PARTNERS' REVIEW MEETING
Expenditure Tracking of Health

March 15-16-17, 2011

A REPORT

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
At

CYSD, Bhubaneswar, Orissa
And
Patnagarh – Bolangir

Background of the Meeting: Community Assessment of health expenditure project which started in the year 2009 across two states Assam and Orissa with support of International Budget Partnership (IBP). A year after the inception of the project there was a need felt for stocktaking / review activities that have been carried out by the partners. One of the main objectives of the meeting was to bring together the two partners with the understanding to provide a common platform to share achievements, challenges and innovations over a period of time. From the last one year, various activities have been carried out by the partners and through the Participatory Rural Appraisal methods, information had been collected from the community but it is important to observe what inputs are going back to the community via this process. How is the community taking this process? Whether this process has lead to community empowerment and who has the ownership of this process from the community (leadership by the community). Is community considering health expenditure / out of pocket expenditure as one of its major concerns?
The three day meeting started with keeping the following agenda in mind;

1) Review of Work
2) State-wise sharing by partners
3) Kind of data generated
4) How to come-up with report card from existing data
5) Second Round of Community Enquiry (plan and action)
6) Field visit impact evaluation (work done by partner till date)
7) Future plan of action

Welcome and Review of Work
March 15th 2011

The session started with Sunita welcoming Abhijit and others. She started with a presentation by stating the objectives of the meeting. She said that it is important to set the parameters for report card generation as it is different from community monitoring. Later on she shared the objective of the project- to give information around out of pocket expenditure, need based planning, community's involvement Abhijit said that he would like to hear one sentence from each person that how do they perceive this project and also tell how do they see these activities e.g Process, Out Come. Following are the findings of people's sharing;

Objective stated by Participants	Type of activities
Reduce Out of Pocket of expenditure (4)	Out Come
What are the different health problems	Out Come
Demand generation	Out come
Increase community involvement and interest around health expenditure	Process and Outcome
Increase of govt. health budget.	Out come
Ensuring participation and planning around health enrollment of community in whole process of community.	Process
Community making health an economic issue.	Out come
Community empowerment and reduction of financial burden on health.	Process
Increase transparency regarding health budget.	Process and outcome

Abhijit highlighted the common issues that people stated - community, health, finances, planning/budgeting, expenditure.

There are two to three ways of looking into these things

- Paternalistic
- Empowering and rights based

When Health economists makes plan / expert view – drug costing / generic drugs / procurement – the entire idea is around efficiency – Management, how to provide money/ community based health insurance – their way of looking health system is different which is less expensive – they assume system is less efficient/ community is poor. And their planning focuses on;

- Insurance
- Quality of training
- Health education
- Utilize public health system
- Cheap health services

Difference between Community as Receiver and Community as Citizen

Community As Citizen: Empowering and Rights based approach:

Community becomes aware of its own health problems, health rights and entitlements and health budgets and then the community starts planning or getting involved in planning for new health budget, uses the health system and monitors. Here is expert is not owner, community is the owner.

Community as Receiver: Paternalistic Approach:

Monitoring would be done by the external experts, community is not involved, no empowerment is taking place, done in total exclusion, and community is given only cheap services.

Note: Between the Community Monitoring and this Project the Common Link is the Monitoring.
Through this project:

1. Through this project finances are added in health, as it was felt that there is a need to shift health from emergency to deliberate planning of expenditure. Community doesn't think about the ill health. There is fatalism about health that is why deliberate planning is not done.
2. The community becomes an active agent in planning including financial planning.
3. The community's involvement is reflected through VHSC (GKS in Orissa) and RKS.

It is important to have community involvement, planning, transparency PLUS reduce the out of pocket expenditure.

In order to ensure/achieve these outcomes, second round of community enquiry is required. The project is getting over in 2011 and to see the outcome thus the analysis of progress of the project is very much needed.

The partners' presenting should reflect that where our community at this stage of project is in terms of Process and Out Come.
Sunita presented the progress of the project till date;

1) Mobilization of the Community is over – several rounds of meeting have taken place.
2) 24 village Enquiry is over

3) Meeting with RKS has taken place
4) Health Mapping of all 24 Villages are over.
5) Wall/message writing is over
6) Financial Entitlement Kit has been translated and printed in Boro, Assamese and Oriya.
7) Group Discussion
8) Individual Interviews
9) Collection of case studies
10) Informal sharing of findings with community.
11) Training of RKS and GKS is going on

Abhijit asked – what is the out come of these meetings, how would they benefit the community? *The main objectives* of these meetings are to unit people on their health issues.

User group of Entitlement kit / Entitlement kit for whom:

- *VHSC leaders*
- *Community*
- *Providers*

Suggestion: The Entitlement kit should be given to SHG groups, Women leaders – it will not solve the purpose if only given to formal system. The idea behind entitlement kit is to generate entitlement awareness and empower community.

Question: Can we give Entitlement to each and every household

The idea is that each and every person should get aware of their entitlement. For this purpose, we can use different mode of communication has to be used for different groups of people;

Types of Group	Appropriate material
For more sophisticated group / literate group who can Read and write	Entitlement Booklet
For Group who can Only read	Wall Writing
For Groups who are illiterate	Natak , Songs, Slogan etc
Note: We should judge best modes/ways for entitlement awareness. It should be people specific and context specific.	

