



“COMMUNITY PARTICIPATION IN HEALTH: REPORT OF COMMUNITY CONSULTATIONS”

Preliminary Responses As Background Material For Community Consultations To Inform And Support High Level Expert Group Recommendations On Citizen Engagement And Community Participation In Health ¹

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TECHNICAL PAPER

Context: Community Consultations were instituted to inform and support HLEG recommendations pertaining to Citizen Engagement and Community Participation, with the objective of distilling the knowledge and experiences of different groups and organizations engaging and working at field level. Written feedback was solicited from over 20 organizations engaged in direct community efforts, such as non-governmental organization (NGO) programmes and those focused on participation by *Panchayati Raj* Institutions (PRI)/local elected representatives. Eight responses were received as of January 2011.

This paper presents a broad perspective of the eight responses to areas of enquiry listed in the questionnaire (Annexure 1). It also provides details of ongoing efforts in each of the eight organizations. Organizational profiles of the respondents are provided in Annexure 2.

KEY AREAS OF WORK

Major Developmental Focus:

- **Health:** Education/Health literacy; Health service provision; Maternal and child health; Community health; Community health insurance and Microfinance.
- **Nutrition:** Monitoring of entitlements to health and food.
- **Education:** Support better access to quality education through the public system; *basti* level non-formal education centres; innovative science teaching in government schools including getting science and maths textbooks written; and training of teachers.
- **Protection:** Protection of *dalit* and tribal land rights
- **Human Rights:** Rights of the urban poor; youth rights (gender, sexuality, health, which may be termed citizenship training); child rights; rights of persons with special needs (*dalits*, *adivasis*, and other rural poor); and unorganized daily wagers.

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- **Livelihood:** Entrepreneur development programmes.
- **Income Opportunities:** Development of off farm income opportunities.
- **Women's Empowerment:** Campaign and action for women.
- **Community Empowerment:** Involvement in health care and development issues; empowerment to demand transparency and accountability in public services viz. public distribution, forests, revenue and police administration, local and federal governance.
- **Community Development:** Civil rights of the urban poor – organizing *basti* level people into Community Development Committees, capacity building of these citizen groups to engage with the local administration to get their entitlements.
- **Community-based Protection and Management of Natural Resources.**
- **Water resources:** Biosocial projects in water management.

Specific Health Focus:

- Universalization of comprehensive quality health care through strengthening of primary health care.
- Public private partnerships (PPP) in health care.
- Health care management and health service provision.
- Maternal and child health including a focus on men's involvement.
- Health needs of vulnerable people, those living in underserved areas (*adivasis, dalits, rural poor, urban slum communities*).
- Capacity building and skills development.
- Health education and literacy with a focus on behaviour change.
- Referral services.
- HIV/AIDS, tuberculosis (TB) control.
- Health insurance and community financing mechanisms.
- Development, training and career paths of human resources for primary health care.
- Structuring models of alternative health care with a recent focus on non-communicable disease.
- Operational research specifically in the fields of TB and reproductive child health (RCH).
- Linking with government programmes for proper implementation, mobilizing women and communities for implementation.
- Sale of low cost Allopathic and Ayurvedic medicines.

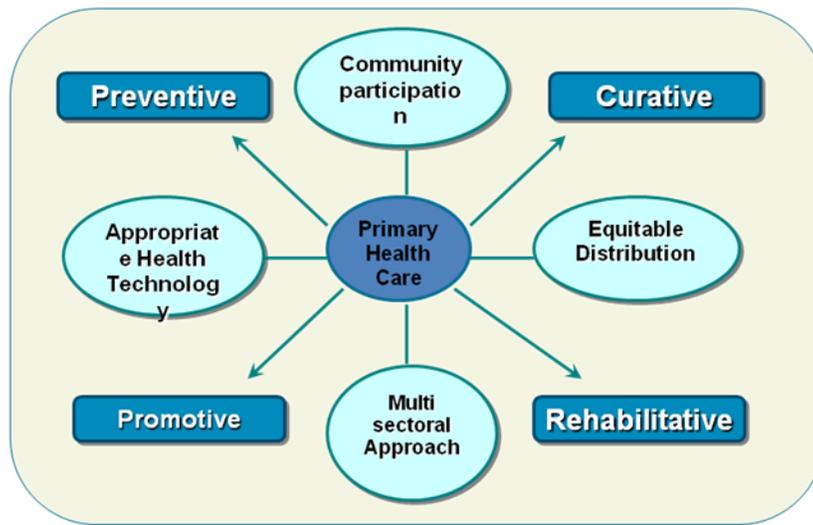
- Occupational health.
- Modernization of traditional medicine.
- National Rural Health Mission (NRHM) focused activities, partnerships, monitoring efforts.

WORK PHILOSOPHIES, APPROACHES AND LEVELS OF ENGAGEMENT

THE KARUNA TRUST

A PPP is a partnership where the public (government) and private (either profit, or not-for-profit such as NGOs) sectors work together towards a common purpose, in this case good quality health care. PPP is not privatization - it is used for strengthening the public health system. For instance, Primary Health Centres (PHCs) located in remote hilly tribal areas and not functioning well are selected for PPP. The Karuna Trust runs seven mobile medical units in Karnataka, a help desk in two district hospitals and a First Referral Unit (FRU) under *Thai Bhagya* scheme in Chamrajnagar district.

Model



Primary Health Care

Services provided in comprehensive primary health care

- All staff stay on the PHC/subcentre premises.
- 24 hour Emergency/Casualty Services.
- Out patient department (OPD) service. Home based care when needed.
- 5 to 10 bed inpatient facility.
- 24 hour labour room and Essential Obstetrics facility.
- Essential new born care.
- Minor Operation Theatre facility.
- 24 hour ambulance facility, referral for emergencies.
- Antenatal/postnatal care, family planning services, reproductive tract infections /sexually transmitted infections.
- Availability of essential medicines and laboratory tests free of cost.

- Implementation of National Health Programmes including NRHM.

Innovations in PHCs

- Mainstreaming mental health into primary health care.
- Vision centres -testing and providing spectacles.
- Telemedicine.
- Emergency medical service (EMS).
- Staff training and motivation.
- Innovation in Accredited Social Health Activist (ASHA) training.
- Promotion of traditional medicines such as herbs. Establishing herbal gardens in PHCs.
- Promotion of generic drugs and rational drug use.

Involvement of the community, NGOs and PRIs in the programme

Communities: The programme seeks to involve the community by empowering the Village Health and Sanitation Committees (VHSCs) for community planning and monitoring, focusing on women's self help groups (SHGs), community health insurance and microfinance.

NGOs: Collaboration with local community based organizations (CBOs) and voluntary organizations (VOs). Capacity building of Vos for PPP.

PRIs: Involving PRIs in VHSCs and *Rogi Kalyan Samitis*; PPP with *Zilla Panchayats* in Karnataka.

EKJUT

The organization aims to save maternal and newborn lives and improve maternal and newborn health through community mobilization. From 2004 to 2008, Ekjut led the evaluation of a participatory intervention with women's groups to improve maternal and newborn health in three districts of Jharkhand and Orissa. By 2010 this intervention was scaled up to eight districts involving over 20,000 women, who meet every month to discuss health issues.

