches? Illustrative examples of successes and setbacks of different community monitoring for accountability in health initiatives with a focus on enabling factors and challenges (contextual, organizational and others) of different approaches

2. **To identify and critically assess the existing resources and resource gaps in knowledge, skills and conditions for effective use of community monitoring in health** and identify areas for potential action to address the identified gaps with a focus on:
    a. Mobilizing and strengthening civil society/people's capacity (What resources are required to support interested organizations to adapt community monitoring for accountability in health with a focus on processes/ questions, tools, analytical issues, and advocacy and dissemination strategies? What resources exist for this? What are the gaps? How can these gaps be filled?)
    b. Documenting the impact of community monitoring in health initiatives (Which indicators are important to capture the progress and impact of such initiatives? What indicators can be built-in within the initiatives to document the effectiveness and impact?)
    c. Community monitoring for accountability in health for use by marginalized and criminalized populations (Can community monitoring for accountability in health be effectively adapted to promote accountability in services for marginalized and criminalized populations such as sex workers, drug users, and sexual minorities etc.?)
    d. Identifying socio-political preconditions, enabling and retarding contextual factors that can significantly influence community monitoring processes. Understanding how to strengthen enabling factors and minimize retarding factors. Grasping specific limitations and pitfalls related to the community monitoring approach which may need to be dealt with by appropriate precautions and measures.
3. **To identify strategies to strengthen the field of community monitoring for accountability in health, including introducing the approach to interested but uninitiated organizations**
    a. Linking practice, learning and documentation in mutually reinforcing ways within the promising community monitoring for accountability in health initiatives (How can learning be in-built within community monitoring for accountability in health initiatives? What resources/support is required to stimulate reflection and document experiences for disseminating community monitoring for accountability in health practices for different audiences?)

Expected outcomes:

1. Enhanced exchange and understanding of the current contexts, concepts and designs for and practices of community monitoring in health
2. Reflection and exchange of learning on design of and processes for community monitoring approaches
3. Identification of gaps in knowledge, skills / capacities and conditions for effective practice and use of community monitoring for accountability in health and areas for potential action to address the identified gaps
4. Identification of strategies for introducing the approach to interested but uninitiated organizations

5. Reflection on and identification of areas and processes for exchange of information and capacities and interaction between practitioners of community monitoring
6. Creation of a community of practitioner-learners interested in advancing the field of community monitoring for accountability in health

ANNEXE 1.

Community monitoring for accountability in health: The AMHI project supports civil society groups to effectively and strategically use community and budget monitoring as mechanisms for ensuring greater government accountability and transparency in health care to its citizens at the local, national, regional and global levels. Among the diverse understandings of the concept and practices of 'community monitoring in health', the AMHI project considers the following understanding as being most aligned with its work:

> ***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 providers and policy makers to improve the services***

Some of the essential elements of such initiatives include: a theory of change for the specific context in which it is implemented; instruments to collect and analyze data; clear advocacy strategies that are based on the findings of the assessment; collective learning informing the next round of performance assessment.

As such, the essential features of community monitoring in health are:

1) It is based on an **'accountability framework'** and linked to government responsibility for the provision and/or overseeing of health services as a right to the people
2) It reflects the **'people's or community perspective'** on health services and how governments are responding to their health rights towards realizing its health-related commitments
3) It is an **'empowering process'** where capacities of participating people/community is enhanced to address power imbalances that affect their health
4) It is linked to **'advocacy/action plan'** with the aim as changing or improving the implementation of health policies or programs and not a stand-alone activity with information collection as an end in itself

Key operational concepts concerning community monitoring –

1. Centrality of rights as basis and approach
2. Importance of underlying community organization and mobilization
3. Necessary element of positive/creative conflict which ensures change
4. Direction of changing the balance of power between health system and community
5. Need for engagement with and reorientation of providers and officials
6. Community monitoring should operate at multiple levels, extending upwards (not just limited to peripheral providers and / or implementation issues, but encompassing higher level officials and design / system aspects)

Concept of Social Accountability: Social and public accountability refer to the process whereby citizens are engaged in the monitoring and assessment of performance of public policies, and thereby influence the process, outcomes and impacts of these policies and the corresponding expenditures that are allocated to implement them. Even though the internal accountability (involving government and public service providers evaluating their own performance against targets) has been long over-emphasized over public accountability, the concept and practice of social accountability have emerged over the past decade as key strategies to address both developmental failures and democratic deficits.