The Ant – From the Ant, Jaya Rajbanshi made presentation. Jaya started her presentation by mentioning the geographical coverage of the village. She said that the DPM had been informed and summarized about the project. The process of recruitment of human resources was done immediately and the staff was trained. Village meetings were held for rapport building as new VOs were recruited. Secondary information was collected from the DPM. Training of the VHSCs was conducted on budget monitoring and NRHM entitlements. The community enquiry process was done in the 12 villages.

One of the findings – villagers has started asking question to the ANM of Malipara Sub Centre and hence she has stopped coming to the village which is a negative outcome of a positive process. Abhijit said that let us analyze which villages need support.

In Amteka area – villagers has started questioning on VHSC funds. VHSC has leadership role and it is good. RKS is also participating in this activity. In one of the under construction PHCs has been occupied by Army which is not accessible for Community. Community complained about it to NRHM but nothing has moved yet.

Abhijit suggested that if people are not utilizing this PHC why should we focus on this. We should work with only those health centre which has been utilized by community and lacks facilities. Amteka area people access Subejhar area PHC. With this project we can't deal with larger issues. Every problem should have easy solution and not very complex which can't be solved through this project.

Analysis of Village of Assam: Red shows the problem or need more support: Green Shows local ownership and empowerment.

PHC	Sub Centre	Village
Makrapatkiguri	Boro Laogao People are getting free medicine	Southlaogao
		Borolaogao
		Bandhuguri
		Lawkriguri
Subhejhar	Malipara People have started asking question	Khubjrabguri ANM is not staying
		NandorBadi
		Kantalguri
		Malipara
Amteka	Amteka	Amlaiguri VHSC leadership
Army is staying in under construction hospital	People have started questioning ASHA	Borosalangi VHSC leadership
Hospital Management Committee is taking interest as well		Alengmari VHSC leadership
		Belguri VHSC leadership

Note: Same type of Exercise can be done for Orissa as well.

Assessment tools need to be developed. Jiban and Sunita will work on it. This will help to ensure the sustainability of these VHSC.

1) Most of the people are aware about their health related expenditure – not all of them (Jiban's observation – in Orissa most of the people are not able to talk about it – as VHSC is not sharing about funds or not discussing it with other CBOs, idea is not defusing as VHSC members are only having discussion among themselves. People are coming and have interest on this issue but those who are not coming are left out from all information).
2) Abhijit - there are two levels of analysis – 1) Local leadership is not doing its role - local leadership is not taking this message. *[But how about the messages that we have written on the wall, is it reaching to the people or not. Suggestion: In the wall writing, we can write name of the person and number stating that for more information "Contact so and so" this could be person who are involved with the project. Those who have taken training under this project, they should play an active role to disseminate the information – this message should go to them clearly].*
3) Let's create a pressure, in our country as there is a major leadership gap – In citizenship, we chose representative but in feudalism we chose our Neta/leaders but these two are different.

We can question representative but we can't question leader. We have to convert it in citizenship and create a pressure on leaders to become representative.

4) We should demand that on every hospital's wall, the name and number of RKS members must be written – "In case of any problem or suggestion please contact these member". It could be displayed on flex, board or wall – each PHC and CHC should have this and also they should take responsibility of each Sub Centre.
5) Name and members of VHSC and RKS in pamphlets and can be distributed.
6) Whatever information is there, it is our duty to provide them to people and push representative quality.

Summary of the presentation:

1) In few villages, few people are aware about health expenditure and has started questioning
2) In some villages GKS and RKS is active
3) Because of questioning - Tension between ASHA and ANM
4) In this context, leadership is not that clear
5) Modify the Jeevan sudha scale and do it on the third day to assess the 24 community groups
6) Need to focus on process rather than activity

Point to bear in Mind: *Who is our community? Who has community centre of power and gravity? Who is functioning as mobilization power? If we see VHSC as our community, do they also feel equally responsible?*
This is important to know because we are spending energy and have expectation and if the community/ VHSC is not equally responsible then the output will be very weak. Sustainability of the process is important.

Point of Action

In the last one year, find out is there increasing local interest and identify individuals whose interest have increased in this process? In those few villages where VHSCs are asking questions, you find them strong or they are interested in the process - List them up.
We need to do the sorting of weak and strong VHSC – because we will have different strategy for each. We need to focus on the strength and weakness and plan appropriate strategy.
Find out if community has started linking health with expenditure.
Among the 12 villages which are the villages who you think that can be stronger, sort it out.
We need to find out who will take interest in this process.
Find out with this process whether – community interest has increase or decrease?

We have to bear in mind that - Training is not part of outcome as it is a facilitative activity. We want that community should ask question about the expenditure on health. And questioning – to VHSC, RKS, ASHA etc about their expenditure and budget?

District expenditure analysis of Assam – need to deliver as soon as possible

Jiban pointed out that the process at the village level got much delayed and in fact there was gap in process as well like – if the mapping was done one day, the other activity didn't take place that is why whole energy got lost. The mapping exercise creates tremendous energy and it should have had maintained.