The intervention followed a two track approach:

1. Empowerment of women through a monthly participatory learning and action cycle in the study intervention areas
2. Strengthening the VHSCs in both the intervention and control areas

Tracking change - a robust surveillance system² covering a population of 2,28,000 enabled the team to gauge the impact of this community mobilization initiative. The findings have been published in *The Lancet*.³

These findings include the following: over three years neonatal mortality was 32% lower in the intervention clusters of villages and 45% lower during years two and three. There was also 57% reduction in moderate postnatal depression in year three. There were significant improvements in home care practices. While the study was not equipped to detect significant differences in maternal mortality, informally the maternal mortality ratio was found to be 20% lower in the intervention than in the control clusters. Qualitative evidence from the Trial's process evaluation shows that community mobilization through women's groups have contributed to the prevention of some maternal deaths. The Trial results were also analyzed from the viewpoint of equity and it was found that the poorest and the marginalized have benefitted the most. Women's 'agency' was measured by an index based on questionnaire answers to indicate how autonomous women were in terms of general decision-making. Women's agency increased year by year. There was also diffusion of benefits among all the women living in the villages.

Ekjut believes that community mobilization for its purpose depends on the emergence of a critical mass of informed, committed individuals who are motivated and have the capacity to act to improve maternal and newborn health. Even where the needs are great and the solutions obvious, this dynamic cannot be forced. Community mobilization is an organic process that evolves over time, it can be facilitated, but it cannot be imposed. It is a capacity building process in which members plan, carryout, and evaluate activities on a participatory and sustained basis to improve their conditions, either on their own initiative or stimulated by others.

Led by local women facilitators, 244 women's groups opened up to non-members when they met monthly to consider the causes and underlying problems leading to maternal and newborn deaths in their communities, to share experiences, to develop practical strategies together with

² Barnett S, Nair N, Tripathy P, Borghi J, Rath S, Costello A. A prospective key informant surveillance system to measure maternal mortality – findings from indigenous populations in Jharkhand and Orissa, India. *BMC Pregnancy Childbirth*. 2008; **8** (6). doi:10.1186/1471-2393-8-6

³ Tripathy P, Nair N, Barnett S, Mahapatra R, Borghi J, Rath S et al. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *The Lancet*. 2010; [375\(9721\)](https://doi.org/10.1016/S0140-6736(10)61182-1): 1182 – 1192.

community leaders and men, and to implement these strategies. ASHAs and *Anganwadi* workers (AWWs) too were invited to participate in these village meetings.⁴

The Ekjut Trial was a collaboration between Ekjut and the Centre for International Health and Development at the University College of London, from which Ekjut received technical support. Ekjut also received field support from PRADAN.

Quantitative scale up: After the Ekjut Trial was over the intervention was replicated in the control villages and impressive reduction in newborn mortality was again achieved.

Currently a little over one thousand women's groups meet every month in eight districts of Jharkhand and Orissa.

Functional Scale up: The groups that originally achieved impressive gains are now being helped to combat malnutrition and under five mortality among children, and to address broader women's health issues. This approach is also being piloted in two districts of Madhya Pradesh using the Madhya Pradesh Rural Livelihood Project platform (MPRLP).

Political Scale Up: It has now been established that community mobilization for maternal and newborn health has to be a complementary strategy, functioning together with home visits in the underserved areas with high newborn mortality rates. Ekjut has been invited to involve ASHAs in mobilizing communities and to evaluate the effectiveness of the community mobilization process. Two pilots are also underway to develop strategies to deploy community mobilization to combat malnutrition in Orissa and Madhya Pradesh. Findings of the Ekjut Trial have been shared with senior government officials of three states besides being otherwise widely disseminated.

CHILD IN NEED INSTITUTE (CINI)

Working towards an integrated programme, CINI has developed an approach called 'Child and Woman Friendly Communities', which is a participatory rights based approach for communities' involvement in the development of the village. While CINI works in the field with communities and service providers, it also provides technical assistance to governments. Recent technical assistance in health include working on the operational guidelines for flexi-funds in NRHM, running the ASHA programme in two states and providing support to the Human Resources policy in Jharkhand.

⁴ Rath S, Nair N, Tripathy P, Barnett S, Rath Sh, Mahapatra R et al. Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation. *BMC International Health and Human Rights* 2010, 10(25). doi:10.1186/1472-698X-10-25

One of CINI's key areas of intervention is in propagating community based monitoring (CBM) and evaluation of public services, especially in the areas of health, nutrition and education. Enabling the community to review and assess public programmes empowers them to seek accountability from public mechanisms. Furthermore, community members gain essential skills in taking stock of their situation, carrying out dialogues with public officials and actively planning for their future.

CINI's approach to community based monitoring is to focus on awareness generation and capacity building. The Initiative follows a two pronged strategy in reaching out to government officials and service providers - orienting them on the concept of community audit, and how to train community members to conduct the audit. It also develops participatory tools in the form of pictorial score cards that are simple and can be easily grasped and completed by local people.

CINI initially worked with the Centre for Health & Social Justice and the Population Foundation of India on CBM and have now begun working on it with over 450 communities. It is empowering Village Health Committees (VHCs) and *Sahiyya Sathees* (ASHA mentors) to conduct regular quarterly appraisals and come up with a community report card for the various health centres in their area. In Jharkhand the PRIs have just been elected and it is expected that work with them will commence soon.

In a project supported by the Department for International Development (DFID) and the European Union (EU) through Interact Worldwide, CINI worked with adolescent groups to take forward the same process, that of CBM.

The CINI process involves seven steps: (i) a one to two month sensitization process with the community; (ii) collectivization (strengthening an existing group like VHC or youth club, or starting one); (iii) collective analysis where the report cards are prepared; (iv) prioritization in which the community takes up a few of the issues identified; (v) planning (vi) negotiation and implementation; and (vii) evaluation by means of collective analysis.

THE ACTION FOR NORTHEAST TRUST (THE ANT)

Health services were non-existent before 2006 in our field area near the Bhutan border with a population of 200,000. Vast areas had not been covered for Pulse Polio. Hospitals were mainly

private and very expensive. Here many of the tribal families have poor landholdings and are debt ridden.

The only employable skill that the tribal women have is weaving. To make this a tool for women's empowerment, besides making it a source of dependable income, THE ANT decided to try out a strategy of making outfits for metropolitan areas like Delhi and Bangalore where people were ready to pay a premium for handlooms, so that the women would have home-based livelihoods and yet earn double to triple of the farm wage.

It is part of THE ANT's strategy to "*work with the strengths of the weakest*" instead of reinventing the wheel. Bodo tribal villages each have a population of 250 to 400 persons, and the programme began with a village meeting explaining its aims and objectives.

The weaving programme which started in 2002, with the help of a designer to make weaving into a marketable craft, was later converted into an independent Trust. There is an Executive Committee of weavers elected at the Annual General Meeting, who in turn can elect/select the Trustees. The Executive Committee hires and fires the staff that includes MBAs and designers. The Assistant Managing Trustee is an ex-President of the Executive Committee and supervises the day to day affairs of Aagor, as the programme is called, besides being the signatory for all cheques and accounts.

By using a non-bleeding yarn, acceptable designs and high quality tailoring so that an urban customer finds it easy to wear and wash the product, earnings have been enough to distribute around Rs 20 to 25 lakhs every year as wages to THE ANT weavers.

The Executive Committee also selects future weaver members, and does this through objectively verifiable criteria, to select the poorest of the poor in villages. These weaver members have to pay Rs 10 per month as a membership fee to qualify for an annual bonus, which has been paid out for seven of the eight years of the weaving programme.

No PRIs exist in the area as there exists a Schedule VI Territorial Council in Bodoland. The Committees which take the place of *Panchayats* at the 10,000 population level have very little relationship to the programme as they were formed much later than Aagor, and also because they are basically seen to handle only the Rural Development Authority programmes for the government.