Appendix 2: List of convening participants:

Name	Country	Organization	Email
Abhay Shukla	India	Support for Advocacy and Training to Health Initiatives (SATHI)	abhayshukla1@gmail.com
Abhijit Das	India	Centre for Health and Social Justice (CHSJ)	abhijitdas@chsj.org
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Cynthia Eyakuze	USA	Accountability and Monitoring in Health Initiative (AMHI)	ceyakuze@sorosny.org
Daygan Eagar	South Africa	Budget and Expenditure Monitoring Forum (BEMF)	eagar@section27.org.za
Erin Elizabeth Howe	USA	Accountability and Monitoring in Health Initiative (AMHI)	ehowe@sorosny.org
Françoise Girard	USA	Public Health Program, Open Society Foundations	fgirard@sorosny.org
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Gurjeet Singh	India	Child In Need Institute (CINI)	gurjeetvsrc@gmail.com
Hussein Khalid	Kenya	Muslims for Human Rights (MUHURI)	h.khalid@muhuri.org
Itai Rusike	Zimbabwe	Community working Group on Health (CWGH)	itai@cwgh.co.zw
Jashodhara Dasgupta	India	SAHAYOG	Jashodhara@sahayogindia.org
Jens Byskov	Denmark	DBL - Centre for Health Research and Development	jby@life.ku.dk
Kandice Arwood	USA	Accountability and Monitoring in Health Initiative (AMHI)	karwood@sorosny.org

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Tukisang Senne	South Africa	SHARISA	tukisang@gmail.com
Vinay Viswanatha	USA	Accountability and Monitoring in Health Initiative (AMHI)	vviswanatha@sorosny.org
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Appendix 3: Convening Agenda

SUNDAY, JULY 17	
17:00-19:00	**Registration in the reception (please stop by to pick up seminar materials) -** *Jurgita Poskeviciute and Team*
19:00-20:00	**Dinner at the Chief's Boma restaurant at the hotel**
MONDAY, JULY 18	
6:30-8:30	**Breakfast**
8:30-9:00	**Registration and Information** *Jurgita Poskeviciute and Team*
9:00-9:15	**Welcome and agenda overview** *Cynthia, Eyakuze, Convening Advisors, Vinay Viswanatha* ***Objectives:*** • Setting the tone for the workshop. • Clarify the convening objectives and expectations from the convening from the perspective of organizers. • Giving an overview of the agenda and introducing workshop principles.
9:15-10:00	**Participant Introductions** *Jorge Romero Leon (Facilitator)* ***Objectives:*** • To establish an environment conducive to participation and openness in a relaxed but engaging setting. • To mutually familiarize participants and their organizations.
10:00-11:15	**Sharing community monitoring experiences from the field - Plenary Presentations** *Cynthia Eyakuze (Moderator), Presenters: Walter Flores, Abhijit Das, Abhay Shukla and Rene Loewenson* ***Objectives:*** • To launch reflection and begin to develop a shared understanding of what we do using three community monitoring experiences that are varied, diverse and long standing. • Introduce key terms of reference, key elements of our work and key lessons from a practical standpoint.
11:15-11:45	**Tea Break**
11:45-12:15	**Sharing community monitoring experiences from the field - Marketplace Presentations** *Jorge Romero Leon (Facilitator), Presenters: Jens Byskov and Jashodhara Dasgupta* ***Objective:*** • To provide a platform for practitioners to share their work to facilitate appreciation of diversity, generate interest and start dialogues among participants
12:15-13:15	**Building a shared language/collective glossary** *Walter Flores(Facilitator)* ***Objective:***

