CENTER FOR HEALTH AND SOCIAL JUSTICE

Workshop on Decentralized Expenditure Tracking and Monitoring in National Rural Health Mission

December 13th – 14th, 2011

Organized by: Center for Health and Social Justice
Basement of Young Women's Hostel No. 2 (Near Bank of India)
Avenue 21, G Block, Saket
New Delhi-110017

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Context

Decentralisation, communitisation and accountability are key principles of NRHM and there are mechanisms which promote this including- district planning, community monitoring, institutions like the Rogi Kalyan Samiti and Village Health and Sanitation Committees and the mechanism of Untied Funds. In the first phase of the NRHM which is drawing to a close, some initiatives were taken to ensure accountability through the mechanism of community monitoring, however there were no 'official' mechanisms for financial accountability which included a strong role for communities. Independent efforts were made by some civil society organizations to test and pilot different mechanisms for financial accountability including the review of untied fund spending, district planning, community based expenditure awareness, tracking of supplies and medicines and so on. This workshop aims at bringing together some of the organizations who have been involved in such experiments and to share experiences and find ways to take this process forward.

Objective(s) of the Workshop

1) To develop a shared understanding on the need for decentralized expenditure tracking and monitoring in NRHM
2) To share experiences of expenditure tracking and influencing local planning within NRHM
3) To develop plans/processes for expenditure monitoring / tracking and related advocacy into existing practices

Day One December 13th 2011

- Context and Welcome: Dr Abhijit Das
- Experience Sharing and Presentation- CBGA
- Experience Sharing and Presentation- SAATHI
- Experience Sharing and Presentation- CHSJ
- Any Other- General Discussion

Context Setting and Welcome

By Dr Abhijit Das

Abhijit Das welcomed all the participants. He stated that in the last 4-5 years, in India, there has been a new experiment to do a little inquiry into the social programmes where the citizens can examine public programme functioning. We would like to take that process forward. Under NRHM, Community Monitoring has been initiated in many states. Through this process, effectiveness of public programmes has improved because of closer inspection by the public.
Where we have got a little space to carry this work forward, we have also faced obstacles in some places like Rajasthan and Orissa. The space from Government is not a continuous space. The government has often reluctantly provided space. It has been part of state PIPs but not been implemented everywhere. Even in Maharashtra where Community monitoring is a success there is constant call for exit strategy. This is a contested space. But this doesn't mean we should not use this space, we should work to increase this space.

In the last 2 years, in the expenditure component, in NRHM there is an increase of budget and decentralization and also of planning of budget. Untied fund is at every village and district hospital, where some amount of money is made available for local planning. So we are trying to see how we can extend community monitoring, citizen oversight into the realm of money. Also, if there is no monitoring on budget, oversight on programmes is not very useful.

Abhijit then welcomed all the members present that included our partners, some experts and friends who were here to help us all explore what is possible. He also formally welcomed Dr. Aaron Katz from the University of Washington who has been involved in Public Health policy for decades. Aaron has been a mentor and a technical expert on our project with International Budget Partnership. During the meeting, we would try to take feedback and suggestions from Aaron.

After the context and welcome, Abhijit asked all those present to give a brief introduction to their work and their involvement with budget tracking.

Abhijit thanked participants for the description of their work and lauded the commitment shown by all participants towards increasing financial effectiveness.

Financing Mechanism and Budget Tracking under NRHM - CBGA

By Javed Khan (Please refer to Annexure 1 for presentation)

The presentation will focus on decentralization in terms of planning, budgeting and budget tracking. After this it will discuss the policies and the method to use to analyze the expenditure. In the end we will share some of the experiences.

All development programmes and policies in India are introduced through 5 year plans of the Planning commission. The Government of India assessed in late 1950's and realised that the top-down approach is not working and a three tier panchayati raj system was envisioned from 1959. In 1992, 73rd amendment was implemented. Subsequently however a constitutional body at the district level was planned for decentralized planning. The DPC will take place and ward panchayats will discuss the plans, which then will go to the Village panchayat, then to the block for discussion and then finally to the district. This was envisioned in the district plans.

Areas of activity for the panchayat will be identified. The 73rd amendment identified 29 subjects, including health and sanitation. Standing committees will be established at the panchayati level which will from 29 subjects, focus on 5-6 subjects depending on the local priorities. In this way, health and sanitation were considered priorities at the village level even at the time of the 73rd amendment and that local committees will think in detail about these.

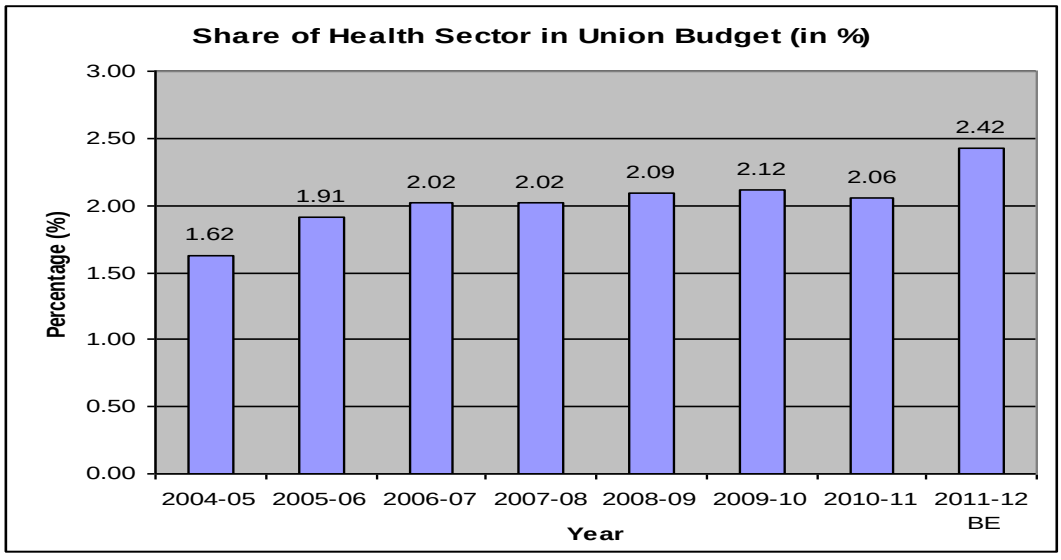
In 2005, in NRHM, decentralized or community led process began. It also spoke of panchayati raj system. The panchayati raj is a 3 tier system which has the Principle of Subsidiarity- the sub-centre, primary health centre and community health centre have powers but they do not overlap as they have powers at the appropriate level -planning to be done by village level not district level. Yet the upper bodies will be involved in monitoring. NRHM also spoke of clear power demarcations.

