isif⬢asia

Project factsheet information

Project title	Using mobile application and mapping platform to increase accountability in delivery of maternal health services for tea garden workers in Assam
Grant recipient	Nazdeek 5 Stuyvesant Oval Apt. 4C, New York 10009 USA www.nazdeek.org
Dates covered by this report	01 – 03 – 2014 / 28 – 2 - 2015
Report submission date	10 – 5 - 2015
Country where project was implemented	India
Project leader name	Jayshree Satpute, Co-Founder, Director of Litigation, Nazdeek
Team members (list)	Francesca Feruglio (Nazdeek): francescaferuglio@nazdeek.org Sukti Dhital (Nazdeek): suktidhital@nazdeek.org Barnabas Kindo (PAJHRA): b4kindo2001@gmail.com Basant Horo (PAJHRA): basant.horo@rediffmail.com Jaspreet Singh (ICAAD): jaspreet@icaadglobal.org Evha Rani Matki (no email address available)
Partner organizations	PAJHRA (Promotion and Advancement of Justice, Harmony and Right of Adivasis), Stephen Ekka (Director). pajhra@rediffmail.com Sahityarathi Path, Dhanoa Nagar. Tezpur-784 001, Assam – India ICAAD (International Center for Advocates Against Discrimination), Jaspreet Singh (Director). info@icaadgloblal.org 706 Riverside Dr. - Suite 9D. New York, NY 10031 - USA PNJSS (Purbanchal Nari Jagriti Sangram Samity) vill. Khonamukh. P.O. Nonke Patgaon. Sonitpur – 784 101, Assam, India
Total budget approved	AUD 35,000
Project summary	Tea garden workers in Assam (India) face extreme socioeconomic exclusion, with women workers routinely denied access to healthcare and nutritional benefits. As a result, Assam has the highest maternal mortality rate in India. To address these gaps, Nazdeek in partnership with Promotion, Advancement, Justice and Human Rights of Adivasi (PAJHRA), the International Centre for Advocates Against Discrimination (ICAAD) and Purbanchal Nari Jagriti Sangram Samity (PNJSS) developed a pilot project combining social accountability, legal empowerment and technology. The project, launched in March 2014, established a pool of 42 participants in two Blocks of Sonitpur District of Assam, who identified and reported cases of reproductive health and food rights violations occurring within and outside tea gardens. The reports are sent via SMS using a coding system developed as part of the project activities, that covers over 30 types of violations and approximately 20 different health facilities. Data collected is gathered on a web platform running on Ushahidi software, where the information sent by participants is represented on a map and database. The project team has also set up a verification system so that each report is verified via phone, while most serious cases (for instance those involving maternal and child health emergencies) are promptly investigated. The project team has developed a short-term and long-term strategy to seek remedies for the cases of violations reported. This includes actions to be taken at ground level such as fact-finding, filing of complaints and representations to government officials. Lastly, data collected is analyzed and utilized to advocate for increased access to essential reproductive healthcare for women living in tea gardens.

Table of Contents

Project Summary

Ninety percent of maternal deaths are preventable. The highest number of maternal deaths in the world occurs in India, where according to the United Nations around 50,000 women per year die for pregnancy-related causes. Assam leads the country with the highest maternal mortality ratio: 390 deaths for 100,000 live births against the national ratio of 212. (1)

The Central Government and the Assam State government have enacted policies and programs to curb maternal and infant mortality rates and guarantee universal health care. However, insufficient budget allocation, weak implementation of policies and poor monitoring and oversight have resulted in gross violations of health rights. Women in Assam are routinely denied access to adequate health services due to poor infrastructure, undue payment, and discrimination based on ethnicity or caste. This is particularly so for women hailing from Adivasi (tribal) communities who live and work in the tea gardens of Assam. Health facilities in tea garden areas, whether run by the State or by companies, often lack equipment, staff and referral systems necessary to ensure safe motherhood and protect women's and infants' lives.

These violations of the rights to health, food, life and equality are neither reported nor addressed. Basic tools to communicate, inform, and document violations are virtually non-existent, and women lack access to mechanisms to hold public and private entities accountable for the failure to provide life-saving treatment as required by law. Information on availability of health services is difficult to obtain due to poor tracking and assessment by the government. As a result, communities and local advocates lack solid data to support demands to increase accountability in service delivery.