	• To explore what we mean of key working terms and develop a shared understanding to inform and facilitate future discussions.
13:15-14:15	**Lunch Break**
14:15–16:00	**Community monitoring for social accountability: Basic concepts** *Abhijit Das (Facilitator)* ***Objective:*** • To explore the importance of some of the basic concepts that define our work in terms of how they have influenced and continue to influence the contours of our community monitoring work.
16:00–16:30	**Tea Break**
16:30-18:15	**Community monitoring for accountability – The road map for change** *Marine Buissonniere (Moderator), Panelists: Walter Flores, Jens Byskov, Sita Sekhar, Gertrude Mugizi* ***Objectives:*** • To understand how the organizations define the change they want to see from their work and the pathways they follow to achieve the desired change. • To understand the destinations of progress and the routes to travel on the way to achieving progress. • To understand the assumptions, such as the final destination (the ultimate change), the context for the map, the processes to engage in during the journey and the belief system that underlies the importance of traveling in a particular way. • To develop a shared understanding of the value of having a conceptual framework to plan and execute a successful transformational strategy.
18:15-18:30	**Review of Day One**
19:00-20:00	**Buffet dinner at the Chief's Boma restaurant at the hotel**
TUESDAY, JULY 19	
6:30-8:30	**Breakfast**
8:30–8:45	**Announcements and addressing logistical issues** *Jurgita Poskeviciute and Team*
8:45–9:00	**Sharing community monitoring experiences from the field - Marketplace Presentations** *Erin Howe (Facilitator), Presenter: Rakhal Gaitonde* ***Objective:*** • To provide a platform for practitioners to share their work to facilitate appreciation of diversity, generate interest and start dialogues among participants
9:00–10.15	**Community Monitoring tools, methods and practical approaches – Group Work** *Abhay Shukla (Facilitator)* ***Objectives:*** • To develop clarity about key factors of community monitoring, the types of work undertaken by organizations implementing community monitoring projects as well as the challenges they face. • To lay the foundations of a shared understanding of the work we do, its

	basis, scope and limitations. • To develop awareness about of the broad diversity of approaches, and the tools used by different approaches for enabling community monitoring. • To explore common challenges and strategic responses.
10:15–10:45	**Tea Break**
10:45–12:45	**Community Monitoring tools, methods and practical approaches - Plenary Presentations** *Abhay Shukla (Facilitator)*
12:45–13:45	**Lunch Break**
13:45–15:15	**Context matters: Understanding how context influences strategy and identifying successful implementation strategies in challenging contexts** *Abhay Shukla (Facilitator)* ***Objectives:*** • To explore how contextual factors affect the perspective of community work on the ground, and develop a shared understanding of how organizations adapt to meet specific challenges. • To develop a nuanced understanding of how convening participants develop and adjust their strategy in challenging environments, on the basis of their diverse and distinct experiences.
15:15–15:45	**Tea Break**
15:45–17:30	**Measuring success? Identifying results and tracking progress in community monitoring strategies** *Rene Loewenson (Moderator), Delegates: Ariel Frisancho Arroyo, Artwell Kadungure, Rakhal Gaitonde, Renu Khanna and Walter Flores* ***Objectives:*** • To explore in detail how participants understand success, how they understand and assess progress, and how they adjust to track it, and learn to monitor institutionally. • To understand how experienced and successful practitioners monitor results and track progress in different contexts, facing diverse challenges. • To explore what value, if any, institutional learning processes, monitoring and evaluation schemes add to community monitoring work.
17:30–17:45	**Review of Day Two**
18:30	**Departure from the lobby of hotel for group dinner at 'Cradle for Humanity'**
WEDNESDAY, JULY 20	
6:30-8:30	**Breakfast**
8:30–8:45	**Announcements and addressing logistical issues** *Jurgita Poskeviciute and Team*
8:45-9:15	**Sharing community monitoring experiences from the field - Marketplace Presentations**