The Humanity – Mr Gouranga made the presentation on behalf of Humanity. He shared the project area. They have taken SDH as most of the people use SDH. There is mismatch in data of ANM, AWW and PRI and hence there was problem in compilation of data.

Question: Abhijit asked what is future use of Village Profile that partners have prepared. In response to this Gouranga said that it is very useful data, as it has been used as validation of data from various sources.
The process has also helped them to improve the data amongst them. They had faced problem in Village Health Mapping. There is long term use of village profile as it contains information about disease and health expenditure. Earlier, it was seen that people including the providers were concerned about health only and the expenditure part was excluded from their life. He said that we are facing problem in getting data from the DPM's office.

They shared the findings of the training with the providers followed by one training of GKS. They have to train volunteers again as most of them dropped out. The new volunteers are now getting some incentives as well.

Sunita said that The Humanity was taking ownership of everything, community was no where in the picture thus it was decided to create a ownership group.
Question: What was the background of the volunteers? Did this process helped change their attitude about the issue?
In response to this Gourango said that they had very mixed background, some of them were associated with the organization, some of them wanted to work on the issue and some of them were interested in the topic, some of them are leaders of the village, Some of them are GKS members, some of them are CBO/NGO workers.

We used to meet with community on regular basis. The wall writing which is done across 12 villages basically talk about how much money is given at each level. The message talks about GKS, RKS, and JSY money. People were not aware about expenditure, even the provider like ANM didn't know about the expenditure. People don't keep account of expenditure. We still have to calculate entire village expenditure.

When people saw message around JSY during GD people came to know about Rs 250 (travel allowance to reach institution for delivery) and they are asking about this money and now the adverse impact is that ASHA is not helping. ASHA doesn't tell the telephone number of the Janani Express. ASHA incentive needs to be increased.

Indoor Residual Spray is not done now in many villages as the spray is done by health department on the basis of prevalence of Malaria positive cases. People were not giving their blood sample to ASHA and AWW and they were going to private. But now there is;

1) Quality treatment
2) Govt medicine is not good
    a. Private doctor mean government doctor doing private practice. The question is why the same doctor's medicine doesn't work. Quality of health care is not given by the doctors in the facility.
3) Expenditure on health is very high as there is a rise in price.
4) Rate of interest on loan has increased.
5) GKS fund has created lots of problems and there was resistance in sharing the village register – it is a creative conflict and not the destructive conflict – GKS should create their own Chanda. The village health plan should be discussed in the Palli Sabha (next financial year budget, what are the issues) and Gram Sabha (they consolidate the Palli Sabha plan and proposals) – they should make health budget.

6) Now cash book has been maintained – how planning has been done and how expenditure has been done.
7) The people spraying DDT are asking money from VHSC but they said they have already developed their plan, thus there is some conflict going on. They are asking them to get the money from the districts.

Solbandh PHC:

1) RKS has been formed after Humanity intervention during Community Monitoring project.
2) Majority people are going to SDH rather than PHC and CHC.
3) Soon after introduction of JSY fund, delivery cost has increased – out of pocket.
4) Most of the participants expressed that in SDH nurses are demanding 300 to 500 rupees.
5) Community doesn't know about flexi fund.
6) For Home deliveries JSY money is not given to any women.

Review of the activities:

Women's participation increases when women facilitation was there. It was also seen that in Khutnapani village even when there was no women member, the participation of women in the meeting was quite high(45 in number) It was felt that discussion with women in the community required a certain skill.

It was also informed that data collected through PRA exercise has been documented in Oriya and translation into English language. The photo documentation of all the activities in 12 villages has been completed. The entitlement health kit has been translated into Oriya and reviewed and subsequently printed. Wall writing has also been done in all the 12 villages.

Challenges:

- Reluctance on the part of the provider to give time for the same work again
- In Rakhiguda village, on the day of meeting, the GP office distributed PDS rice (@Rs.2.00 per kg.) to the BPL families which affected the attendance of the meeting
- Heat wave from April-July, heavy rains in August, extreme cold in winter
- Delay in receiving format
- Community could not spare time
- Mismatch in the data – secondary and the one collected from the community
- ANM are also engaged in their work, to complete the interview had to visit ANM several time

Opportunities:

1) Community people are eager to know about financial entitlement. In each village, two to three people are more interested. We need to think about it, who could be part of the group and with whom we want to develop more relationship. Or we can develop a federation of people who can take forward the agenda of the project. For example in Assam, Bodoland Students federation, Namghar etc. We need to identify the local leadership and we need to think about RKS and other leadership and GKS and other leardership.
2) GKS can be trained and emerged as a vibrant village institution.
3) There is scope of data sharing and follow-up is needed.
4) Social Audit health expenditure is needed.

5) The sharing need to be done at the district and state level other organizations needs to be organized.

Question:

1) Why enquiry is not complete?
    a. They don't have any women worker. We need to identify the local volunteer who is a high school pass out and can work with the project. The solution need to be long term.

2) How much it is based on research and how much it is associated with community empowerment process?

Name	Community	Research
Gouranga	75%	25%
Deepti	50%	50%
Sunita	60%	40%
Gajen	40%	60%
Pradeep	40%	60%
Jiban	35 %	65%
Jaya	70 %	30%
Total		

3) Concern – Need to shift the balance form research to empowerment process?
4) Sunita should share the program theory.