To address these gaps, Nazdeek in partnership with Promotion, Advancement, Justice and Human Rights of Adivasi (PAJHRA), the International Centre for Advocates Against Discrimination (ICAAD), and Purbanchal Nari Jagriti Sangram Samity (PNJSS), developed a pilot project combining social accountability, legal empowerment and technology. The project, launched in March 2014, established a pool of 42 participants in two Blocks of Sonitpur District of Assam, who identified and reported cases of reproductive health and food rights violations occurring within and outside tea gardens. The reports are sent via SMS using a coding system developed as part of the project activities, that covers over 30 types of violations and approximately 20 different health facilities. Data collected is gathered and translated using a customized plug-in for an Ushahidi web platform, where the information sent by participants is represented on a map and database. The project team has also set up a verification system so that each report is verified via phone, while most serious cases (for instance those involving maternal and child health emergencies) are promptly investigated. Lastly, the project team has developed a short-term and long-term strategy to seek remedies for the cases of violations reported. This includes actions to be taken at ground level such as fact-finding, filing of complaints and representations to government officials. Data collected has been analyzed and utilized to advocate for increased access to essential reproductive healthcare for women living in tea gardens.

The pilot project was initially foreseen to last nine months, however in October 2014 it was extended by three months, i.e. until February 2015. Activities include: acquiring appropriate hardware (March), developing the SMS and web technology as well as the coding system (March and April), identifying and selecting participants (March), developing training materials (April) and delivering trainings to participants (April-May), launching of the project and conducting field test (May onwards), gathering feedback from participants (June-July), analysing how

the technology can be improved (October-November) and compiling a comprehensive report with the collected data, to be used for advocacy and litigation, including by submitting it with relevant authorities (February).

Overall, End MM Now has proven to be an invaluable platform for women to monitor and claim access to basic rights and entitlements. Community members have already noted initial positive changes in the delivery of health services (see Outcomes and Impact sections below). Civil society has access to strong quantitative and qualitative data to fight for women's health rights through advocacy and litigation.

Background and Justification

*Tips: The reader should be reminded of the **context** your organization is working, and where the project has been developed in.*

*This section provides a window to **understand the challenges** faced by the community you are working with.*

*Include a detailed description about the situation **before the project start**, describing any relevant aspects that make the project relevant in such a particular scenario.*
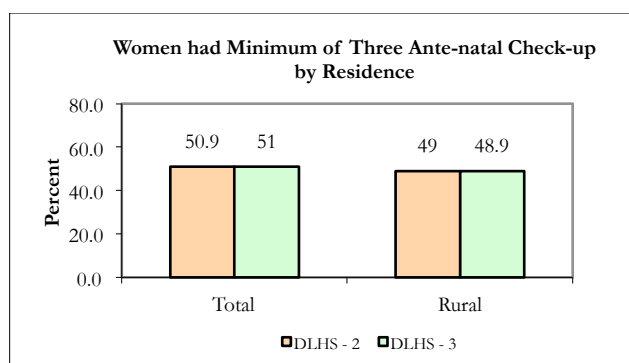
The reader should be provided with a clear description about the problem(s) to be addressed through this project and the motivation from your organization and team members to get involved and offer a solution.

Ninety percent of maternal deaths are preventable. India leads the world with the highest number of maternal deaths. (1) Assam leads the country with the highest maternal mortality ratio, with a maternal mortality rate of 390 per 100.000 live births against 212 per 100.000 in the rest of the country. (2) These numbers are primarily due to the lack of adequate health infrastructure and services. According to a 2009 study by the University of Guwahati (Assam) only 21% of health facilities in the District of Sonitpur offer 24-hour delivery service, only 39% have a labor room and only 17% have inpatient service. (3)

Profile of Sonitpur District

	Assam	Sonitpur
Blocks	219	14
Population	31.169.272	1.924.110
Literacy rate	73.18%	67.34%
Infant Mortality Rate	55	68
Maternal mortality Rate	301	251

Below are indicators from the District Level Household Surveys (DLHS) conducted by the Government in Sonitpur District in 2002-4 (DLHS 2) and 2007-8 (DLHS 3):