Regarding Budget tracking- we have to know what is being spent nationally on health. In India, the public expenditure on healthcare as % of GDP is less than 1% and private expenditure is 3.3%. These figures are different when compared to USA and Canada where the public expenditure is more than the private expenditure.

Country	**Public Exp. on Healthcare as % of GDP 2006**	**Private Exp. on Healthcare as % of GDP 2006**
Sri Lanka	2.0	2.2
Canada	7.0	3.0

Spain	6.0	2.4
South Africa	3.0	5.0
Costa Rica	5.3	2.4
Malaysia	1.9	2.4
Cuba	7.1	0.6
USA	7.0	8.3
UK	7.2	1.0
China	1.9	2.7
India	0.96	3.3

The share of health sector in the union budget was 1.62% in 2004-2005 and in 2010-2011 it is 2.06%. When we talk about the human resource development then we have to ask whether the government allocation is adequate or not.



The Centre and State expenditure on health and family welfare also show that state is contributing significantly to the expenditure.

Year	Centre's Expenditure (In Rs. Crore)	States' Expenditure (In Rs. Crore)	Centre's Expenditure as % of GDP	Total Exp. (Centre + States) as % of GDP
2004-05	8085.95	18771	0.25	0.83
2005-06	9649.24	22031	0.26	0.86
2006-07	11757.74	25375	0.27	0.86
2007-08	14410.37	28907.7	0.29	0.87
2008-09	18476	38578.8	0.33	1.02
2009-10	21680	43848.18	0.33	1.00
2010-11 (RE)	25055	-	0.32	-
2011-12 (BE)	30456	-	0.34	-

The funding mechanism in centrally sponsored schemes, builds in state ownership so even in NRHM, the states must contribute. 85% is centrally contributed and 15% is state contribution. When we talk of community monitoring and decentralized expenditure tracking- the village plan, panchayat plan and project implementation plan is made. It is the PIP that determines to a large extent the budget allocated in NRHM.

The funds allocation is as follows: the first two installments are released unconditionally but subsequent ones are subject to expenditure of at least 50-60 percent of funds allocated.

The Union Government's contribution to NRHM does not figure in the State budget as funds go directly to the State Health Society, bypassing State budgets.

Proposed Outlay for Eleventh Plan by the government in Rs. Crore (at Current Prices) is 89478, while till 2011, only 77 % has been allocated. When the entire amount has not even been allocated, the utilization of course will be worse.

Proposed Outlay for Eleventh Plan (Rs. Crore) [at Current Prices]	Allocations Made during 2007-08 (RE) (Rs. Crore)	Allocations Made during 2008-09 (RE) (Rs. Crore)	Allocations Made during 2009-10 (RE) (Rs. Crore)	Allocations Made during 2010-11 (RE) (Rs. Crore)	Allocations Made during 2011-12 (BE) (Rs. Crore)	Total Budget Outlay Made in the 11th Plan (Rs. Crore)	% of Allocation in the 11th Five Year Plan

89478	10669	11930	13378	15037	17924.8	68938.8	**77.0**

We can see the per capita per annum expenditure of states on NRHM below:

State	**2006-07**	**2009-10**
Bihar	26	84
Chhattisgarh	83	101
Himachal Pradesh	88	251
Jammu & Kashmir	47	135
Jharkhand	31	64
MP	53	107
Orissa	51	161
Rajasthan	48	152
UP	38	114
Uttarakhand	51	147
Arunachal Pradesh	*267*	*549*
Assam	*74*	*256*
Manipur	*88*	*263*
Meghalaya	*79*	*292*
Mizoram	*304*	*600*
Nagaland	*171*	*293*
Sikkim	*171*	*598*
Tripura	*88*	*228*
Andhra Pradesh	50	93
Goa	28	112
Gujarat	41	110
Haryana	33	136
Karnataka	35	114

Kerala	12	113
Maharashtra	22	95
Punjab	33	88
Tamil Nadu	49	105
West Bengal	31	82
INDIA	**40**	**113**

Similarly, the below table shows the capacity of states in utilizing allocated funds:

	2007-08		2008-09		2009-10		2010-11	
State	Exp.	Exp. as % of Allocation	Exp.	Exp. as % of Allocation	Exp.	Exp. as % of Allocation	Exp. (Upto 31.12.10)	Exp. as % of Allocation
Bihar	**423.25**	**71.7**	**783.19**	**100.7**	**798.98**	**92.7**	**461.51**	**46.1**
Chhattisgarh	197.77	88.8	162.12	62.5	239.06	**81.5**	147.87	44.0
HP	56.55	84.0	94.84	122.0	167.28	**171.7**	86.58	78.3
JK	75.27	86.5	111.94	109.5	153.94	**113.6**	91.41	59.4
Jharkhand	124.99	46.9	299.3	101.8	194.49	**55.5**	189.24	47.3
MP	645.7	93.6	686.97	112.8	745.5	**105.4**	520.25	68.7
Orissa	295.07	76.9	334.05	85.0	645.31	**140.6**	370.94	75.2
Rajasthan	537.65	94.0	909.16	152.4	997.11	**157.4**	670.74	90.3
UP	956.47	72.2	1546.06	89.5	2212.4	**118.3**	1131.62	54.0

Uttarakhand	335.33	61.6	563.75	88.1	722.32	**106.3**	461.38	59.7
All India Total	**7010.07**	78.5	**10565.1**	103.7	**13121.95**	**113.1**	**7832.96**	60.9

When we talk about expenditure tracking, the following can be used for tracking-

- Through data collection at state, district and block level
- Utilization Certificatess
- Quarterly Progress Report,
- Financial Management Report
- Statement of Expenditure
- State PIPs
- District PIPs

In two districts studied by CBGA, it was found out that ANMs were not able to utilize Untied Fund. ANMs were afraid of using them because the guidelines had restrictions and so it was used for purchasing some instruments or chairs and tables. Therefore, there is a need to provide simple and transparent guidelines for utilizing untied funds at SC, PHC and CHC level as well as VHSC funds. Both these funds remain underutilized in most places. Untied funds at the disposal of Chief Medical Officers are a major form of leakage. These funds were mainly seen to be utilised for minor repairs and maintenance, for buying fuel for generators, local purchase of emergency drugs when in short supply, providing shelter to patients and attendants, employing contractual staff for ambulances and improving quality of care.