Partnership and mentoring – feedback – how do we see CHSJ as a funder or partner. What is the relationship dynamic?

Presentation of Theory of Change

At the ground level, when we are looking at the change – we don't look at the intentions, we look at the action – for community how the final thing place down to the action. Policy should not only stick to paper but should look at the broader framework. Only higher authority related change is not democracy, it has to do with people's change, the change need be personality driven but should be a bottom –up approach.

Suggestions:

- Prepare a note of allies who could influence the objective of the project and prepare a note with photo and result etc and distribute the findings. The matter could be common 50% and different 50%. We can look at the local level leaders and other important people who can bring about change at the policy level/ local level.
- We can show something like Malaria and white discharge; public step and it can be aligned with village health action plan and district health action plan.
- Need to change people's behaviour but how to do it?
- Government programme initiated through the community enquiry process need to get conversion with DPM
- Trust in public system has to be built up

Observation: Findings of the community enquiry reflects that no public provisioning of the problems and if any policy is introduced, it would be impact of the community enquiry and it is a positive step in this context.

In Assam, can we identify the issues, agents, places where we need to emphasize upon? Have we made adequate influences with policy makers? Need to identify platform for change.

Research component:

Objective:

- To find out the health related problems
- To trace out of pocket expenditure
- To find out fund planning and expenditure planning
- Find out how community arranges expenditure and the consequences

Suggestion:

- Need of a framework to read the sarkari document
- Need of analysis closer to the community
- Result should come out as score card and not as academic paper

Suggestion on data analysis:

- Analysis would be slightly different and the pattern needs to be thought about
- Analysis not in counting, more of qualitative analysis
- Need to share at two levels- community score card has to be made in the filed area and need of a minimum consolidated report card which makes sense to the Medical Officer
- Data analysis – acute infectious diseases, chronic diseases that don't need hospitalization.
- Don't go by disease; go by formal and informal payment.

Parameters of report card:

1) Cost (drugs/informal payment etc)
2) Behaviour
3) Quality of treatment
4) Availability and Quality of Drugs

Assam's experience of facility inquiry – supply is not based on need.
What are the targeted interventions?

Suggestion:

Community Report Card: Health Expenditure NRHM provision
For common health we can have three columns
Listing of problems:

1) Health problem Women | Men | Children

Health problem 1	Provision and care – Main provider Mostly Public / Mostly Pvt / Both	Cost (Mostly paid partly medium low)	Consequences (High medium low)	Note
Health problem 2				
Health problem 3				

We can write a note in the next column to show that how much people are spending and to show the story.

Health expenditure and consequences
Use of Public Facility
Use of Public Provider as private
Use of private
Cost of Care
Cost of care at public

Community Report Card
General Health
Main Health Problems
Health Seeking Pattern/behaviour
Cost and consequences
Facility Utilization experiences
Relationship with RKS and VHSC - Flexi Financing of Communitisation

Maternal Health
- Normal delivery
- Complicate
- Cost
- Consequences
- JSY

Flexi Financing of Communitisation

Have we got any area specific 10 messages or not? Which can be our next wall writing message?

Example:
- Why we have to pay for malaria?
- Why women have to pay that much even after JSY money?

Need to think of 10 questions for public health system – and as well as for community
We need to think about what we will see – objective and method
Create as small structure:

Field Visit
March 16, 2011

Briefing meeting at Patnagarh
The field visit has been arranged at Tentulikhunti village
The team would meet the following people-

1) ASHA
2) AWW
3) GKS
4) Village Leader
5) SHG / General women

Issues that could be discussed:

1) NRHM
2) JSY
3) GKS / Untied Fund
4) District Mission
5) Village Plan
6) Cost of Care / Informal cost / Wage loss
7) Free Medicine / AMG / UTF
8) Use of public / private facility
9) Hospital Management Committee (Knowledge around this)

How much they know about the government structure?
Suggestion: One copy of each village profile should be given to the village. The information that has been collected could be used as baseline (as it has been collected with lots of verifications), the document ownership should be created and one representative group should have in their hand. This should not be in hands of functionary group.

What should be done at the village?

After getting this information, have they taken any action at their family level or community level? This could be in any form – like questioning doctor, distress sell etc.

Issues around how to sustain the movement, people should be part of the movement and support should be provided from their end, other wise it would be hard to sustain any movement.
Who is your support: People's support and other organization's support? Are people not using the Panchayat level set up?
What is the mobilization strategy and strength? Apart from Humanity, what are the other organizations, which are supporting mass level activities? Bhartiy Kisan Sangha and Right to Food Campaign-Orissa

Later the question was raised – are these groups interested in health or not.

What is the next sustainable mode of people led democracy?
Panchayats do not co-operate in – RTI, social audit and public health

Principle to success in Social Audit:

- Data availability (evidence and how to tally with the other evidence)
- Audit Framework (this should be commonly agreed)
- Most of the audits are taking place on government framework.

We need to see at which platform we have to go and at what level. Question is level of change in audit. We have the Supreme Court support, at the local level service delivery need to be strengthened and we have to make sure how to ensure their participation.