	Vinay Viswanatha (Facilitator), Presenters: Sita Sekhar and Gurjeet Singh ***Objective:*** • To provide a platform for practitioners to share their work to facilitate appreciation of diversity, generate interest and start dialogues among participants.
9.15–10.00	**Mapping of available resources** *Rene Loewenson (Facilitator)* ***Objectives:*** • To explore what knowledge and technical assistance resources are available to participants, and develop an initial reference list. • To assess needs met by existing resources as well as gaps. • To jointly explore the value of support for learning and assistance, and discuss alternatives for creating a learning community.
10:00-10:30	**Summaries of collective experience, strengths, weaknesses and gaps** *Synthesis Team (Barbara Kaim and team)* ***Objectives:*** • To take stock of the discussions in the last two days and assess its usefulness for the practice. • To deepen our shared understanding regarding the features, commonalities, strengths and gaps. • To draw out key common lessons to inform and strengthen our practice.
10:30–11:00	**Tea Break**
11:00–12:05	**Strengthening community monitoring practice – Group Discussion in a World Café** *Abhijit Das (Facilitator)* ***Objectives:*** • To identify actions that can strengthen the practice • To develop a shared understanding of the value of learning process for improving our work • To explore the value of participating in a horizontal community of practice
12:05–12:45	**Strengthening community monitoring practice – Plenary Presentation** *Abhijit Das (Facilitator)*
12:45–13:00	**Next steps and concluding remarks** *Cynthia Eyakuze*
13.00-14:00	**Lunch**

Appendix 4: Sharing Community Monitoring Experiences from the Field – Market Place Presentations

Interspersed throughout the 2 1/2 day meeting, delegates were given an opportunity to share their work in more detail. In total, 5 people came forward to take advantage of this space:

1. Jens Byskov
2. Jashodhara Dasgupta
3. Rakhal Gaitonde
4. Gurjeet Singh
5. Sita Sekhar

Below is a brief overview of each presentation.

1. The React Project: Response to Accountable Priority Setting for Trust in Health Systems – Dr. Jens Byskov

Note: more information about REACT and the Reasonableness for Accountability model is available in the main text of this report, Section 6.2
Jens presented a number of materials produced by the REACT programme, being implemented in Tanzania, Kenya and Zambia. He began his presentation by noting that the focus of his work is essentially on the values that lie behind the ways communities set their priorities. When you do priority-setting, values such accountability and equity of access are important but it is difficult, especially at district level, to know how to balance these in relation to national policies and strategic plans, especially in resource-constrained communities.

REACT is a UNDP funded programme which includes a national research component, working in collaboration with the Ministries of Health, an action research team and an evaluation team. Evaluation is a continuous process, sometimes on an annual basis, sometimes monthly. The organization has an extensive baseline including both qualitative and quantitative information, and with this information is able to explore various components of the health system including management, human resources and then specific issues like HIV and AIDS, malaria, obstetrics, care and generalized health care.

Jens concluded by noting that it is not always easy to attribute change directly to their work and data can be quite messy. Nevertheless, they are able to reflect on some results. Essentially in Kenya it was difficult because of various upheavals, Tanzania did a lot of sensitization, and Zambia achieved more concrete results.

2. Women's Health Rights Forum – Ms. Jashodhara Dasgupta

The context: This presentation (Click Here) of community monitoring was based on experiences from a civil society forum known as Healthwatch Form and a network, called the Women's Health Rights Forum, made up of marginalized poor rural women. The work was being undertaken in Uttar Pradesh which has a very strong patriarchal structure, high levels of violence against women, and health indicators that show high levels of maternal deaths and illnesses. So, the context was very specific.

Civil society programme: Unlike the work presented by Abhay and Abhijit on CBM under NRHM in India, this programme was entirely a civil society response. The program did not have a proper

baseline or percentages or end line surveys. The program mostly drew on facilitator's experience and analysis that the health services were failing poor women, especially in terms of availability, accessibility and social exclusion. The facilitators also saw clearly that conditional cash transfers were working against poor women. This was because the state had diagnosed maternal mortality as a demand- side problem and was not looking at service-side indicators and failures.

Unequal power relations: Unequal power relations constantly surfaced in their documentation of the interaction between poor rural women and health service providers and the facilitators believed that these power relations had to change for any sustainable improvements in women's health. Hence, they have been mobilizing the rural women under the umbrella of the Women's Health Rights Forum (WHRF). The facilitators have been working to strengthen the organization and work of the WHRF for many years and WHRF which had 2,000 members in 2006 had rapidly expanded to have 11,000 members by 2010.

Monitoring process: The facilitators from SAHAYOG have been training women leaders in the Forum as community monitors.