A para culture has been created at the village level and this sometimes makes people uncomfortable. Also, there is a lack of a culture of training at the level of Rogi Kalyan Samiti and VHSC. Pachayat should also be involved in this.

Discussion

The question was raised that why there was a big jump in allocation at the centre's level from 2005-06 and 2010-11. Javed stated that it may be due to the appointment of human resources and the construction activities. It took some time to build capacity to initiate this programme and gradually the states were able to appoint staff and purchase drugs.

The NRHM form is deposited in state health society which has its own budget. The state must contribute 15%. There is a component where state has to send money to the society, which is why further allocation from the society takes time. The state sends aggregate budget depending on installment also.

What is the kind of coordination between VHSC and Panchayat body which will further improve process of planning, implementation and monitoring? In reality they are often not working together. It was envisioned in NRHM that the village level planning will be improved when the budget is known. For instance in the untied fund- a member from panchayat/ sarpanch and the ANM/ASHA will have a joint account and they will decide on what to spend. Yet, some problems remain. Guidelines must be made simple and improved as budget is not going to the village level.

Financial management is so weak. The allocation also depends on how much you have been able to spend till then. It sometimes takes more than a year to settle advance and clear bills. Rajasthan got a prize because of highest expenditure but there are little changes on the ground level. Whatever money was spent in two districts, got spent in the last quarter and all bill vouchers were between 25-31st March. In most other places also, most expenditure is in the month of March when accounts have to be closed.

In Chattisgarh, the monsoon is between May and September and all preparation and maintenance for it must be done by May but the fund is received during October-November, rendering it useless for the monsoons.

Documents are not available very easily and sometimes we have to go through the Right to Information Act. Also, MIS and Data keeping of NRHM is really poor. The same information is different in different places.

Monitoring of medicine availability and distribution at PHC level – Saathi

By Dr. Nilangi Sardeshpande (Please refer to Annexure 2 for presentation)

Nilangi stated that one thing which helped them in their work was that they were the state nodal agency for community monitoring. Those who do not have this identity and space provided by the government, might find this work more difficult.

We realized that a major problem was that people don't get medicines in government hospitals and in spite of going to public facilities; the expense is a lot and the majority of expense is on medicines. When we started working on this project, budget tracking initially was not our focus, but that why medicines are not being provided or are not available- for which we wanted to look at the budget. When you want to track budgets you have to look at the systems which are doing the purchasing. Purchase of medicines, bringing them to the Primary health Centre and the budget must all be seen together.

We found that usually all information is available except expenditure details and supporting documents. Medicine procurement sees a lot of corruption. While there may be transparency in other areas, there is complete opaqueness in procurement, especially so at the lower level.

We also found it paradoxical that we have production capability and they are priced low, in fact we are supplying medicines to outside nations, yet within India, the medicines are unavailable and the lack of access to medicines is a critical issue.

Our focal point was PHC and what are the areas of corruption in procurement and distribution. Procurement of medicines is not part of NRHM. There is a tussle between the Health departments and NRHM where the latter has increased the capacity of states. The actual procurement is through the health department where the local politics plays a major role. There is also lack of uniformity in information keeping, when the pharmacist changes and is not trained, there may be a gap of 6 months when there will be no record maintained. Usually information is not in the form where it can be used. Corruption is seen when medicines are bought in large quantities when it is not needed, just because the margin of profit is a lot. Medicines may be available, but not reported.

We tried to see what is the per capital budget allocation for medicines in Maharashtra but there are so many sources of medicines- sometimes medicines are allocated directly, sometimes it is a budget that gets allocated- that it is very difficult to do any analysis. In untied fund, there is a component where medicines can be bought locally but locally purchasing medicines increases the cost. The same if purchased at the state level after pooling will bring down the cost. A paracetamol bought at the state level may cost you 10paise but at the PHC it is likely to cost 1rupee (10 times as much). This is also an important part of tracking budget- the effective utilization of funds. In a comparison

between Tamil Nadu and Maharashtra, while both states have a per capita expenditure of Rs20/- since Tamil Nadu buys the medicines cheaper, they have medicines available. Corruption is also when medicines are bought in excessive bulk and all near expiry date.

About 35% to 40% of essential medicines were completely unavailable in the studied PHCs. Only 25% of medicines were available in satisfactory quantity. Around 10% medicines were excessive in stock. There were many essential medicine having zero stock and were still not supplied to PHCs for a very long period.

All medicines are sent in the same combination to all districts- instead of sending additional supply of anti-malaria tablets to an affected area, they may be sent in same quantity to areas which don't have this problem. Similarly, anti-snake venom is also sent to areas where there are no snakes, while in areas where there are snake bites, people often die due to lack of available medicines. It is important to do a disease profile of the area. Therefore, transparency in procurement is an essential component to see the efficacy of budget.

We also did expenditure tracking of untied funds to explore the various reasons for the problematic expenditure. We found that statements of expenditure were usually sent as lump sums- Rs25000/- spent on stationery- but to get an itemized bill would be difficult. Similarly, 70% of purchases are often clubbed under 'miscellaneous' expenditure which makes it difficult to understand and analyze them. Often, large sums of money had been spent on one item but it wasn't possible to know the decision making structure behind that. We are trying to upscale this study to get a better idea.

In one district we found that 88.6% (Rs 22,150) of the Untied Funds was spent on stationary. 41.3% (Rs 66,670) of the RKS funds and 44.7% (Rs 5,36,979) of the IPHS (Indian Public Health Standard) funds were spent on purchase of equipments and instruments. Rs42,500 of the RKS funds were spent on water storage and repair and Rs39,650 of the RKS funds were spent on furniture.

We also realized that no one wants us to look at funds utilization. It is one thing to get the detailed itemized bill, but we need to actually go and verify that the items mentioned are actually present- water coolers and water purifiers were purchased, but were they present and functioning. A pediatrician has not been appointed but all the medical equipment and apparatus has been purchased.

Discussion

Do we need to always go through Right To Information? There should be a state monitoring committee and that should be in charge of procurement. This is our advocacy demand.

What is the mechanism for deciding which medicines will be purchased and where? There is guideline for this. There is rate contracting. Rates are fixed by state departments and districts place order and purchase at that rate. These rate contracts are for two years or whatever time decided. It is a contract and cannot be changed in between. Now they are starting with e-tendering.