Pradeep- talked about the PDS and NREGA and stated that it is different from NRHM. PDS has nothing to implement and under NREGA there is no grievance redressal mechanism. Food Security Monitoring would take some time, considering the commitment of volunteers requires a continuous and rigorous effort.

Suggestion:

- Need of a bottom up push with a strong people's movement.
- Need to integrate and infiltrate
- Common Sangathan can be set up as a structure which can do the monitoring of every department.

In few villages

- Mother Committee – ICDS
- School Management Committee – MDM
- Vigilance and Monitoring Committee - NREGA
- GKS –
- Retailer Level advisory Committee – PDS

After filed visit:

- Women's Group
- GKS
- Common Group

Theory of Change: where we are after one year of project and in future what we would like to do. Assessment of inputs.

Meeting with GKS / Village leader:

There were six members present. AWW (convener), Member GKS, Chairperson of GKS, ward member. ASHA was not present. The group mainly discussed about the work. They have used the untied grant for road construction and cleaning of the village. Till date, they have received only one year's money. They are yet to receive the grant of 2010-11. They have used the money for purchasing dari and terracotta pot. As GKS they have not discussed any thing formally but they talked based on their experience.

Discussion about Sub Center – most of them have visited the Sub Centre for their own health related problem. PHC – they have not gone to the PHC. At PHC, they only get medicine for cold and cough. JSY– they have to spend money in order to get the money. Due to non release of fund

they are not able to plan and complete the planned activities. They have discussed that they will not use the VHSC fund for road and drainage construction.
Village health expenditure map - they are not aware about it and they are unable to do the assessment and people are not sensitized about the expenditure. They know that this exercise is done but are unaware about the objective of the exercise.
Village Health and Sanitation Day – Mamata Diwas – Focus is on pregnant women and GKS members AWW is present. Adolescent related health problem is also discussed.

Common Group/ Men's group: The discussion started with a round of introduction by the participants. Though the group did not know about all the provisions under NRHM, they were aware about some of the activities undertaken under NRHM. They did not know about GKS and its activities but knew who all were the members of GKS. The group also stated that they were aware about some of the activities undertaken by the GKS like cleaning of drains in the village. When asked who had the GKS money, some of them said that it was with the women members whereas some thought it was with the ward member. They also mentioned that there was no audit conducted of the GKS money. They were also unaware about District Mission. They did not know what is PHC, CHC and their difference. But knew it through the name of the locality where it is located. They were totally clueless about the funds of PHC and CHC. Regarding sub-centre, they said that they did not get any medicine from the sub centre.

Women's Group/ SHG Group: The discussion started with a round of introduction by the participants. They were aware about NRHM and JSY. The group informed that despite facing lots of difficulties, they preferred to go for institutional delivery in order to save the life of the mother and the child. To avail JSY card, they have to pay Rs 320 as tips and if they do not pay it they do not receive the JSY money. For normal delivery, they spent around Rs 3000-Rs 3500 and most of the time these expenses are borne by taking loans on interest basis. Regarding the attitude or behaviour of the provider, the group said that the behaviour was good if money was paid and bad if they don't pay money. The nurses sometimes scold the women in labour and beat them also.

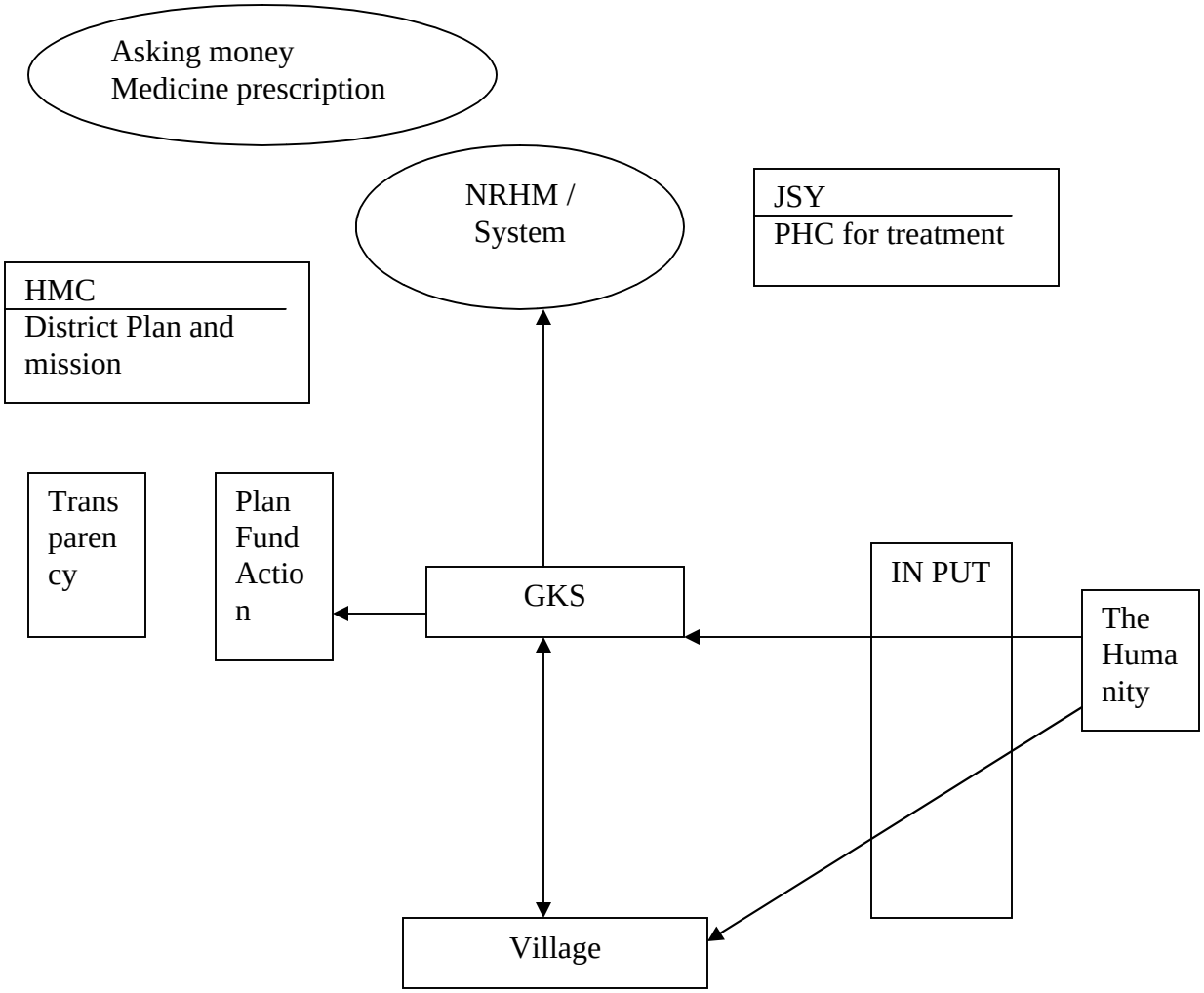
Do they get free medicine from the hospital? No, but even when sometimes they get the medicine their condition do not improve. So, they go to the private doctor. They do not know who the GKS members are. They do know about the GKS but are unaware about its composition.