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH (FRCH)

FRCH has been involved in the piloting of the community based monitoring activity of the NRHM in the past two years, as a resource organization in its field research area of Parinche in Pune district of Maharashtra. Overall this activity has been largely NGO driven with support from NRHM both in terms of funding, as well as the personal involvement of some NRHM officials. The strategy of involving communities was drawn up in consultation with two district

and state level organizations MASUM and SATHI-CEHAT respectively. FRCH was assigned the area under Parinche PHC because of its close relationship with the community in that area through its health projects, and the significant presence of its own trained community health workers who have continued to function there over the past 15 years. The model was based on the selection and training of VHSCs in understanding their health rights, the working of the public health system in terms of subcentre, PHC and Community Health Centre (CHC) functions, extension work in antenatal care and immunization, and investigations of denial to healthcare. The selection of the VHSC members was done by holding *Gram Sabhas*. In villages where people's participation was weak, the FRCH community health worker held meetings, along with the system's multipurpose workers, to induct appropriate persons into the VHSCs.

Training was undertaken by the FRCH and its trained health workers at its institutional resource centre at Parinche. Whilst the initial training was of 4 days duration, revision of the syllabus was an integral part of subsequent training sessions where reporting tools were formatted and modified.

A colour coded reporting format was developed for easy comprehension by the community. The denials of health care were recorded as case histories and produced at *Jan Sunvais* or peoples' hearings attended by district and state level officials, with the expectation that these lapses would be addressed. An attempt was made to disseminate the advantages of this activity through the regional media.

An interim external evaluation of these pilot initiatives was also undertaken. At the end of this phase, the Planning Commission Member in charge of health and her team visited key areas to learn the extent of denial, and the nuances in the relationship between communities and the public health system engendered by the CBM.

The CBM has entered into Phase 2 of its activities, tackling more complex issues such as village planning and the optimal use of untied funds. The VHSC function of supporting ASHAs has only recently been initiated with the recent induction of the ASHA into non-tribal areas of non-Empowered Action Group (EAG) states. It is anticipated that the first ASHA-related issue will be the payment of a fixed remuneration to the ASHA, based on her performance.

SAHAJ - Capacity Building of Community Development Committees

Objectives: To develop and strengthen Community Development Committees, which can undertake community based advocacy for their entitlements, especially health entitlements including social determinants of health.

Approach: Helping different community groups – local leaders, women, adolescent boys and girls – become aware of their entitlements, organizing them into collectives, building their capacities to negotiate with power centres and assert their rights.

Process: Building rapport with various community groups. Awareness raising of several change agent groups – local community health volunteers, adolescent peer educators, male peer educators, Community Development Committees and capacity building of these groups.

Facilitating campaigns and community action. Working with the media. Using cultural means – eg. theatre – for consciousness-building at the community level.

PRAYAS

Prayas has been engaged in evolving a framework of health care security through community mobilization, public health education and social sensitization of Government health care providers in 141 villages of Chhoti Sadari block of Pratapgarh district in Rajasthan.

The objective of the programme is to ensure that safe, effective, rational and inexpensive health care services are available to people as their essential right. There are two important components of the project:

1. To undertake ground level activities directly with the community and health care providers.
2. To launch campaigns and policy dialogue for gender sensitive and people supportive health policies and programmes both at state and national level.

The following basic principles were adopted for all initiatives under the programme:

- Recognizing health as a basic human right will be the basis for all advocacy interventions.
- Seeing health from the viewpoint of social determinants of health and the extent of equity in health and health care services.
- Advocating for equity in access, participation and outcomes in health and health service utilization and for the reduction of inequities.
- Enabling people, communities and people's organizations to participate in decision-making which impact on health.
- Working in partnership with people, communities and organizations to ensure inclusiveness across sectors, communities, stakeholders, individuals and organizations with specific focus on women and marginalized groups.

The project had special significance as it was implemented keeping almost every section of the community in the loop in one way or the other. Women being an obvious focus of the programme had larger participation through various activities, but the involvement of males was also ensured. Following a planned strategy the intervention started gradually and then steadily escalated its activities and people's participation.

Self Employed Women's Association (SEWA)

One of the major foci of SEWA is health education to provide basic life-saving health information, knowledge and skills to local women, so that they can take care of their own and their families' health. SEWA's approach to health education is access at the door-step of the

women in the village/slum, for women, by women and with women – all of whom are poor, informal workers.

The education must be sustainable – financially viable and in the context of women being decision-makers. Topics are decided by the women and typically involve the use of folk, low-cost methods – street plays, wall paintings.

SEWA charges a small fee for the training sessions. Mostly health education is funded by the sales of medicines by the cooperative. Women get “Know Your Body” type information from experienced trainers, then they become educators themselves.

All the women are SEWA members and also members and share-holders of the cooperative. They own, run and use the programme and hence are involved in every aspect of running health education and the cooperative itself. Health education is carried out at a time convenient to the members of the community. Other NGOs have been involved as trainers. Some now ask us to come and provide health education and training. (e.g. NGOs in Rajasthan, Uttarakhand) PRI members come to the health education sessions. Health education is also provided to VHSC members.

PROGRESS IN ACHIEVING COMMUNITY/NGO/PRI PARTICIPATION

KARUNA TRUST: Has been successful in achieving Community, NGO and PRI participation in health care – as shown by the process and outcome indicators. The Karuna Trust Model of PPP has been scaled up to another five EAG states and 100 PHCs.

EKJUT: The hallmark of this intervention is the participation of village institutions. All of them are invited during the “Community Meetings” periodically convened by the group members during the meeting cycle.

CINI: The community participation approach is being applied in all intervention programmes. So far the only public programmes that compulsorily include community based monitoring as part of project implementation and review are the National Rural Employment Guarantee Act and the Sarva Shiksha Abhiyan. Other crucial programmes such as NRHM and Integrated Child Development Services have provisions for community based monitoring but are yet to include it through legislation. CINI seeks to expand the space for community involvement by creating a groundswell for legislation on this issue.

There is an urgent need for more resource allocation to undertake training and support of community representatives to scale up the CBM exercise across the state. Scaling up is essential to increase visibility and enhance outcomes. Government officials also need to be oriented on the concept of community accountability and their role in the CBM exercise.

THE ANT: Students' unions in the northeast have always been seen to represent the common interest and political aspirations of the community. It is not surprise that many peace accords have been brokered by students' unions. THE ANT has worked with the All Bodo Students' Union (ABSU) closely and also with those of smaller communities in the area. While there has been opposition to us in the bureaucracy and by some of the political players, it is this association with students' unions that has helped us in surviving, and thriving.

THE ANT has also helped the students' unions to adopt the watchdog role for entitlements of the poor to food and health issues. Engagement with the students' union has also helped in that the ABSU now preaches and adopts the non-violent path for its actions.

The group has also been founder members of two NGO Associations. The first is the People's Rights Forum in Guwahati whose members work essentially on Right to Food schemes; and the second is the Lower Assam NGO Forum.

ANT has also started the Institute of Development Action to help NGOs train their personnel as well as other development players.

Relationships with PRIs have not been very fruitful.

FRCH: Phase 1 of CBM has resulted in significantly high levels of utilization of the public health system in the villages. The drop in accessing private health providers has augmented family savings and earnings. Success in Phase 1 has raised the expectations of the community for a rights based approach even in other sectors of development. In health, the community has started questioning the providers and stating their demands for more regular services. This is perceptible even in isolated hamlets.

Community demand has resulted in allocation of optimal human resources in underserved areas and has led to great improvements in the availability of drugs and materials.

There is a change in the perception of service providers particularly at the Medical Officer level. They say that there is greater joy and accountability in their work and more regulation in their daily duties. Whether this has percolated to other levels is still debatable. There is stated doubt whether CBM will be sustainable without NGO involvement. Handholding will be required for a long time until confidence and the roots of a participating community take hold. CBM is a slow

and incremental process which will have its local momentum based on local realities. The criteria for its success or failure will need to be articulated judiciously.

PRAYAS: The project marked out activities such as trainings for village health animators, Traditional Birth Attendants (TBAs), AWWs, Auxiliary Nurse Midwives (ANMs), Traditional faith healers (Bhopas), Local community heads (Gadda patels), adolescent girls and boys, and SHGs.