Women had Minimum of Three Ante-natal Check-up by Residence

Institutional Deliveries by Residence

Women Received Atleast One TT Injection by Residence
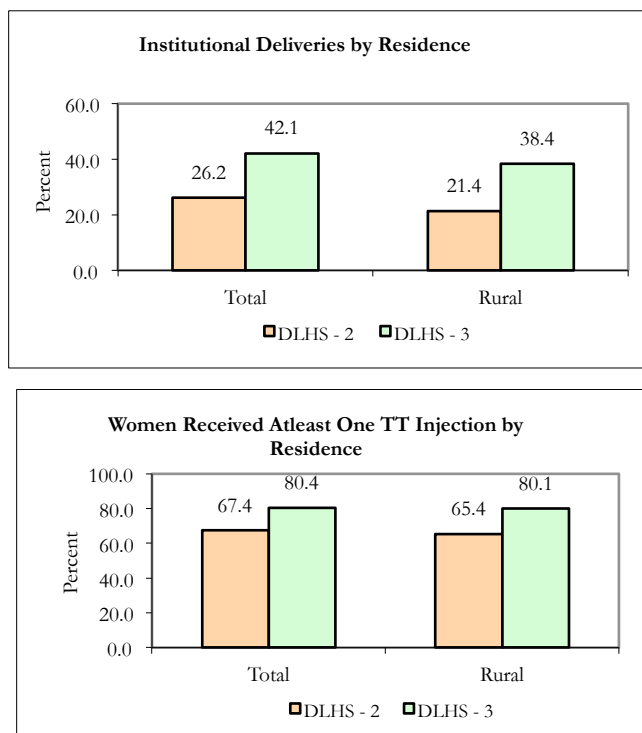
In India, the right to life is protected under Article 21 of the Indian Constitution and has been interpreted to encompass various rights and protections including the right to health and food, placing clear obligations on the Central and State Governments to provide adequate access to basic services. Indeed the Supreme Court has proclaimed: "the right to life in any civilized society implies the right to food, water, shelter, education, medical care and a decent environment. These are basic human rights known to any civilized society. The civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Conventions or under the Constitution of India cannot be exercised without these basic human rights." *Chameli Singh v. State of UP* (1996) 2 SCC 549.

In addition, because reproductive health services are services primarily needed by women, the Government's failure to provide and remove barriers in access to reproductive health services is a violation of women's right to nondiscrimination and special protection under Article 14 and 15 (4), and international instruments including Article 2 of the International Covenant on Economic, Social and Cultural Rights, and Article 12 and 14 of the Convention on the Elimination of Discrimination Against Women. (5)

Based on the legal obligation spelt out by national and international laws, the Central Government and the Assam State government have enacted policies and programs to curb maternal and infant mortality rates and guarantee universal health care. The main umbrella scheme providing for a range of health and food entitlements for pregnant and lactating women and their children is the National Rural Health Mission (hereafter NRHM). However, insufficient budget allocation, weak implementation of policies and poor monitoring and oversight have resulted in gross violations of health rights. Women in Assam are routinely denied access to adequate health services due to poor infrastructure, undue payment, and discrimination based on ethnicity or caste.

This is particularly so for women hailing from Adivasi (tribal) communities who live and work in the tea gardens of Assam. With more than 1.2 million permanent workers, and hundreds of thousands of seasonal workers, the tea industry is the largest private sector employer in India. One of out of every 7 workers in India's organized sector is a tea plantation worker. More than 50 percent of these workers are women. The tea garden workers, mostly Adivasi and lower castes, are fourth generation descendants of indentured immigrants brought by the colonial

planters 150 years back from the tribal tracts of Bengal, Bihar, Orissa and Madhya Pradesh. Today, over 25 lakh (2,500,000) families live in Assam's tea gardens where they lack access to services and facilities, in contravention with the Constitution of India and other relevant laws, such as the Plantation Labor Act, 1951, and the Assam Plantation Labor Rules, 2010. These laws guarantee workers and their families rights including access to:

- A doctor;
- A labor room; and
- 24-hour-per-day 'normal delivery service.

Health facilities in tea garden areas, whether run by the State or by companies, often lack equipment, staff and referral systems necessary to ensure safe motherhood and protect women's and infants' lives. For instance, a recent Government report has found that PLA is poorly implemented in the gardens:

- There is a shortfall of 280 garden hospitals in the State;
- Not a single group hospital has been established in the State;
- The number of doctors, midwives and nurses is often below legal requirements.

 Lack of monitoring and accountability also allows for serious gaps in the local food rations distribution system (Public Distribution System), resulting in a shockingly high rate of anaemia among women living in tea gardens areas.