Do you know about the wall writing in the village? Do you know that every year village health plan is made? Majority of them said that they do not know about it.

The group also said that in case of any epidemic like cholera or malaria, if the doctors are informed even on the phone, they come immediately with saline, medicine etc and treat the patient in the village itself free of cost.

Debriefing:

- Discussion required on the context of program theory also
- Analysis of our input
- Reflection on village activities



Next day's agenda: How to use community's assets?

Why people worry about health – health = tremendous expenditure.

Question to Gajen: Did you learn any thing about Orissa village after looking at your own village. We have directly worked with VHSCs and if we will ask the community, they will not able to tell us anything.
Jaya to Gajen: Will VHSC be able to tell us why we are there and what we are doing?
Jaya: In Orissa, both community and VHSC are stronger and there is display of the GKS members in the village walls. In Orissa, there is a reference point. On the other hand in Assam, VHSC committee is based on paper. Ownership and accountability of GKS member is very less – sustainability is an issue. If we are not there, I still doubt how much information, GKS will be able to give. Community doesn't give time and we at the Ant is not able to develop that relationship. We are only looking at it as a project – but what would be the benefit of the community.

Deepti – Community awareness is very less, in Assam people thought that we are doctors but here people knew that we are from Humanity and they participated and participation of community is strong.

Communication style and methodology
What is the style of Boro communication?

Sharing of Maharashtra Project:
Effect of cultural message is very easy to recall. We need to share the result of study in a very interesting way. .
Shared the Bus related changes. What could be learning that can be taken from other project?

Have we made this project very intellectual – the investigation has become so overwhelming, thus the empowerment process have become very weak.

Agenda for next day:

1) Morning Village
2) Debrief
3) Report card
4) How to link with more entitlement awareness.

Field Visit and Debriefing Meeting
March 17, 2011

Observation of field visit
Gouranga: Mobilisation for meeting was less as migration already had been done and most of them had gone for collection of Mahua seed. Project objective was to create awareness and this has not been done. Even the process has not been reflected well. Display has no impact and people are still not motivated. The book distribution will also not have any impact as well in mobilization. So, there is a need to think of a different strategy to mobilize the people. Some volunteers are there and we can do mobilization through them. What are the tools that we use. In this particular village two to three ASHA volunteers.

Gajen: We also have problem in mobilization of community. We can think of songs or street play/theater etc.

Abhijit : we should think about the script of the play.

Jaya: Whenever I go to the field, I tend to compare. In Orissa, ASHAs are taking lead, GKS members are also taking lead in terms of distribution of money. But in Assam it would be a rare case wherein GKS money would be utilized for the benefit of the community. ASHA was quite strong and she talked about work that has been done by her very strongly. In Assam, ASHA has more authority and she does whatever she likes to do. Community and ASHA have very good relationship in Orissa.

Gouranga: When we had the first meeting, GKS had not used the money but after the meeting, they have made proper utilization and this process is still continuing.

Jaya: In Assam also instruction has been given to buy things.

Pradeep: People's participation is very less. People have used GKS money in good way and have not used it as per the MOs instruction. Apprehension: government has many programme and many government sponsored committees. NGOs have promoted their own committees and so mobilizing people and covering all aspect of programs is very difficult. People come with their own agenda and promote that. Every body can't know about every program.