Apart from this, regular meetings were held with the Village Health Committees, Committees at PHC, CHC and District levels, animators, TBAs, adolescent girls and boys. These activities helped develop a scientific perspective towards health and also created accountability on the part of the service providers regarding prevailing health services in the region.

Mass sensitization programmes like women's health assembly, adolescent health fairs, public hearings, special days celebrations, workshops with media and exposure tours, proved to be extremely useful in reaching out to large numbers of people with health messages, and promoted increasing consciousness amongst the people regarding various health issues.

The programme evolved a community based mechanism of health security through the partnership between the providers of the social determinants of health and the community. This worked through an institutionalized framework of convergence at various layers and levels of service deliveries. The improvement of public systems will contribute to improvement of health, the goal being to reduce morbidities, disabilities and premature mortality caused by deprivation of basic services.

SEWA: The Association has never faced difficulty getting "community participation" because SEWA is of the community (women), by and for them. They are involved in each and every step from building their own cooperative, raising the share capital and running the cooperative. Health education is carried out in their own communities, their own villages and slums.

SEWA has a good rapport with many NGOs and NGO forums and work together on health issues. A *Dai Sangathan* as founded in Gujarat to train Traditional Birth Attendants (TBAs) and present their issues at policy level.

Similarly, SEWA has little difficulty in working with *Panchayats*. The members know and respect SEWA. Most important the association has a presence in their villages and some of our members are elected to the *Panchayat*. SEWA provides health care and other services.

Some *sarpanches* are hostile because SEWA organizes for collective rights, at times exposing some of the local-level corruption. But by and large, the *Panchayats* are supportive and cooperative, and even arrange *Gram Sabhas*.

ENABLING FACTORS

KARUNA TRUST

- Willingness to partner with the public health system.
- Advocacy with government for partnership.
- PPP policy at national and state level.
- Successful demonstration of pilot PPP in Karnataka.
- Partnership with Community, NGOs & PRIs.

EKJUT

Six broad, interrelated factors influenced the intervention's impact: (i) acceptability; (ii) participatory approach to the development of knowledge, skills and 'critical consciousness; (iii) community involvement beyond the groups; (iv) focus on marginalized communities; (v) the active recruitment of newly pregnant women into groups; and (vi) high population coverage.

CINI

- Dialogue with government agencies helped create acceptance for the participatory processes involved in the mechanism of community audit.
- A proactive officer at the helm – either a District Magistrate or Civil Surgeon.
- Clear and simple tools for the process.
- Willingness and zeal demonstrated by community members especially women leaders, supported implementation and scaling up of the programme.
- Follow up and strong negotiations with the government based on the Report Card (key role of the NGO).
- Involvement of the marginalized section of the community in the dialogue process.
- The process of the community audit also opened up a vast avenue for media advocacy on health issues. Many programmes and services, otherwise not prioritized, are now receiving media attention which helped further the cause of community audits.

THE ANT

- Tribal sense of commitment to the social cause as opposed to an individual cause.
- Good designer willing to work at a pittance.
- Risk takers amongst the Board as even today the success of the programme requires taking a loan of almost Rs 1 crore by the Trust from financial institutions.
- A great deal of poverty leading women to seize the employment opportunity.

- Institutions like NABARD and TRIFED, which were the only government institutions ready to help without a “consideration.” Also, TRIFED pays within a week or two of purchase, while big retail chains take between four to six months to pay.
- Fab India, which helped growth through its huge market presence, accounting for between 33 to 50% of our annual sales.
- Grant support in the founding years from donors like Ford Foundation and the British High Commission.

FRCH

- Driving of CBM by NGOs dedicated to health rights issues and with experience of health systems in the state.
- Close relationship and trust between the target community and the NGO and the willingness of the NGO to facilitate the representation of the community. Clearly a long period of NGO community interaction was advantageous to encourage community participation. This relationship fructified in the selection of the most appropriate members of the community as well as in quality based training.
- Use of local FRCH trained community health workers in selection and training and in community mobilization activities.
- Dedicated staff, infrastructural and some financial support to the local CBM programme by the FRCH.
- Empathetic and proactive stance of health authorities. Prompt and visible redressal of grievances is the prime factor to encourage community participation.
- The convergence of Health, ICDS and VHSC to form an integrated village planning unit.

SAHAJ

- Community centered approach.
- Working with community representatives to help them solve their own issues.
- Capacity building using a range of methods – training workshops, accompanying community representatives to government offices, competitions, debates, participation in citizen action (rallies, public hearings, *dharnas*, demonstrations).
- Training on the Right to Information Act has had especially powerful results.
- *Jan sanvaads* on different issues with health care providers, religious leaders and others have been energizing.

PRAYAS

- Strong team of workers from various fields and backgrounds with great competencies. The team includes both young energetic professionals and senior experienced experts and researchers.
- Resources and funds were available to carry out the necessary activities.
- Long experience of working in Rajasthan and has a good understanding of the social, economic, religious and political concerns of the state.

- Experience of working at the grassroots level with the community, working on advocacy based issues, and also of conducting research and studies at state and national level.
- Network of partners and organizations from different backgrounds, both within the state and outside.

SEWA

- Being a membership based organization working at the grassroots level, aware of local people's needs and priorities.
- Being a union with an integrated approach – not only health, but also financial services, employment, water and sanitation etc.
- Focus on building up women's leadership, knowledge, skills and functioning as health educators.
- Fostering of solidarity and sisterhood through the union and cooperative.
- Capacity and skills to undertake the intervention.

CHALLENGES

KARUNA TRUST

- Shortage of MBBS doctors and ANMs and large turnover of staff.
- Resistance from private health care providers/institutions in the area who feel threatened about losing business.
- Corruption among district health officers which can impact on timely sanctioning of grants and collection of drugs.
- Vested interests influencing the decisions of the *Zilla Parishads* against the partnership.
- Discrimination between government run PHCs and PHCs run by NGOs.
- Lack of budget for administration, monitoring, supervision and capacity building.
- Resource constraints to address gaps in government funding and for implementing innovations.

How Karuna Trust addresses these challenges:

- Establishing an ANM school to overcome the shortage of trained and committed ANMs and advocating with the state to depute doctors.
- Capacity building and motivation of health care personnel to improve the quality of human resources.
- Mobilizing resources locally and from non-resident Indians to fill the resource gaps.
- Transparency, accountability and good governance.
- Improved drug supply, logistics planning and management.
- Computerized health management information system (HMIS) with regular feedback on PHC performance.

EKJUT

The intervention team and group members faced several challenges. The team initially experienced difficulties in building a rapport with marginalized tribal communities and dealing with the expectations of financial gain.

- Facilitators had to contend with dominating group members and cancellations during festivals and cultivation periods. They managed to keep control when men were present during sensitive discussions as well as during rare disruptions from non-group members. They had to ensure participation even when there were internal conflicts within villages.
- There were considerable improvements in home care practices in the intervention areas, but increases in care-seeking were slower. As marginalized groups, the tribal communities and the poorest among them had difficulties in accessing services. The remoteness of villages, poor access to transport and bad road conditions compounded the social isolation of these communities. ANMs made irregular visits to villages and mothers had difficulties in accessing antenatal check-ups. Several members had bad experiences in the health facilities or reported that these were not equipped to deal with emergencies and had inconvenient working hours.