- Community monitors use simple pictorial tools to carry out health monitoring exercises in which they look at abuse in the health system at local level. For example: how Community Health Workers (CHWs) are employed; how formal, government health workers are demanding informal cash payments; how untied funds from the Village Health and Sanitation Committees are being misspent and such other issues.
- Monitoring also included documenting cases of maternal deaths and denial of health care. The women began to take up such cases in local advocacy/activist programs.

Taking action: Every year, women throughout the 10 districts in which the Forum works, organize meetings with their local health managers and health providers to discuss their findings. Apart from this, they also have village level engagements with the locally elected councilors and also with the frontline providers with whom they are trying to build alliances in order to negotiate better care.

Results:

- Considerable improvement in small local pockets in terms of more responsive health care providers, and less pressure for informal payments.
- Better communication between health providers, health managers and women.
- Women are more able to articulate the problem and demand solutions.
- New issues have emerged as the women have insisted that they also want to look at livelihood and food security entitlements and so they are now monitoring beyond the health programme to include nutrition and other facilities offered by the state.

BUT these are all very small local efforts. Even though the women have met the Chief Minister (the head of the State Government), the Health Minister, Parliamentarians and made their submissions to government, the systemic and structural changes that are needed to ensure that health care is responsive to the health needs of rural women have not yet taken place. This is a longer term struggle.

3. Society for Community Health Awareness, Research and Action (SOCHARA): Community Based Monitoring in Tamil Nadu, India – Dr. Rakhal Gaitonde

Our approach: SOCHARA is based in Bangalore, South India. As the name suggests, its main aim is to promote community health awareness, action and research. The approach used by the organization was summarized in three diagrams:

Diagram 1 - Creating hope: We believe that the most important ingredient to helping people become active problem solvers was to create 'hope' for an alternative world, an alternative to immediate reality. We do this through the experience of working together, irrespective of their political affiliation, gender, class, or whatever. And this involves social capital, that is, the building of trust and reciprocal relationship which go beyond individual experience to community solidarity.

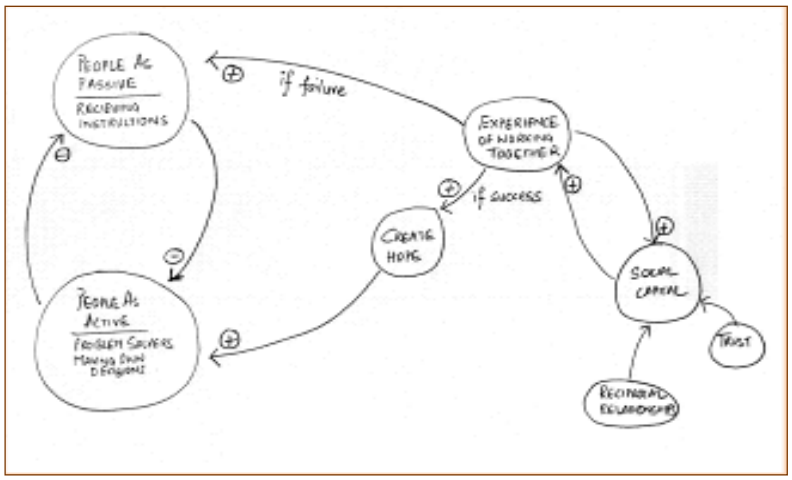

Figure 13. Creating 'Hope'

Diagram 2 - People must start dreaming for if people cannot dream, there is no hope. That dream is supported by the local NGO who gives technical support, but does not interfere with the dream. We recognize that a community is not homogeneous; nevertheless, it is important that the different groups in a community develop a shared understanding of their priority needs. This, in turn, results in a village health plan. If the village health plan does not meet peoples' priorities then the people will become passive and there is a loss of hope. But, if the plan is responsive then hope will grow and people will become proactive citizens.