Abhijit: Participation was not less. People are interested in their lives. For the community, it is a solution for life program- giving information, starting with example of the community. Need to take concept to materialize - from concrete to abstract. When people have more chances of decentralization, communication style needs to change. We need to consider people as adult and treat them equally He mentioned about the – Reflect Literacy Program. Reflect methodology- Use a concrete example, can be a story, play, song etc. Try to understand the problem of the story, the reason behind the problem, is that problem related to our day to day life, what is the solution of the problem- this is the Frierian model.

Gave an example of a play that starts with problem and when the problem starts in the play, it has been asked from audience to come and play the certain role and solve the problems - this really helps and understand. We have to change the situation, character, response and relationships. In this way, it comes in people's hand how to do the creative thinking and solve the problems. Later on, we go back to the village and can refer back to the play which people remember very easily. We need to invoke hopes. We need to connect with people from common point of connect. Songs to do awareness is little problematic and it become very directive but we need to help people to solve their own problems. Paulo Fierie says that don't treat adults as children – because children will accept everything without questioning but adults have live their life and have understanding and they will use our information as a judgment and this type of information will be rejected. People have become conscious of their oppression and have come up with their own solution. For this, people require analysis.

Gave example of Russian scientist Ivan Petrovich Pavlov. Pavlov's description on how animals (and humans) can be trained to respond in a certain way to a particular stimulus drew tremendous interest from the time he first presented his results. His work paved the way for a new, more objective method of studying behavior. In a series of experiments, Pavlov then tried to figure out how these phenomena were linked. For example, he struck a bell when the dogs were fed. If the bell was sounded in close association with their meal, the dogs learnt to associate the sound of the bell with food. After a while, at the mere sound of the bell, they responded by drooling.

Example of B. F Skinner - With pigeons, he developed the ideas of "operant conditioning" and "shaping behavior." Unlike Pavlov's "classical conditioning," where an existing behavior (salivating for food) is shaped by associating it with a new stimulus (ringing of a metronome), operant conditioning is the rewarding of a partial behavior or a random act that approaches the desired behavior. Operant conditioning can be used to shape behavior. His ultimate aim was not only to control the behavior of isolated persons, but to gain insights into how to control society as a whole. Skinner argues that our traditional concepts of freedom and dignity must be sharply revised. They have played an important historical role in our struggle against many kinds of tyranny, he acknowledges, but they are now responsible for the futile defense of a presumed free and

autonomous individual; they are perpetuating our use of punishment. and blocking the development of more effective cultural practices.[38] He asked: What do we mean when we say we want to be free? Usually we mean we don't want to be in a society that punishes us for doing what we want to do. Okay — aversive stimuli don't work well anyway, so out with them! Instead, we'll only use reinforcers to "control" society. And if we pick the right reinforcers, we will feel free, because we will be doing what we feel we want!

Gave another example of Paulo Freire and his books: Pedagogy of the Oppressed and Education for Critical Consciousness.

"Pedagogy of the Oppressed" Paulo talked about

- Education of Confirm – Conformist
- Reforming Education – little change
- Transforming Education – challenging ideology

We don't want to make humans like dogs and pigeon. People have become critically conscious and Critical consciousness is the ability to perceive social, political, and economic oppression and to take action against the oppressive elements of society. He further said that learning in humans should not be seen as being equivalent to learning in dogs and pigeons - and we should focus on raising critical awareness.

Famed Brazilian Artist Augusto Boal on the "Theater of the Oppressed"Boal - used theater for mobilization. He said that Humans are capable of seeing themselves in the act of seeing, of thinking their emotions, of being moved by their thoughts. They can see themselves here and imagine themselves there; they can see themselves today and imagine themselves tomorrow. This is why humans are able to identify (themselves and others) and not merely to recognise."

"The Theatre of the Oppressed is theatre in this most archaic application of the word. In this usage, all human beings are Actors (they act!) and Spectators (they observe!)."

"Theatre is a form of knowledge; it should and can also be a means of transforming society. Theatre can help us build our future, rather than just waiting for it."

People should become more skilled to raised questions.

Pradeep: There are lots of problem – personal, internal, external like corruption etc. In Orissa implementation is very bad

Abhijit – Where is the solution, there is no need to keep on talking about problem. Situation is very different since last ten years. There is the need to work at all the three levels –

1) Macro
2) Messo – district level
3) Micro – village level

Information should flow at each level equally. We should do the RTI with organization and another one should be on the name of people's organization. How to use one hat at one time is important

and should not be used at the same time as it will increase the vulnerability of ours. He gave the example of Uttar Pradesh when privatization was stopped. How to equalize frustration and how to work at different place at the same time?

Deepti: There is a need to strengthen the relationship between GKS and community.

Jiban: During community monitoring, they have got training and through this project also they were trained, still they are not doing anything as per the plan. They are planning to put lights and also they are purchasing other stuff. There are too much compartmentalization and other people are not able to know about the decision. The capacity of GKS needs to be built up and there is a need to promote the relationship.

Sunita: Just empowering GKS is not going to solve the problem nor will it automatically start involving the community to bring them forward to demand or raise the questions. The community should be empowered enough so that they start questioning and demanding.