Community Expenditure Tracking – in Two States of India

By Sunita Singh, Pradip Pradhan and Jiban K Behera (Please refer to Annexure 3 for presentation)

The first phase of community monitoring took place in 9 states and CHSJ was a part of the Secretariat and we were providing technical support. At the time we started our project, we had assumed that VHSCs have been established and members have been trained and they know what community monitoring is about and there have been one or more rounds of community monitoring in that area. For this reason, Assam and Orissa were chosen and those blocks were chosen where community monitoring was taking place. We went with the assumption that at the village level there was high prevalence of disease and people go very ill-frequently to public health facilities and there is poor quality of services in public facilities. Community doesn't do planning and monitoring. It has no knowledge about funds and how much expenditure it incurs. There is low community involvement in planning and monitoring. There is low awareness about health and financial entitlement among community members.

We wanted the community to build its stake in its own health and in the monitoring of facilities. We did community mobilization. Songs were made, entitlement kit was made, wall writing was done, posters were made, etc. We also did training of VHSC, RKS, and Community Leadership. We did orientation of providers- MOs, PHCs and Sub-centre providers. We have planned a Sharing advocacy also.

Project Objectives were to increase communities' involvement and interest in public budgets and expenditure; to increase transparency and accountability regarding health expenditure utilising communitisation provisions in NRHM and finally to increase community faith in and increase utilisation of public healthcare services. The Short Term Objectives were to develop a community health and financial mobilisation and education package; develop a community level tool for monitoring budgetary expenditure; to build capacity in community leaders to monitor expenditure around flexible financial outlays at community and district level and finally to test the intervention and develop a tested package which is ready for replication within the current NRHM context.

For this purpose the method/ activities were to develop inputs by Mobilisation of the community, Orientation of VHSC/ RKS members/ Community leadership, Orientation of providers / Interaction, Community Enquiry, Sharing of results between community, leaders and providers for feedback and planning, Follow up and advocacy, Review

inputs, processes and outputs, VHSC training issues/ package, Community enquiry package.
We realized that decision makers who have the power to influence this issue include at the Provider level – ANM Medical Officer, District CMO; at the level of the NRHM mandated managers – DPM, BPM; the State level functionaries – Consultant, Mission Director, Director of health services, State NRHM officials and members of Local self governance: VCDC, Panchayat.

The expected outcome at the community level was increased awareness about health related expenditure and increase ability to negotiate with provider; reduced financial burden and out of pocket expenditure; Increased utilisation of public services; Community engaged in health related planning and monitoring through programme provisions.

At the community level we also did village mapping and in fact gave a copy of the village map to the village itself. We also did sharing of the report card and gave instant feedback to the community. We did interviews with the medical officers and asked about the fund allocation. We did some desk review. We conducted Mobilizing meeting under Community Enquiry. Through the freelisting exercise, we told the villagers about the local diseases. Villagers were actually surprised to know how much they spent on health care- direct and indirect cost.

Some of the issues which we have encountered:

The environment is not in the direction of community monitoring. No one is prepared for this. While working with the community and GKS members- we saw that funds are allocated in March and immediately the utilization certificate has to be given. So there is a practice of sending false bills. A plan often comes to the village so even the untied fund in reality is not an untied fund.

Further problems on the ground include that even if the ANM does not visit the village, she gets paid and there is always reluctance on the part of the community to register complaints against the officials. During delivery the doctors ask the patients to purchase the medicines. Doctors do not come for the public hearings.

There is often a resistance from the government's side and we have to turn back. We have submitted many RTIs to get information and 8 months have passed but we have not received information. We have complaint to Information officer also but the case has not come up for hearing.

One of our objectives was that if the community is aware of its own expenditure perhaps its own health seeking behaviour will change and it will push for public system utilization. We found that there are some changes in behaviour. People are aware and sensitive. They have written complaints about absence of doctors or medicines. But in most cases, there is no alternative other than going to the private doctor. It is also true that the private doctor has more to lose if the medicine does not work. In public health

facilities, we saw that symptoms and treatments do not corroborate. The patient will most likely not be cured.

On the bright side, there has been some progress also. Doctors are with us and are sensitized also. We have strengthened the GKS and they have made their own plans. But a lot of work needs to be done at PHC, CHC level.

We wanted to see if people become aware of enormous health expenditure they have to incur due to the current health seeking behavior then will there be a realization that I am in deep trouble. Will there be a concern about the very high cost. Unfortunately, the most expensive is often considered the best. The enquiry process that CHSJ started, was a means to reflect and think about the expenses in a non-critical time. When there was no health emergency, then to allow that kind of thinking to take place.

Discussion

There was no awareness about Janani Express and delivery kits. How should we make the community aware that this is their right? Right now we focus a lot on teacher – student ratio in schools. What should be the doctor - patient ratio in hospitals?

One way is that you need better administrative service. The upper body should pressurize the lower body and use power to influence. But this goes against the democratic principle. Also, when you are sick, there is no space for negotiation. You will spend as much as you are asked.

Another important problem is that usually our planning is not done keeping in mind the local realities. The services that we are claiming to provide should be possible at ground level. It is very frustrating that you build community's interest in availing public facilities, only to find that the public facilities cannot render the services. In some places the situation is grimmer. In Kandamal district in Orissa, a sweeper is running the PHC.

There is a provider level frustration also. The Medical officers are understaffed; ANMs are looking at 5000 people. They are overworked.

We must also strategize on how we can use the election time for the community's benefit.

The political answer to these problems is to make many centres and duplicate all the services in all of those centres. However, this method fails precisely because no centre tends to have all the services that it should. So to find the entire set of services in any one centre is almost impossible- rendering all the centres seriously lacking. The management solution to the problem is to have one good centre and focus all the services in that centre so that at no time will any service be missing from at least one centre. Also, we can loan services out of that centre.

Need for and Opportunities for Decentralized Expenditure Tracking - Discussion

As CBOs and NGOs, our strength is community relationships. We used to work with community. For some years now the government has told us that government can be good. Now we have spent a lot of energy on making the government good. Earlier we used to run alternate service delivery mode. Now all our focus has become government.

A problem however is that if we do decentralized expenditure tracking, we are asking information very close to where the correct/incorrect decision took place. In that case the threat became very high.

So we must examine what our intent is. Do we want to bring out corrupt officers or do we state that the system is such that it allows for corruption. Sometimes our anger is towards a person, not the system. Also the data should be collective so that one person/thing is not targeted.

Also we must ask how many times should the community be involved in monitoring- first for health and then again someday for education and then for something else. We are paid for this as this is our job. But for the community, this is not something they get paid for. People do not think of health as an issue. Food, water, sanitation are issues.