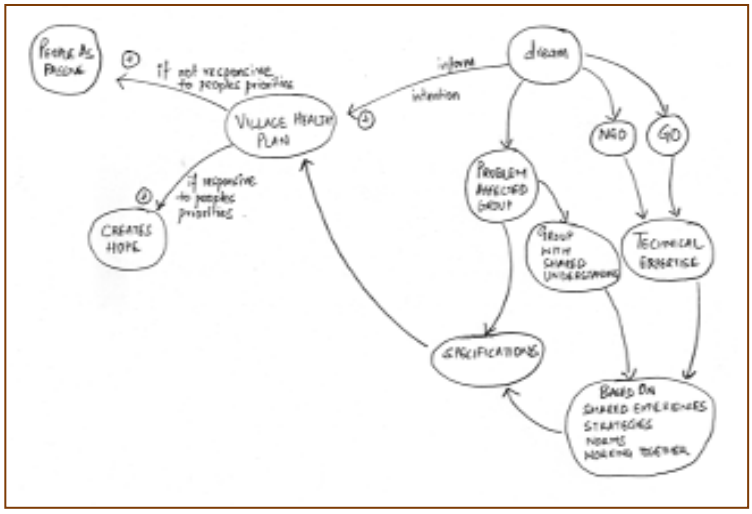

Figure 14. Facilitating 'the Dream'

Diagram 3 - Monitoring: There is a desired status (the dream) and a current status (the reality) and there is a 'gap' between them. The purpose is to close the gap, and this is where monitoring comes in. Findings arising from the monitoring process are fed back to the district authorities and Panchayat (both of whom are far from the village) and also to the community, all of whom would need to take the necessary corrective actions. This in turn would inform strategy and hopefully improve the current status. Our belief is that increasing the community's power to act, will increase their sense of ownership.

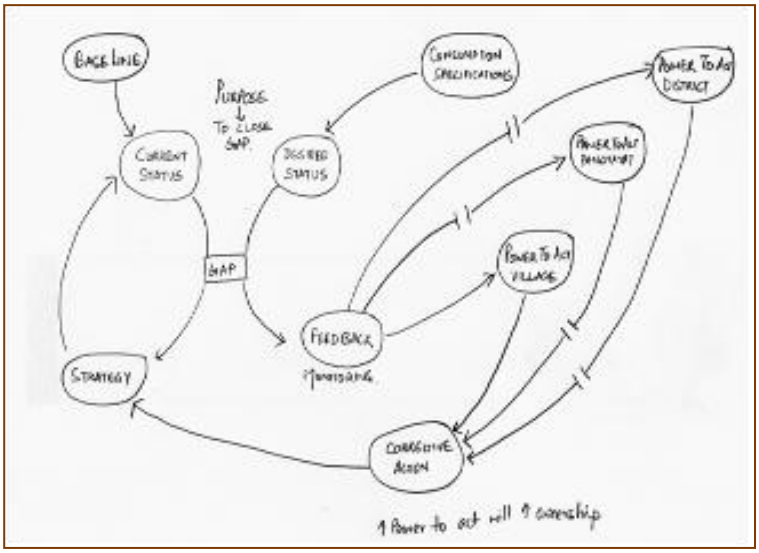

Figure 15. Monitoring to realize 'the Dream'

The tools: We start by getting feedback from the community on the development of the tools. Once the tools have been approved, village health and sanitation committee members go to the individual beneficiaries of the service to get their input. So, unlike in Maharashtra, we do not organize large community meetings, but go to, for example, mothers with very young children to respond to questions about immunization, or mothers with under 6 year olds to explore what services they are receiving. Answers are color-coded – red for things that are not happening, yellow for things that are happening but in an unsatisfactory manner and green for things happening in a satisfactory manner. We try to develop the tool in such a way that it is not only assessing the service, but is also giving feedback to the community on what could be happening to make sure the service is more comprehensive.

We also undertake a facility survey, which includes a very detailed questionnaire using photographic and diagrammatic representations of all the equipment that should be at a clinic. Each piece of equipment is reviewed: green if it is there and working, and red if it is there and not working or not there at all. Then we cluster the equipment into the services needed so people can get a sense of why certain services are weak based on what equipment is or is not available.

Finally, we put all the information into a report card for review, discussion and planning. In terms of planning, the goal is to discuss how to change the red indicators to green. All stakeholders play a role, whether it is the village health worker, or the NGO or community representatives. We also develop a time frame in which this should happen. All we are trying to do is create 'hope' so we need to make sure that the plan is realistic.