CINI

- The use of CBM sometimes made the government officials feel threatened and they resisted the project activities intended to prepare for public dialogue. Similarly, the community audit was also perceived as a threat to vested interests and power structures among front line workers who attempted to dismantle the process. In such instances CINI tried to further the dialogue process by involving participants from higher levels of the government department. This helped us diffuse potential conflict in some of the cases.
- Since, so far, the scale of our intervention through CBM has been limited, it is difficult for us alone to sustain the mobilization and momentum for implementation across the state. Therefore CINI is now focused on mobilizing resources and collaborating with partners across the state to scale up our activities.
- Complicated tools for preparing the report card which required help to decipher meant that the professional staff had to provide this help, increasing their load and slowing down the programme. The answer is to simplify the tools and ensure that the analysis is done by the community itself
- Ensure that rather than the NGO, the community is always empowered in the dialogue and in the forefront, especially during the dialogues with the ANM, AWW, ASHA at the village and block levels. Most communities, especially tribal and marginalized communities are shy to come to the forefront.

THE ANT

- Lack of capital – while car and house loans are available at cheap interest rates, THE ANT pays around 12% to 14.5% per annum for our capital from commercial Public Sector banks, and they also impose limits that restrict growth.
- Most retail runs on huge margins that are necessary to pay for huge rentals and property costs. If government owned property is obtainable and made available cheaply on

rent to NGOs, THE ANT could sell more goods at a lower price, thus increasing the buyer base and increasing livelihood opportunities. The high rental costs restrict sales.

- Customers in India still have a mindset that wants cheaper stuff from poor people. For example, while most do not have a problem paying a MRP at forty times the wholesale price for medicines when it is printed, and twenty times the manufacturing cost for a beverage with a MRP printed, we tend to argue about prices when we deal with vegetable vendors and rickshaw drivers.
- The lack of industry in Assam means that materials have to be transported from a great distance. For example, high quality bleed free cotton yarn has to come all the way from Tamil Nadu.
- Too few trains and frequent *bandhs* upset delivery schedules and even participation in *melas* at short notice.

FRCH

- The perception of threat by the state health authorities who view this as a punitive measure. This stance reflects the lack of orientation to CBM in the system as well as lack of commitment to the CBM even at higher state levels.
- Lack of awareness of CBM in the general public. Mass media may be an effective instrument for putting forth specific facts but is feeble for conveying concepts and for mobilizing public opinion.

The FRCH plans to address this problem at a micro level by holding meetings with target groups such as school children and youths and SHGs to promote awareness about the CBM concept. Engendering a more broad based support for the idea is needed. While researchers have documented case histories of care denial, there has been no rigorous process of community documentation, which can serve as an evidence base. This should be initiated at the earliest.

- Indifferent participation by PRIs (and some VHSC members) in CBM. This is apparent up to the *Zilla Parishads* at the district level. The evolution of rights and responsibilities as a democratic ethos has only weakly permeated the public and community psyche. There could be a time disconnect in CBM initiation and the political evolution of the community. Phase 2 of CBM plans to launch a concerted effort to increase involvement of PRIs in CBM. Outcomes should be awaited to gauge the efficacy of this approach.
- Motivational approaches (though not financial) for community participation need to be found. Exchanges between community representatives across regions may be one such approach.
- Lack of convergence between Health and ICDS functionaries at the field level. This will increase with inflows of discretionary funds at the field level unless a sense of common purpose is achieved at the village level.
- Communities feel that their participation in CBM may render them vulnerable to vindictive action by the public health system. Whilst grievances are often voiced at village level meetings, there is considerable hesitation when complaints have to be articulated at higher levels.

- Differences among NGOS as to whether CBM should go beyond health and encompass all sectors of development such as education, water, food. There is considerable debate on this issue. FRCH feels that currently the focus on health should not be diluted.
- The NGO-System interface and the need to understand how to resolve the conflict.

SAHAJ

- The team members themselves are learning the scope of the intervention. For example that budget analysis and advocacy based on CBM can be very powerful. Our team members need training in how to analyze the Municipal Corporation's budget.
- Documents and critiques are generally not available in Gujarati. Most material is in English, for example a critique of the JNNURM or the National Health Bill draft. Our team is proficient in Gujarati, thus the availability of material in the appropriate language becomes a challenge.
- The team members are excellent in field work and community mobilization but not so good in documentation and policy analysis and so, in terms of translating their own understanding to the community leaders, there are some lacunae.
- The Vadodara Municipal Corporation has a reputation for being passive in comparison to the Ahmedabad and Surat Corporations. Thus not much headway was made in creating a partnership with the Corporation. SAHAJ could easily be playing a complementary role for citizenship development directed towards the formation of Ward Committees and other citizen bodies mandated by the JNNURM.
- SAHAJ has taken an adversarial role in the post-Godhra violence and is thus not very popular with the administration.

How SAHAJ overcomes challenges

- Getting national level resource persons who know Gujarati or Hindi who can share with the team policy critiques, review their documentation etc.
- SAHAJ is reconciled to its position vis a vis the State – the organization prefers not to partner with a fascist state than compromise on its values.

PRAYAS

- One of the major challenges faced by the programme was to mobilize people's support and gain their trust. Initially intervening was not easy. It took a long time for the grassroots workers to win over the people and gain their support, which happened only after repeated meetings and conversations.
- The other challenge was to keep people's trust intact and to keep them involved. As several sections of the community were made part of the programme it was necessary to ensure were given importance and had unique roles to play during the course of the programme. Gender was a major issue. As the programme required extensive participation by women and young girls, it was initially a challenge to bring them out of their houses for meetings and workshops.
- Another huge challenge was to keep a balanced relationship with health service providers of the region as on occasion they were considered redundant, and yet it was necessary to maintain cordial relations with them. Hence health service providers were

often kept involved throughout the programme by being invited to participate in different activities and made to feel important.

- State and national level campaigns brought up huge challenges, one of which was to keep the momentum of the campaigns going as some of the campaigns went for long durations. In such cases it was extremely difficult to keep people's support consistent and their spirits high.
- There were also occasions when there was not much support from the government or the health departments and this hindered the pace of work, but the issues were resolved by regular talks and discussions with government officials.

SEWA

- It takes time to train women as health educators. One has to go according to their speed. Patience is needed.
- The approach used for poor, less educated women has to be different. They need lots of encouragement, support and patience.
- How does one show the outcome of health education ? It is not a linear relationship.
- The inputs have to be repeated many times. The training is not a one-time activity.
- Funds for health education are not easily available, even though its importance is recognized.

How SEWA addresses these challenges:

- By developing a team of 50 experienced health educators and 400 other health workers to take education forward.
- Developing tailor-made health education programmes.
- Developing tailor-made, appropriate health education training materials.
- Carrying out capacity-building, leadership and public speaking programmes.
- Getting funds from the sale of medicines and using these for health education.

CONCLUSION & WAY FORWARD

This document provides a very broad understanding (with specific organizational profiles) of ongoing constructive community participation in the delivery, accountability and increased convergence of health care and related services. It may be utilized as a preliminary contribution to a larger effort of understanding community-led, or community-centered health coverage initiatives across the country. The larger effort would involve direct community consultations with a particular focus on groups with special needs, better understanding of what exactly Universal Health Coverage means to ordinary people, and where the country stands in the process of such provision.

ANNEXURE 1: QUESTIONNAIRE

December 2010

UNIVERSAL HEALTH COVERAGE IN INDIA

High Level Expert Group Convened by the Planning Commission of India for the 12th Five Year Plan

Recognizing the importance of defining a comprehensive strategy for health for the Twelfth Plan, the Government of India has identified a High Level Expert Group (HLEG) on Universal Health Coverage, chaired by Prof K Srinath Reddy, President, Public Health Foundation of India (PHFI). The Expert Group is expected to review the experience of India's health sector thus far and suggest a 10-year strategy. This review may be complemented with the experience of other countries, while highlighting what has worked, what is relevant, replicable along with the limitations of varied approaches. The Expert Group will present to the Planning Commission in a progress report a summary of interactions and ideas as a framework to achieve provision of health care for all. This progress report would then be used by the Planning Commission, in developing the "Approach Paper" for the 12th Five-Year Plan.