If community takes an initiative then the change is seen definitely. In the community there must be awareness of problem and the solution must be found at the community level. The time needed for this work is a lot- it has to be much more than one year. For community negotiations 1 year is inadequate. This was done in a project mode. But to get the whole community together, get a consensus and to see their priorities will take time. And health seems to be a technical issue so there is often a power relationship with it.

If we convince the community on the need for something, like low-cost toilets, then the money will not be needed from government. Kedarnath spoke of a village, where they managed to stop open defecation. The village also received a prize money for being 'Open Defecation Free', the money was again spent on repairing the toilets that were made. Therefore, sometimes due to heavy investment on the government, there is a paralysis. We should continue to work with the community.

So what should be the role of the community in budget tracking? Will it be better done by a 3rd party stakeholder because it may require technical skills? The community is capable of monitoring 300-1000 rupees. Monitoring purchase/procurement is practically not feasible for a community especially in tribal groups.

We can use the panchayat meetings to do our monitoring also. As the ASHA, ANMs and PHC doctors are present in these meetings, we can use the discussions also to do our investigation.

Most state governments have not given any financial help to Panchayat government. That's why centre is helping panchayat. For youth leaders to have interest in panchayat the community must be interested in panchayat. Does the community as a whole have any interest in the panchayat? Does the community think that its problems will be solved or addressed by the panchayat? If the expectation is not high, then we need to reinvest in the panchayat and build trust in it. We must not lose trust in the democratically elected institutions.
Sometimes it is easier to talk about decentralization and get the government to take steps but at the lower level, the ground must be prepared for it. All policies should not re-strengthen the local hierarchies. In this respect we can try and involve the youth.

We must also ensure that there are some simple mechanisms to stop corruption like marking and labeling assets bought with the untied funds- with the year and price. This will ensure that the same asset is not passed off as being bought each year. Similarly, documentation must be simplified and it should be clearly specified what is a good purchase or what is allowed. Government documents are very lengthy and complicated for the community to have success with them.

Point to be noted:

1) Our objective is to make the public system follow structures that are built.
2) Communities start participating in planning and monitoring of expenditure. When community does this, it is because they are concerned only about their welfare. So we must invest in community empowerment so that health is an issue and there should be health planning in village and then the government takes some steps and so there is hope for the community. Problem analysis and planning should be done by the community
3) We must use existing planning platforms- untied funds, RKS, Panchayat.
4) At the community level, we must observe these platforms and ensure that the platforms directly interacts with us. There should be direct interaction.
5) We must take the help of technical agencies to make this process simpler.
6) All expenditure statements and all products must be made transparent and there should be acknowledgment.
7) Some sections of community require special training- like the youth.
8) In our minds, we must strengthen the democratic spaces- the panchayat may be corrupt but it is an elected body- it should be an important part of community monitoring that panchayat is strengthened. We have to develop the culture of democracy and questioning.

Advocacy with Local Authorities – By Aaron Katz

The discussion made Aaron realise that realities are the same in India and the US. The work is difficult. On community level we are trying to change traditions. We are making changes in the bureaucratic setup as well as in the political structures. We must understand and remember that the person with whom we work- the bureaucrat is also a person and he/she would be interested in doing the work well. He/she is doing the work in spite of the limitations. The bureaucrat is not our enemy. Just as we have our frustrations, so does the bureaucrat. That person does not even have a clear role description, what are the expectations, what is the work that they must do. If we can give them the information, then it helps them. We can fill this information gap. They may not know what decision is made above or below them. We can collect and provide information. Another interest that the bureaucrat has is to be seen as competent and successful. As advocates we can help bring them into that light. This is true of elected officials that if they have an idea what will help their community, they will do it. As a strategy, the elected representative can show that this is his/her idea. If it is something we believe in, then it does not matter who gets the credit as long as the work gets done. The bureaucrat likes a good reputation which makes them get elected again.

All of this is about relationship- another lesson is of developing maintaining relations- whether we agree with them or not, in local and state level politics we have to fight with the same people today and work with them tomorrow. The relationship must sustain over arguments and victories.

These changes take time. It takes time to build a culture in community/ bureaucracy and in order to sustain our effort over time, we have to build institutions/ structure/ NGOs that can last over time and be persistent. This will happen after a 2-4 year project so we have to build organisational capacities that can do this work over time. Communities don't fragment their life into health, education, etc., so people who are working in rural communities do not have a lot of time and all the time cannot be spent on influencing authority. So we must build community authority because some people will have an interest in health- like teachers and organisations can provide vehicles for these people to help them in areas they are interested in. One person can not do all this. Multiple interest community coalitions must be strengthened.

Aaron further stated that this decentralization that we are experiencing is a part of American life from the beginning- the US has many local governments. In order to have influence over time at all of those levels, we need organisations at all of those levels which collaborate. Aaron's organisation does budget monitoring- it is part of network of similar state organisations, which are coordinated by a national level organisation. Through this network we can influence central government issues, but also the state level and feed from state to central. There is a network that goes up and down. Decentralization is very important to have all the different levels of effects. We need change at all levels. We cannot work alone at one network.

Some organizations like peoples' organization (membership organisations) have a formal group of members and have many ways by which individual members can be involved from little involvement to being involved in an organised lobbying effort. Other organisations which are non membership organisations are involved in community coalitions. We have a history of organisations. We don't like governments having too much power in the US. We have created over tens of thousands of organisations including voluntary organizations which provide services which we think the government must provide. Americans have very many opportunities to involve in such organisations. You will find many leaders who arose from these organisations- like Barrack Obama. This history of volunteerism is 300 years old. Somewhere they put pressure, some where they provide services. Aaron also said that it is a part of his family tradition to be involved in this work.

In the US, there are legal structures and laws that facilitate civil society activity. A law that is common in both countries is the freedom of information. There are many laws that are for NGOS to provide services to communities. There are also tax laws that help to support NGOs by way of a taxation exemption to the donor. Without the tax benefit, many CSOs would not exist. The political leadership can make a difference on how accessible bureaucracy is to civil society. In some programmes CSOs are also part of the visioning so they are not treated with suspicion.

Given that the socio economic status in India is different, a huge number of people will not be a part of CSO volunteerism.

Aaron was asked that in the US, you can take for granted that people would be aware and can question policies, which is not so in India. Aaron clarified that the contexts are different and it is more a matter of degree. There are many people in US who are not aware of what is happening in their own communities. Poverty and illiteracy are much deeper in India than in US but still there are communities that are very disempowered. So there is a huge challenge and we have to start with what we have. You must start with building organizations which may be small- like a social club for youth. But you have to help community build confidence and have a sense of power when they work together. Aaron accepted that work in India was difficult and yet that he knew in his experience that people working together can do very big things although it takes times.