Abhijit: What is the periodicity of the village visit?

Gajen: Our work take place as per our monthly plan. I don't visit the community directly; I only go for important events. Gave example of conducting a training – introductory visits, then meet VHSC members. We discuss about the problems. VOs are not able to visit all the villages.
In Banduguri village in the last six months they have gone about 30 days. – This was just to build relationship.

Future Plan

What	GD enquiry (Most urgent) OR – 4 (April 1st week) AS - 1 (March) Analysis – summary – Sharing Result should also be part of the training – entitlements roles and responsibilities (the workshop can take both formally and informally)	GKS training / RKS training Capacity building leadership (formal and informal meetings)
With Whom	GKS/ RKS and Community/ Health and other functionaries and plus more leadership people (they can put pressure on GKS) – district/ sub district and state level (we need to identify two such people)	
How	Report Card, public meetings / Jan Samvad, short written report with little statistics and background information. 1) Creative communication will be done village wise. Slides stories, slogans (this is called digital story telling) 2) One Jan Samvad per PHC. 3) Public Meeting every each village with report card. 4) Slogan chanting 5) The health map and the data that is collected could be given to GKS as an annexure Follow-up with community	
When	Sharing process	
	Second Enquiry The Jiban Sudha scale will be implied to access the result of the findings.	

Our main energy need to be at the community level with little focus on the GKS and Health departments. Use creative communication. We can't use news paper as people are illiterate and cannot read.

We can use the data from the study and can show the script that has been thought by Gajen. After the play Q and A is very important on what people have seen, how they analyze the problem. Creative communication should be used instead of play. Flock Natak, the discussion was around how to mobilize resource from the existing resources. What could be the alterative creative communications? Create a story by flash card and make a story then a film and show this to the community. Each village visit should contain these things.

Timeline

Orissa	Assam
April 1st week –Group Discussions and other interviews	To be shared later
March End – Free listing and Mapping report.	
April 15th - Analysis and Summary report	
May - Creative Communication preparation	
June 15th to August - Sharing with the community	
September – Next enquiry process	

Action Plan:

- The ultimate analysis needs to take place at the field level
- The basic structure of report card has to reach to partner by one week
- Design of formal workshop – the leadership input is needed – this will be ready by first week of April
- Report card is a support from our side
- We should have conversation going on - creative conversation and we should discuss about/ more specific. Local person should design and plan
- Report card should be specific to the village

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Annexure I

Tentative Agenda for March 15th 16th and 17th meeting

Objective(s) of the meeting

8) Review of Work – Presentation (by Sunita)
9) State wise sharing by partner (Presentation done by partner) – Oral presentation (By Gouranga and Jaya)
10) Kind of data generated – Presentation and discussion
11) How to come-up with report card from existing data - Presentation and discussion
12) Second Round of Community Enquiry (plan and action) – Discussion
13) Field visit impact evaluation (work done by partner till date) – Meeting GKS member and Women (Mahila Mandal) of the village
14) Future plan of action – Discussion

S / N	Particular	Date	Time
	Day 1 - March 15th		
1	Sharing of Project development till date Assam and Orissa team	March 15th CYSD Meeting hall	11:00 AM to 5: PM
2	Lunch Break		1:00 PM to 2:00 PM
3	Feedback and discussion – Abhijit	March 15th CYSD Meeting hall	
	Leave for Bolangir by train	March 15th	7:17 PM
4	Day 2 - March 16th		
5	Arrive in Bolangir	March 16th	
6	Hotel Booked in Bolangir		
7	Leave for Patnagarh	March 16th	8:00 AM
8	Meeting with Humanity Office	March 16th	9:00 AM to 12:00 PM
9	Lunch Break	March 16th	12:00 PM to 1:00 PM
10	Field visit Tentelkhunti Village (meeting with GKS member, women and AWW others)	March 16th	1:30 PM to 5:00 PM
11	Debrief Meeting at Humanity Office	March 16th	6:00 PM to 7:00 PM
12	Back from Patnagarh	March 16th	7:00 PM
	Dinner	March 16th	8:00 PM
13	Day 3 - March 17th		
14	Leave for Patnagarh	March 17th	8:30 AM
15	Field visit - Babejori Village	March 17th	10:00 AM to 1:00 PM
16	Lunch Break	March 17th	1:30 PM to 2:00 PM
17	Meeting at Humanity Office (How to come-up with report card, way forward, advocacy issues, report etc)	March 17th	2:00 PM to 7:00 PM
18	Back from Patnagarh	March 17th	7:00 PM
19	Dinner	March 17th	8:00 PM
20	Abhijit, Gajen and Jaya Back from Bolangir to BBI (Train)	March 17th	10:15 PM

Annexure II

List of Participants

S/L	Name of the Participants	Organization
1	Abhijit Das	CHSJ
2	Gajen Brahma	The Ant
3	Jaya Rajbanshi	The Ant
4	Gourango Mahapatra	The Humanity
5	PradeepPradha	The Humanity
6	Shyama	The Humanity
7	Shankar	The Humanity
8	Deepti Morang	CHSJ
9	Sunita Singh	CHSJ
10	Jiban K Behera	CHSJ