The Secretariat of the Expert Group is located at PHFI in New Delhi and is supported in its activities by a dedicated team of 25 staff and faculty of PHFI and its constituent Indian Institutes of Public Health (IIPH).

Six Terms of Reference (ToRs) have been formulated under the broader framework of Universal Health Coverage. One of these, ToR 4, headed by HLEG member Ms. Jashodhara Dasgupta, Coordinator, SAHAYOG, Lucknow, is to **develop guidelines for the constructive participation of communities, local elected bodies, NGOs, the private for-profit and not-for-profit sector in the delivery, accountability and increased convergence of health care and related services.**

The ToR 4 group is initiating a process of Community Consultations to inform and support the specific work under the ToR.

Objective of Community Consultations

To distill the knowledge and experiences of different groups and organizations engaging and working at field level. Responses received would be compiled according to areas of enquiry listed in the questionnaire below, while highlighting significant experiences and success stories through case study narratives.

Brief Questionnaire to be filled by in by the Organisation [Please restrict responses to these boxes, and ensure the total number of pages does not exceed the current four pages provided]

Organizational profile/structure/funding/age

1. Focus areas of work

2. Please identify one key programme or intervention that you have been involved in.
 - What are the objectives and philosophy of this programme/intervention?
 - What approach have you followed in this programme/intervention (MODEL)?
 - How have you proceeded with involving communities / NGOs / PRIs in this programme / intervention (PROCESS)?

3. What do you consider as enabling or facilitating factors for this programme / intervention?

4. Describe (from your experience) challenges and obstacles associated with this programme / intervention. How has your organization addressed them?

5. What has been the progress in achieving community/NGO/PRI participation?

ANNEXURE 2: RESPONDENT ORGANISATIONS

KARUNA TRUST

Set up in 1986, Karuna Trust had its origin in the work and experience of Vivekananda Girijana Kalyana Kendra (VGKK), which was providing basic health care to tribal communities from BR Hills in Chamarajnagar district of Karnataka. When VGKK extended its health services to tribals outside of BR Hills through a clinic at Yelandur taluk situated in the foothills, it was found that Yelandur was hyper-endemic to leprosy with a prevalence of 21.4/1000 population. Karuna Trust was established as a response to this problem.

Over time the presence of several other health problems in the taluk became evident. Karuna Trust gradually extended the scope of its work by including the other health needs of the rural community, including epilepsy, tuberculosis, RCH, dental and eye care and mental health. Karuna Trust currently facilitates community driven integrated development programmes addressing their health, education and livelihood needs.

Vision

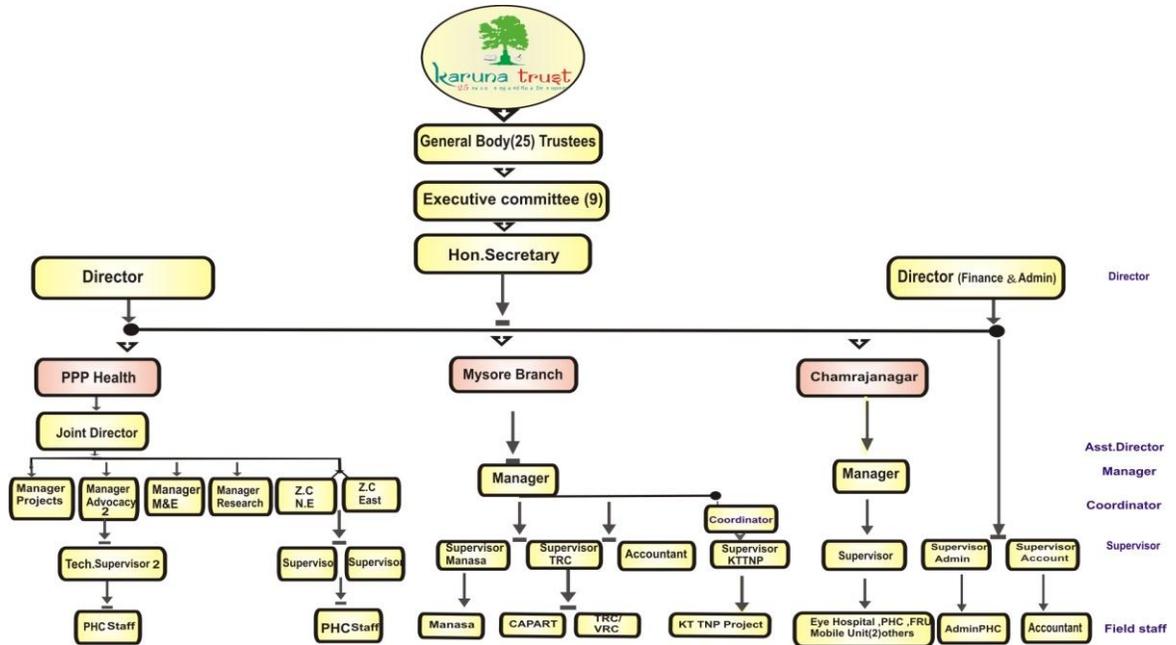
A society in which we strive to provide an equitable and integrated model of health care, education and livelihoods by empowering marginalized people to be self-reliant.

Mission

To develop a dedicated service-minded team with a passion for excellence, which will facilitate the holistic development of marginalized people, through innovative and replicable models.

Objectives

- Provide integrated development for the poor and marginalized people (tribal, rural and urban) through health, education and training for livelihoods.
- Organize and empower rural people to work towards a self-reliant community.
- Work through public private partnerships for innovative, replicable and sustainable models.
- Support and complement government initiatives in health and education to improve the quality of services and encourage community participation.
- Create innovative models for replication and provide benchmarks to influence government policy and reforms.



Funding :

Government (major source), individual donors, local and foreign funding agencies

Age: 25 years old

EKJUT

Ekjut (www.ekjutindia.org) meaning “togetherness” is a registered Non-Governmental Organisation in existence since 2002. (Registered in Delhi -SRA1860 44224/2002 and FCRA No:231660513/21.10.04). It has a strong field presence in nine districts of Jharkhand and Orissa and two districts of Madhya Pradesh. Ekjut is led by a multidisciplinary senior management team located in the district hubs. The entire field staff and their supervisors are from the local villages.

The Ekjut Board consists of Dr Prasanta Tripathy (Secretary) Public Health, Shri Snehil Kumar (President) Total Quality Management, Shri Sudhir Sinha (Treasurer) Rural Development and Ms Vidya Nair (Vice President) Education.

Address for correspondence is – Ekjut, Plot 556 (B), Ward 17, Potka, PO-Chakradharpur, Dist- West Singhbhum, Jharkhand, India 833102 (Phone 06587239625).

Funding source- Centre for International Health and Development –UCL, The Health Foundation, Wellcome Trust, Big Lottery Fund Strategic Grant, IntraHealth Inc., the Government of India and individual supporters

CHILD IN NEED INSTITUTE (CINI)

Child in Need Institute (CINI) was set up in 1974 in West Bengal, as a clinic for children under five. Today CINI is recognized as a national NGO working in the areas of Education, Protection, Health and Nutrition. Guided by its mission of 'Sustainable Development in Health, Nutrition and Education of Child, Adolescent and Woman in Need', CINI reaches over 15,00,000 people in both rural and urban settings across many states of India. CINI started its work in Jharkhand in 2002. CINI has multiple sources of funding with its major funding coming ICCHN, USAID, EU, DfID, SDTT, Oxfam and Plan.