Huge mass mobilization is possible with the poor. We must make health an issue of identity. Some huge mass mobilization has taken place when people have made issues a matter of identity. Water, land are issues of identity and there is often a mass mobilization on these.

Another thing that is disempowering people and communities is that people no longer think of themselves as citizens but as consumers in a market place. There are no connections. In the US also, people going to the hospital as called consumers. This has a disempowering effect. To help people see the common interest and to hold government accountable for money, etc. needs mass movement.

Summing up the discussion Abhijit stated that we have accomplished a lot in one day and on the next day we will consolidate and think of a coalition and think of ways of advocating and move towards planning.

Day Two December 14, 2011

Objective(s) of the Session

- Ways forward - working with different stakeholder groups, State level, District level, Block level, RKS, VHSC and Community
- Consolidation

Ways Forward

-Working with different stakeholder groups, State level, District level, Block level, RKS, VHSC and Community

All participants were asked to summarize their biggest learning from the previous day's learning.

Sharing of Day on Learnings;

1) The budget expenditure can be tracked and decenterlised planning is state's priority.
2) The Community participation is important and it expenditure tracking is possible with the help of community participation.
3) The community participation can be ensured by bringing community issues on top.
4) It is important to oppose issues / decision that are not good for community rather than opposing person.
5) There is a need to involve Panchayaty Raj Representatives in health issues in order to make community stronger.
6) It has been seen that community doesn't see health as problem, thus there is need to bring health on community's agenda.
7) Budget tracking at the local level very important thus community should be involved into it.
8) The reaffirmed community monitoring helps in empowering citizens by ensuring transparency and accountability.
9) The linkage with women's health and NRHM, expenditure tracking are important.

10) It would be useful to bring in youths of the village and those community members on board who have lost the panchayat elections as they are the people who can appose Panchyat's unacceptable decisions.
11) The community monitoring process helps community to realize about the service entitlements that they suppose to be getting from the system but it is important to get prior information about actual service availability at the centre. This will help in building people's trust on health system.
12) There is a need to have two levels of interventions – at the community level and at the system level. The monitoring of drug supply and other equipments are important component of community monitoring.
13) There is need to balance between community's anticipations and limitations of service providers or bureaucracy. More energy is needed to work with community but also one has to understand that the person in power or the bureaucrat is also working with challenges and obstacles and that he/she is not always corrupt.
14) There are sophisticated ways of doing the tracking but how should the community use them? Investment on community empowerment must be sustained. This will be time taking but results will be sustainable.
15) There has been a re-articulation of faith. Yet the community need not check as an accountant. Our method usually is the inspectorial audit approach. We can take a co-traveler and participant approach at the time of decision making.
16) The youth group has energy and we should think of youth group. The youth can be taken as allies and see how to bridge between community and system.
17) Dissatisfactions within the community regarding service delivery is common there is need to build an alliances.
18) The allocation of medicines and how to manage it properly it essential.
19) The challenges are similar and it reinforced the importance of thinking about stakeholders and how we can find common interest – with youth, elders, and bureaucrats and to help them so that they can help us.

Group Work

Abhijit started the discussion on how we should strengthen our work in the future, especially for the community level health expenditure tracking.

Two groups were made. The first group discussed the community level and the second group discussed the facility level- PHC and Sub-centre level facility.

The discussion was around the following points:

- Issues
- Method (How)
- What additional inputs are needed (not financial) – technical, relations, ideas
- What mechanisms are available at community level?
- What inputs do we already have that we can share?

Group 1- Budget and Expenditure Tracking at Community level

Group members- Shakti, Ratneshwar, Devender, Ragini, Pratibha

Issue: Budget tracking on all issues.
Methodology:

- Community organization
- Capacity building based on issues- training programme of village health plan, need assessment, expenditure analysis, planning and monitoring process, developing leadership to continue this process in the village
- Orientation to community to make it an issue of their existence
- Planning and monitoring process
- Information dissemination
- Social audit
- Exposure where ever the process exists
-

Inputs that we already have: In technical input, we have issue based knowledge, mobilization, organization and community skills, knowledge of community based institutes, good relationship with CBOs, contact with frontline workers.

Additional inputs that we need: Information about budget allocation and utilization of funds at PHC, CHC, VHSC, then at RKS level. We need PIP copies, NRHM guidelines, IPHS parameters, need information on human resources available at PHCs and CHCs. We need to develop a relationship with the ASHA, ANM, PRI level and with the Block level and with external agencies that are working on this issue.

Discussion

While dealing with expenditure tracking, we should not focus on everything- we have to start with what would be feasible and practical. We can have cycles and be multi-sectoral but graded. We should start with health and rights based approach and when they learn the method then it can be applied to budget track other areas. They will develop the habit of tracking and monitoring. Yet we must prioritize what the community should begin with.

We can begin with tracking VHSC and sub centre budgets. If we want to adopt the cross-sectoral approach right from start, right at the beginning which sector should we include? Perhaps we can try NREGA.

It is good to do budget tracking but from the community point of view, the community needs tangible things. A certain level of corruption does not matter to them. We must package budget with services- then they will find it tangible and they will be involved. Community is not so prepared as yet that apart from the services, they will also track funds. Also, why should the community want to do this in the first place?

In a multi-sectoral approach, we could include the drainage problem, which creates health problems- and for this we must influence GKS, PRI and community members.

Also, it may be a good idea to find out which other schemes give funds to panchayats. Like NRHM, which fund is coming is straight to the village and then we can find things that are linked to health.

What are the preparatory activities that are essential to do this work, in terms of capacity building, mobililisation and monitoring. In working with the community, we must involve community groups- youth group, women's group, etc. The community must be mobilized and organised by SHG and PRI. We must have secondary data and we shouldn't go directly to budget tracking- we have to involve community with the planning part right from the start. We have to do a need assessment also in order to get a better idea of the issues.

We must also build perspective in the sense of entitlement where the service seekers are not beneficiaries but actual rights holders. The sense of entitlement should be there to go and question AWW. We are then talking of two types of groups- There must be a representation of rights holders (like youth groups, SHG) and also a democratic decision making platform which we want to reform (like VHSC). If we need to make the existing institutions strong, it will be done by the rights holders.

If we want to ensure that the monitoring can be done by community without any external support, it may take more than 5-10 years. At the community level all this information may be difficult to handle. Just like we cannot look into all social issues, the community members cannot all be interested in everything. Just like we divide sectors between us,

the responsibility in villages must also be divided, and these people should talk between themselves.