In addition to the above, we collate the information based on caste, so the community can assess whether the caste of a person affects their access to services.

As a final comment, the problems that come up obviously need different approaches working at different levels in the health system. For example, the issue of drug availability cannot be solved at village level. So this needs to be taken up to the district. The reality for us is that we are still not dealing with problem solving at higher levels. We believe dialogue with stakeholders, increasing their commitment and building up the hope of the community will improve things, but it is a slow process.

4. Children in Need Institute (CINI): Community Based Monitoring in Jharkhand, India – Mr. Gurjeet Singh

The context: Jharkhand State has a challenging work environment with a low literacy rate, many tribal groups and almost 80% of the population engaged in farming. Multinational corporations dominate the economy and there is a strong tradition of struggle against imperialism. We have a left wing extremist movement in the state which means that we continually have to balance our relationship between the government and the leftist groups.

CBM programme: We have undertaken CBM of health services under NRHM in various districts in the State, focusing on issues of health and education. In India, the National Rural Employment Guarantee Act states that social auditing and community monitoring is mandatory. So, every 6 years the rural council has to do a social audit. We are trying to ensure that this happens. Because of our specific context, we focus a lot on building the capacity of facilitators, and the use of tradition and culture as entry points to community mobilization. Results from the monitoring process are put into a village plan but it does not stop there. It is then taken up to a block plan and finally incorporated into the district health action plan.

CBM tools: We have a strong emphasis on pictorial tools to deal with the low literacy levels in Jharkhand. We also use report cards that help citizens identify and prioritize their health problems. The tools have to be made very simple and community-friendly so they don't appear too technical.

Constitution of the CBM team has been very important. We include youth, health activists and people who have worked in other social movements such as against multinationals or displacement of persons. There are many movements in Jharkhand and so we take volunteers from these movements and train them to become a part of the CBM teams as well.

Finally: We feel that the CBM process is not a fault-finding process but a fact-finding exercise. Ultimately we hope CBM will show the gaps in policy, implementation, behavior of the service providers, and issues of service provision.

5. Public Affairs Foundation: Citizen Report Cards and more – Dr. Sita Sekhar

Sita began her presentation by noting that she'd already given an overview of Citizen Report Cards on Day One of the meeting (See Section 6.3). She was dedicating this session to give more background to the programme.

Background: In 1996, we undertook a study on hospitals that provided care to people from poor communities in the city of Bangalore. These hospitals included public hospitals, the private sector and missionary hospitals run by religious groups. That study showed that the missionary hospitals were the best performing hospitals, even better than the private hospitals. The respondents were people living in very poor localities in the slums of Bangalore. They were asked a range of questions related to different aspects of health services and health delivery. These findings showed us the power of community monitoring for health.

In 1999, we undertook a study on maternity homes run by the municipal corporation. These maternity homes provide family welfare services, including family planning, immunization for children, pre and post natal care and other services. This was the first time we used the CRC in this area and some of the findings were shocking. For example, a woman had to pay about 1300 Rupees (USD20 or USD25) for a single treatment, and additional money to obtain clean bedding or to be given a bed. They were even paying money to see their own baby in the delivery ward! The shocking thing was that they had to pay more for a baby boy and less for a baby girl! We also found evidence of doctors undertaking abortions without putting the information in their reports.

We presented these findings to the Municipal Corporation who came up with a few solutions, including the decision to charge nominal user fees as a way of holding service providers accountable to their clients. The Municipal Corporation wanted to stop the illegal demand for payments. But other problems then surfaced during subsequent CRC surveys, including the way some providers hid the information about user fees from their clients and continued to ask for their own payments.

However, by the time we did a CRC in 2003 we found that there were definitely some improvements. In 2010 we expanded our work in maternity homes run by the Municipal Corporation and started using community score cards and a PETs (Public Expenditure Tracking) exercise. We are also now dialoguing with service providers at the facility level and Municipal Authority level to increase the participation of women in implementation of health services in these maternity homes. We have done two social audits which have shown distinct improvement in services. Since then, the Ministry has set up a task force to undertake this work and the Planning Commission now demands that at least one town in every State in India must undertake a social audit and that funding will be provided for that purpose.