THE ACTION NORTHEAST TRUST (THE ANT)

The ANT was registered as a Public Charitable Trust in October 2000. The Board of Trustees consists of six Trustees of whom two (of three, one died recently) are Founder Trustees. The Managing Trustee also functions as Programme Director. The Trust has I T Sec 12 A and 80 G registration, and is registered under FCRA with the Union Home Ministry.

Gradually all income-generation and microfinance activities have been diverted to new organizations: Aagor Daagra Afad is a weaver controlled trust, Gramin Vikas Samiti is for microfinance activities, and The Ants Craft Trust in Bangalore, which handles retail and wholesale transactions of crafts products for the northeast.

For the first two and a half years the ANT was funded by individual donations, earnings, consultancies and book sales. Later institutional funding came from the National Foundation for India, Ford Foundation, Indians for Collective Action, Association for India's Development, Sir Ratan Tata Trust, Sir Dorabji Tata Trust, Caring Friends, DKA and IGSSS.

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH (FRCH)

The Foundation for Research in Community Health is a Public Trust set up in 1975 to examine issues related to accessibility and equity in health care for the marginalized rural population of India. Governed by a Board of Trustees with an Executive Director, FRCH has a multidisciplinary research and field staff and consultants with dedicated teams for each of its Projects. Besides administrative and logistic support, the teams are mentored by advisory and institutional ethics committees. Funding is through project grants and donations as well as interest generated through a corpus grant from Sir Dorabji Tata Trust.

SOCIETY FOR HEALTH ALTERNATIVES (SAHAJ)

SAHAJ, based in Vadodara, was founded in May 1984. Over the years it has engaged with the issues of the urban poor – those of waste picking women, street and working children, the right to shelter in the face of evictions and slum demolitions, the right to education and the right to health.

Since 1988 SAHAJ has engaged with issues of the urban poor in Vadodara. In 2002 in the post Godhra carnage period, SAHAJ was a focal point within the PUCL Vadodara for organizing relief and rehabilitation for the affected Muslim families. In 2004 and 2005, when floods wreaked havoc in the city, SAHAJ once again, along with other NGOs, organized relief for the affected slum people.

SAHAJ is registered as a Trust and Society. We are part of several pro-people networks like the PUCL, JSA, CommonHealth, MFC, Right to Food Campaign etc. Our funding has been from several sources – the Central Government, the State Government and private Foundations (Ford Foundation, SRTT, SDTT, NORAD, Arbeiterwohlfahrt, TDH etc.).

PRAYAS

Prayas is a 32 year old voluntary organization and is working directly with the socio-economically deprived communities to mobilize them, advocate for their rights and build their capacities for sustained growth and development. In past years Prayas has essentially focused on mobilizing people's groups around issues of access to food, health, *dalit*/tribal land rights, violence against women and people's right to information. It has worked on policy issues such as people's right to quality health care, against coercive population control policies, for the withdrawal of the two child policy, and for the abrogation of legislative lacunae in land tenancy protection measures for agricultural land belonging to *dalits*/tribals. The organization is also engaged in community mobilization for local people's participation in natural resource management pertaining to common property and forest resources.

Structure : Prayas currently has 75 full time staff and 150 part time staff. Activities in the villages are coordinated by the field teams. A team consists of four to seven persons, and each team has at least two women. These field teams are stationed at various locations in the working area of Prayas. Each team may be working in about 25 to 50 villages on the project/programmes for that area. There are 10 such field teams at the moment. Each field team has a field coordinator to coordinate work within the team. There is a team of group coordinators to provide support to the field teams and carry out the tasks of running campaigns, advocacy and policy dialogue. There are six such coordinators at the moment, three among them being women. The coordinators are for gender, health, education, natural resources, rural shelter, and civil liberties (human rights and *dalit* issues).

The overall responsibility for day to day functioning rests with the Secretary and the Director of the organization. However, the organization functions in a decentralized format. Coordinators have full responsibility to manage the budget and carry out activities in consultation with people and colleagues, as worked out in the project document.

Funding: Prayas currently receives funds from the following.; UNFPA, UNDP, IGSSS, DST, Action Aid India, Tata Education Trust, Asha for Education, AID USA, NOVIB, Oxfam India, Government of Rajasthan, Government of India, etc.

Age : Prayas was registered under Society's act in 1979.

Shri Gujarat Lok Swasthya Sewa Sahkari Ltd (SEWA)

SEWA is a health cooperative registered in 1990. SEWA has 825 share-holders. All SEWA members engage in health and health-related activities.

Outreach:

- 250 villages of Ahmedabad, Gandhinagar, Tapi and Valsad districts.
- 185,000 persons reached with health education.

Funding: from share capital, sale of Allopathic and Ayurvedic medicines, insurance sales.

Structure: democratically elected Board of Directors from among the members (825 share-holders)

ANNEXURE 3: KEY THEMATIC AREAS OF WORK

S.NO	NAME	THEMES					
		COMMUNITY HEALTH WORKERS	NGOs IN DELIVERY OF INFORMATION & SERVICES	COMMUNITY FINANCING	COMMUNITY MONITORING, HEALTH RIGHTS & ACCOUNTABILITY	PARTICIPATORY PLANNING	CONVERGENCE
1	SAHAJ	✓	✓		✓		
2	CINI	✓	✓		✓	✓	
3	EKJUT	✓	✓			✓	
4	THE ANT	✓		✓	✓	✓	
5	FRCH	✓			✓		✓
6	KARUNA TRUST	✓	✓	✓	✓	✓	
7	PRAYAS	✓	✓		✓	✓	
8	SEWA	✓	✓	✓		✓	

Annexure 4: ILLUSTRATIVE EXAMPLES PROVIDED BY RESPONDENTS

SAHAJ

The section below is an excerpt from a Midterm Review carried out in Oct. – Nov. 2010. This gives an idea of the progress in achieving the objective stated above.

Campaigns initiated by the community members with leadership from the Committees

Baseline: *Many bastis which are in areas newly included in the Municipal Corporation limits faced eviction because the residents lacked certificates for the plots of land where their houses are located. Almost all (13 out of 18) the bastis faced some kind of problem with water supply – in eight of them the water pressure was low, in two the hand-pumps had become defunct, in two more the water pipeline was not sanctioned and in one basti drinking water was contaminated with drain water.*

Eight of the bastis did not have approach roads and two did not have street lights, which affected the mobility of people. In one area some of the households did not have electricity connections. In general the people were not aware of various government welfare schemes for especially vulnerable categories.

The bastis did not have organized groups and focussed leadership before the project interventions. Though people were aware of the problems and the fact that they were entitled to certain services from the government, little effort was made towards claiming the rights they were being denied. Lack of information about procedures was the most important reason for this inaction.

Midterm: *Key issues that affected the health and life of people from these bastis were discussed during these mass meetings. These issues are presented in box 1. To help people to address these problems, the project organized a number of workshops for the members of the committees as well as for community members.*

Empowered with the information provided during the workshops, the members of the communities played an active role in campaigns for claiming their civic rights. While there are many successes, two campaigns have had an effect on the wider community, people outside of the bastis initiating the campaigns. These are – the campaign for addressing issues around the public distribution system and the campaign for a school in Mujmahuda. These campaigns are examples of the positive influence of project work through community participation.