Group 2- Budget and Expenditure tracking at Facility level

Group members- Swaroop, Mahendra, Shreeti, Kedarnath, Pradip, Nilangi, Jibon and Sunita.

Issue: Sub-centre, CHC and PHC –for monitoring, the smaller the level, the easier it is to monitor and we must know our own limitations. There must be clarity about entitlements at each level. What can be monitored / asked at what level must be clear.

There are many aspects in the facility which we can monitor:

- Infrastructure- electricity, water supply
- Equipment- for urine test, anemia, blood pressure apparatus
- Staff – vacancy and staff attitude (corruption)
- Services- 24 hours delivery services, availability of ANM
- Medicine availability

Without periodic dialogue, monitoring and its feedback, community monitoring is of no use. There will be no pressure of the feedback if it is given once a year. VHSC should definitely be mandated that it will conduct meetings every four months with the health providers and before that in discussion with the community, it should find out what the problems are and this is then informed to the health providers. It could also organise a big programme from time to time. There can also sometimes be a change due to embarrassment especially in cases of corruption and problems due to attitude. Also all possible information must be displayed in the facilities. The lesser the need to ask for information, the easier it will be. Whatever is purchased from the untied funds must be labeled and expenditure noted on display boards. We should also make a performance sheet- something that should be done and was not done, there we can put a zero.

We should use the media to highlight our advocacy work. We must think of scaling up – we can try to convince people in power like MLAs, we can raise questions in legislative assemblies, we can try to strengthen the NGO network to fight the issues.

Inputs must be made to provide training to VHSC members- they should be well aware of what they are supposed to monitor.

Do the RKS members have the community's interest at heart or is it that the RKS does not influence community interest? We have to make a diagnosis of RKS. We should also look at how much we can intervene at which level. Those whose capabilities we trust, on them we should focus our energy.

It should be mandatory to look at untied funds and annual maintenance grant which are locally managed. We should make some criteria for analysis regarding how much is

routine expenditure and how much for the service seeker. So that it becomes emerging-need based and patient-need based and less focused on routine expenses.

With the community we cannot do the same audit that the government does. We must select some criteria- when we want to enquire about PHC, then we can check the cylinders- whether they are filled properly or not. Similarly, if we are looking at infrastructure, then we can look at two key things- labour room and bathroom- if we see these two in good condition, then it indicates that the services are working. The clinic should have an examination room and curtain. These are proxy indicators that we can determine beforehand. What do we expect from the PHC in terms of life saving and in terms of child health what do we expect from CHC.

In PHC, as it is multi-village, some relation building has to be done with VHCs. If we work with VHC but it does not impact the PHC but if we work with 10 VHC or 10 members of the village, it will influence the PHC.

Should there be a VHSC member federation which raises questions and they should be members of sector meeting. There is a need to make the VHSC broad based.

Is it possible that whatever the structure of the VHSC is, the community acts as an observer? The VHSC is my constituted body and I am interested in my VHSC. Till 15 members from the community are not ready to become VHSC observers, till then, the preparatory work is not done.

Yet in reality community is interested in VHSC only because of the money in the account of ASHA and the woman panchayat representative. VHSCs have not been formed as per the guidelines in any place and the training and orientations have also not been done properly.

Can we get the RKS and VHSC together and ask them to have a conversation, especially in making village health plans. It can be done but under NRHM there is no organic relation between the two. Should this be there in the next NRHM? Should we make a case that not only is this necessary but it there will be benefits through this linkage?

When we make the village health plan, we can think further and define which need will be fulfilled by VHC, which by PHC and which by CHC. If we can start this practice, then the facility knows what is expected of them. This can be done for ASHA too. Something which is given from the community must succeed in getting the sanction. Otherwise the entire process of community is then a waste and it demoralizes them.

When we do the need assessment plan, the biggest challenge is that how to incorporate what is needed into the district plan. We do the data collection but what is to be done with the data when the actual reality of what is possible is very different?

There is an interest and intention at the higher levels on budget tracking and groups are interested. So this is the right time to do it.

The message that we should give to the people doing this work is that there must be a linkage between the micro and macro levels. Macro level budget can not be visualized by the community. We have to focus on the micro in daily dialogue with the community. That is our area of interest and we can pursue that. The micro- macro have to learn from each other. Micro budget and tracking and macro budget and tracking should interact with each other.

The macro- micro are not just levels, they are also mechanisms. Macro involves monitoring through examination of documents and evidence like vouchers and statements. Micro is through participation in platforms and process and the various experiences. Micro is more participation based as we are looking at experience.

Summarizing by Dr. Aaron Katz

Aaron stated that the group has talked about many issues and levels but it is important to keep always in mind that we are trying to make two kinds of fundamental cultural changes. One is in the work with communities- we are trying to create a culture of understanding rights and taking responsibility of demanding and expecting rights. Secondly, in the facilities, with the bureaucracy, we are trying to create a culture where they understand they are accountable to the people and know that the people are watching and monitoring and overseeing. To create these cultures we need to identify a few issues that we and the community can win so that the community has confidence that when they monitor things do happen.

We have discussed a number of possible issues that seem relatively easy that are experienced by community and that can be felt. For instance, the notion that drugs are distributed unrelated to disease prevalence of the community. If malaria is there, then malaria medicines should reach that community. Or in the case of deliveries – communities know when babies are being born and the conditions in which they are born. The community knows whether delivery rooms are clean and mosquito nets are available. If small changes can be made at local level, those changes can alter everything. The other thing is that the micro and macro approach need each other. We talked about a PHC that has no doctor- the village cannot solve the problem but it can identify this problem and keep pushing the local authorities to keep pushing above. If many PHCs have this problem and are communicating at the macro level then at the macro level they can make changes which will reflect at the local level. At the state or national level it is very difficult to advocate when we don't have the information from the local level. In bringing cultural changes there is an importance of choosing a few things that we can win and the village can see this.

Concluding remarks by Abhijit

While summing up Aaron reiterated that this had been an interesting reflection in last two days. We have turned the community problems into entitlement and have taken the entitlement to the village. Now we must invert the process. We should take the village problems and ask NRHM for solutions. There will be a fundamental shift in approach. We took ‘standardization’ and ‘national’ to the village, now we should take ‘local’ to the policy makers.

Abhijit closed the workshop by formally thanking all the participants for their experience sharing and insights.

Annexure: 4

Participant's List

Sr	Name	Organisation
1	Javed A Khan	CBGA
2	Swaroop R Pal	Manjari, Rajasthan
3	Devender	Dharti Sansthan
4	Ragini	Gram Sudhar Samiti Sidhi, MP
5	Kedarnath	Gram Sudhar Samiti Sidhi, MP
6	Pradeep Pradhan	The Humanity
7	Ratneswar Sahu	MO Gaon Vikas Abhijan, Orissa
8	Nilangi Sardeshpande	SAATHI CEHAT
9	Jibon Krushna Behera	SODA, Orissa
10	Pratibha D'mello	CHSJ
11	Shelley Saha Sinha	CHSJ
12	Mahendra	CHSJ
13	Shakti Jamdade	CHSJ
14	Shreeti Shakya	CHSJ
15	Sunita Singh	CHSJ
16	Lavanya Mehra	CHSJ
17	Satish Kumar Singh	CHSJ
18	Abhijit Das	CHSJ
19	Aaron Katz	University of Washington

Annexure: 5

Profile of the Participants

Abhijit
CHSJ has been involved with NRHM since the beginning and I have been involved with it even before NRHM started. There was considerable thought put in trying to give it a public partnership and community monitoring direction. There was an attempt to make the government aware about public experiences.

Satish
Involved with CHSJ in the Wok with men on Gender Equality and elimination of VAW. In the project in Maharashtra, we are trying to see how the community can take part in the monitoring. We are also trying to involve the government in this.

Swaroop
Working in Rajasthan in Bundi with Manjari. Got associated with NRHM two and a half years back. Recieved Community Health fellowship through NHSRC after which got the opportunity to work with VHC and ASHA. This was an 18 months' fellowship. Thereafter we founded an organisation with 3-4 friends. We used to do frequent meetings with Village Health Committees. There was no one to work with the Sahayoginis. Government made many promises and yet we got no space to work. So we are trying to find that space.

Mahendra
Associated with CHSJ and now starting work on NRHM.

Devendra
Working with Dharti Sansthan in Murena, primarily on the issues of HIV/AIDS, Water, Sanitation, Hygiene and Declining Sex Ratio in the areas of Gwalior and Chambal. Have been associated with NRHM and even took part in the making the village health plan and how to incorporate it in village. We were also a part of ASHA selection and training and VHSC formation and orientation. We feel that there is no shortage of budget in NRHM. Even in Murena district there are crores of rupees. But there is no monitoring of budget. It is worrying that we have no involvement in how to monitor it.

Shakti
Works with CHSJ in Maharashtra and works on health component and with animators on how to increase community's involvement in health. We also do training of animators on what are their role and responsibilities in VHSC , etc.

Ragini
Works in Madhya Pradesh. Received a Fellowship from Centre for Public Health and Equity (CPHE) through which I started work on NRHM. We have worked to strengthen VHSC, Asha, VHND, etc We started work in 6 villages and we see that the situation is

quite good there. . Immunization is going on well and people are also aware. We have also worked on maternal health, malaria, etc.

Pratibha
Working with CHSJ, on work with men in Maharasthra. We are working to increase the reach of people towards health facilities. We are also starting work in Madhya Pradesh and we will work at increasing the reach of the people towards health services.

Shreeti
Working in research team in CHSJ. We have provided technical support to evaluation studies. We have also done capacity building of grassroot level NGOs so that they monitor local facilities and services.

Kedarnath
Working in Madhya Pradesh in Sidhi district in a Pilot project on NRHM, in a tribal block, I worked in 15 villages. In one PHC, there was a pitiable condition of immunization. We got this information in a jan sanwad that we organised. There are also beggar tribes there and people also had not got the Deen Dayal card. CPHE conducted a community health fellowship programme in MP, through which we increased our understanding of the communitization process. We have no budget shortage in NRHM. Yet more than 100 people died of malaria in Sidhi. There are some villages where there are entire gaps in generations. More than 30-40 deaths in every village. There are some families where 3-4 members have died within a family. People use *jholachaaps* (quacks) more than public health facility.

Pradeep
Working in Orissa in Bolangir since 1996 and this is a poor area. We have an advocacy based approach. We emphasize on Community Monitoring of different programmes. We organise campaigns and programmes, social audits, Community Monitoring by people and orgnizations. We also use RTIs. We have been working with CHSJ for the last 2 years. We have developed and planned how GKS should plan its own progress.

Ratneswar Sahu
Was working with BGVS earlier in the Integrated Population Development Programme of Government of Orissa. I worked on establishing a relationship with the health service providers. Then with CBGA, we worked on monitoring the Right to Education. After that I worked with Network for Social Accountability. Then with CEHAT, I worked on state government Manifestos and doing the pre and post budget analysis. We also provided training to partners on Health budget tracking. My Own Village Development Campaign was initiated and we using it to strengthen the Panchayati Raj Institutions. We are integrating my own village development plan with the district development plan.

Shelley
Working with CHSJ in the Research section.

Aaron Katz
Working with University of Washington, Seattle. Been at the University for 23 years. I work in Public Policy in health sector. Also works in political space. Budget tracking is important because it is through the budget that the government priorities can be seen. This area of budget monitoring has been important for some time. The most important part of a budget is how it is spent. I helped start an organization in my state six years ago. This work is important in every part of the world. A strong civil society is key to a democracy. This work is at a forefront- to look at government and how it spends the money.

Nilangi
Working with SAATHI CEHAT in Pune. In the last 4-5 years, we have been involved in community monitoring in Maharshtra. We are a state nodal NGO. We provide technical inputs to committees formed in the village. We started in 5 districts. Now there are 8 more, so a total of 13. It is mostly successful till now. Earlier we used to call it Community Based Monitoring and now Community Based Monitoring and Planning. Now we are no longer just saying what is not happening but what should happen. This issue of future strategies is raised in planning. We have been getting funds but things have not really changed so we are looking at how are these untied funds being spent? While being associated with the IBP project, we have looked at availability of drugs also.

Jiban
Working in Orissa. Also did a study on community monitoring and the impact of VHSC. Also did training of 400 ASHA workers and in 5 blocks did training of 572 GKS members. Orissa mission director of NRHM says that we must finish money in 15 days.

Sunita
Associated with CHSJ for the past 5 years. First assignment was to conduct social audit. Community Monitoring took place in 9 states, I coordinated in 5 states and moderated and provided technical guidance. Then did coordination for International Budget Partnership in 2 states.

Javed
Working with CBGA which does research on Union and State budgets. It also does trainings on Budget literacy. Also do sectional budgeting- Dalit, child, health, budgeting- leading to training and advocacy.