Box 1: Issues identified through mass meetings

- Water supply
 - less water pressure
 - hand pumps out of order
- Sanitation
 - Overflowing gutters always/during the monsoon
 - Clogged drains
 - Lack of cleanliness around the pond
- Ration cards
 - Do not have ration cards
 - Do not have BPL card despite being in the BPL category
- No anganwadi
- Do not have certificates
- Non availability of pucca roads
- Non-availability of services to handicapped persons

Achievements

Community members organized to seek solutions to specific problems

- *Formation of Matrumandals in 17 out of 18 bastis – with the participation of 271 women to monitor the services provided by the anganwadis*
- *Matrumandals succeeded in ensuring that pregnant and lactating women received nutritional supplements from the anganwadis*
- *165 parents of students of Kavi Dayaram School took out a rally to demand a new structure for the school and better facilities for students.*
- *26 persons visited the Collector's Office to present their demand for the reconstruction of Kavi Dayaram School*
- *Six RTI applications in the names of community representatives were submitted seeking information about education*
- *People from two bastis got together to address the issue of certificates*
- *Residents of two bastis succeeded in getting street lights and in one basti poor households got electricity connections*
- *Residents of two bastis got approach roads*

Case Studies of two Campaigns

Campaign for addressing issues related to the public distribution system (PDS). (December 12 – 31, 2009)

This was a follow-up to a drive generating awareness among the community regarding ration cards. It covered the importance of these cards, types of ration cards granted, rules regarding quantities provided and the rates applicable for each type of card, eligibility for each of these, documentary proofs required and the process of obtaining a ration card. About 2200 people availed of this information and 57 persons or families completed the procedures themselves and got a ration card. Interactions with the community regarding PDS services also brought to light people's problems and grievances about them. The project and community's joint response resulted not only in the issues being resolved for the bastis, but by spilling over to a larger area it triggered a widely publicized city-wide campaign.

The campaign started with a series of meetings in Mujhmahuda where most of the families were being exploited by the local ration shop owner. Those with APL cards did not get rations, while those with BPL cards were sold goods at the higher rates meant for APL card holders. Other card holders such as Antyoday and Annapurna did not receive the services to which they were entitled. At the meetings the project team provided information to the participants about the quantity of rations APL, BPL, Antyoday and Annapurna card holders are entitled to receive, and the rates applicable to them. The participants were also familiarized with the rules and regulations set by the government for the owners of the PDS shops. As a result of the meetings and subsequent discussions the people realized that their ignorance of the schemes was responsible for their exploitation by the shop keeper.

Since all earlier efforts of the community members to claim what was rightfully theirs had been brushed aside by the shopkeeper, and since he refused to cooperate even with the enquiries of the project team, the project team encouraged people to take collective action. People who were angry because of the shop keeper's rude behaviour, practice of favouring people from his own community and inconvenient store timings, decided to come together for an action against him. Under the guidance of the project team the people chalked out their actions.

A small survey was conducted by the Community Development Committee to find out issues about the PDS shop which were found to be the same as those mentioned by people in the meetings (Box 2).

Box 2: Issues identified through a small survey

1. *Inaccessibility of the PDS services –*
 - a. *Ration shop was open only for two hours each day*
 - b. *Rude behaviour of the shopkeeper towards the people*
 - c. *The shopkeeper favours people of his own community*
 - d. *Sells the rations of PDS at the commercial rate*
 - e. *Does not provide kerosene even to those families without a LPG cylinder*
2. *Non-availability of goods*
 - a. *Does not give rations to BPL card holders*
 - b. *Persons with an Antoday card are sold goods at the rate for APL card holders, which is higher, and also given the quantity earmarked for APL card holders, which is less than the Antoday entitlement*
3. *Illegal operations*
 - a. *The shopkeeper runs two shops at a time (a general store along with the ration shop both in the same place)*
 - b. *Fake entries in the ration card*
 - c. *No details of the stock available at the shop*
 - d. *The goods from PDS are sold at market rates for the shopkeeper's personal gain*

After discussion it was decided that an application would be submitted to the PDS department with photocopies of 150 ration cards – owners of which had not been receiving their supplies. The community representatives and the representatives of the project team followed up with the Deputy Collector who promised to take due action.

Not willing to wait for bureaucratic follow up the community representatives, with support from the project representatives, organized a rally where all families who had suffered injustice at the hands of the shopkeeper gathered and shouted slogans against corruption and also against the shopkeeper. The angry group confronted the shopkeeper and demanded their rights. Surprised

by the confrontation by the angry mob the shopkeeper promised to mend his ways.. This rally was covered by the local media.

The authorities took note of the rally and the media coverage it received and suspended the shopkeeper's license for two months. It was also said that a person elected by the people would be appointed to distribute the rations till a more permanent solution could be found. Unfazed, the shop keeper continued threatening and harassing the people. The people from the community got together and submitted an application to the Corporation conveying their fears and seeking protection for themselves and their community. In response to this the PDS officials visited the basti bringing the ration stocks, and unloaded the stocks at the house of a Community Development Committee member (a person elected by the community). The very next day a responsible representative from the PDS department came to distribute the rations.

This boosted the morale of the people and they now feel empowered to raise a voice against injustice.

Subsequently the city-wide campaign resulted in the PDS department cancelling licenses of four shops and also resulted in better behaviour and transparent services from the ration shopkeepers in general.

The rally was reported by the women participants at the group discussions held during the Mid-term Review, as an important activity undertaken by the project that influenced the quality of their lives.

Campaign for Kavi Daya Ram School in Mujhmahuda

The government school in the area was inadequate. The school conducts classes till Std. VII and they were all held in a single hall, which severely affected the quality of education. According to the parents and the tests conducted by the project, the students who studied in this school could neither read nor write. The school also lacked basic facilities such as toilets and drinking water and the roof leaked in the monsoon. Because of the poor state of the local government school parents from this area had to enroll their children in a nearby private school (or commute to another government school about 30 minutes walking distance from the basti). The parents had complained to the school authorities a number of times but to no avail. The project team helped and supported the community representatives chalk out a course of action.

In January 2010, parents of students from the school as well as other community representatives met the Corporator for the area and were told that rebuilding of school was a complex issue, resolving which could be a prolonged process. Undeterred, 165 community representatives took out a rally to the school where they held up placards showing their demands and locked the school. When the group did not disperse despite police threat, the Chairman of Education Committee and the Mayor personally visited the school, met the protesting group and promised a new building by the time the new school year started in June 2010. The promise was not kept and there was no action by the authorities even seven months after the promise.

The project team then conducted meetings in the basti and it was jointly decided that the representatives of the community would meet the Collector and submit a letter regarding the school. It was also decided to use the Right to Information act (RTI) to seek information on the progress regarding reconstruction of the school. Six RTI applications were developed in the names of six persons from the community. These RTIs sought to get information on: Sarva Shiksha Abhiyan, the efforts made at various levels for the reconstruction of the school, and the steps taken by the Collector and government officers regarding the school.

A meeting was held with residents to emphasize the importance of the process initiated regarding the school, which included issues such as right to education, the need for follow up on the promises made by the authorities, the importance of unity and organized efforts, and the importance and potential effect of people holding a dialogue with the Collector. Of the 52 persons who were present for the meeting, about 26 people agreed to visit the Collector's office.

After stalling once, the Collector agreed to meet the group. The meeting was widely covered by the local media. The Collector listened to the community representatives, acknowledged the agitation on the part of the people and said that the Chairman of the Primary Education Committee had all the authority in this regard. This Committee had funds as well as land at its disposal for the redevelopment of schools. The Collector telephoned the Chairman of the Primary Education Committee and sternly asked him to follow up on the reconstruction of Kavi Dayaram School. He assured the people's representatives that the government would provide them with a school that would have all the facilities that a private school offers. He also said that he would ensure that the school would be built in a location within one km of the basti.

Six RTI applications seeking information on various issues related to education were submitted after meeting the Collector.

In October 2010, the issue was discussed and the government declared that it had identified a plot on the periphery of the basti where the school would be constructed.

***Other achievements** in the context of community participation include: people's active participation in the processes for ensuring garbage collection services from the Municipal Corporation, actions for addressing issues regarding problems with drinking water in the areas, demand for approach roads, application for obtaining certificates by about 1000 families from one basti, and application for street lights in two bastis and electricity connection to homes of some poor households from one basti.*