These violations of the rights to health, food, life and equality are largely unreported and as a result unaddressed. Basic tools to communicate, inform, and document violations are virtually non-existent, and women lack access to mechanisms to hold public and private entities accountable for the failure to provide life-saving treatment as required by law. At a more nuanced level, women have poor relations with health authorities in their Block and District, thereby further hindering access to health services. The Government does not track information on availability of health services, and as a consequence communities and local advocates lack solid data to support demands in advancing women's health.

To address these gaps, Nazdeek in partnership with PAJHRA, ICAAD and PNJSS developed a project combining legal empowerment, social accountability and technology. The project involves direct participation of 42 community members who identify and report violations of reproductive rights and food rights through an SMS coding system. The information is gathered on an online map and database and is utilised by local groups and activists to demand better health infrastructure through court litigation or advocacy.

Nazdeek's core mission is to enable communities and grassroots organisations access to justice to reclaim their rights. To do so, Nazdeek connects and coordinates various stakeholders, including lawyers, activists, community leaders and international organisations, developing strategic litigation and advocacy strategies to advance economic and social rights. Nazdeek believes that this project has the potential to ensure that a community that has been facing decades of exploitation can finally demand accountability from the government and private companies. At the same time, local advocates (NGOs and lawyers) see this as a tool to strengthen their work by systematically improving data collection, community monitoring and building community's relations with Government health authorities.

Project objectives

#	Modified Objective	Original Objective	Reasons for change
1.	**To increase awareness and participation within the community by establishing a mechanism to track and report health rights violations.**	Establishing a mechanism to track and report health rights violations (Mobile Application): By assigning key individuals (women, village elders, youth activists, and ASHAs) mobile phones with SMS technology, communities are provided with the tools to promptly report data that would often be inaccessible to advocates. Moreover, the mobile platform seeks to ensure that communities have equal access to health care resources.	While these objectives remain substantively similar, they have been modified for clarity and ease of assessment.
		Ability to Advocate & Educate (Training): To pilot mobile reporting or mapping platforms in an effective manner for the local community members and grassroots organizations it will be necessary to develop training programs and materials in English and Assamese to adequately train those working with the program. This training will include product documentation and material that explains the technology being used, but also will include background information on relevant rights and entitlements, templates for data collection, sample questionnaires for initial interviewing, and in-depth reporting to assist in systematizing the data collection. Additionally, the community itself will be a resource for potentially identifying solutions to better gather data and increase transparency in health systems. They will also be trained to understand the mapping platform, so that they can convey the importance and value of identifying gaps and patterns to their community.	
2.	**To expand access to and availability of health services for women living in tea garden areas through court litigation and advocacy.**	Accountability/ Transparency (Mapping): By developing a mapping platform which tracks incidents of maternal health violations within a specific area, we aim to increase awareness within the community and public at large as to the gaps in service delivery. This results in a more accountable health system with heightened transparency. The system will have to be field tested along with the mobile reporting system to be customized to accurately and clearly share information such as location, ethnicity, gender, age, pregnancies, whether medical care was received, and if not, why service was denied, and whether health centers were adequately resourced and staffed.	These objectives have been modified to include advocacy activities among the steps carried out during and at the end of the project to increase access to services and curb maternal mortality. In particular, while objective n. 4 refers to the steps taken by local groups upon receiving reports of incidents (such as fact-finding, representations with local authorities, filing of Right to Information applications...), Objective n. 3 refers to the steps taken at a more strategic level (on completion of the pilot project) to expand availability of health services and increase accountability in the deliver of services by State and private tea gardens.
3.	**To strengthen the capacity of civil society (NGOs, lawyers) to intervene to address cases of health rights violations**	Litigation: Legal advocacy has proved to be an excellent strategy to guarantee concrete reliefs, strengthen health infrastructure, and redress structural discrimination, making a difference in the lives of many women. Litigation is also a form of direct participation for individuals who would otherwise be marginalized. This project and the data obtained leverages the potential of strategic litigation, maximizing existing resources, avoiding overburden of the judicial system and addressing large-scale failures to fulfill women's rights. Strategic cases will be identified and filed at High Court and at times lower court levels, triggering a ripple effect on the whole State of Assam and with a potential to influence other Indian States on behalf of many vulnerable communities.	
4.	**To collect quantitative and qualitative data related to violations of reproductive rights and food entitlements in the District of Sonitpur, Assam.**		This objective has been added as an underlying rationale of the whole project to address the lack of information available to community and civil society regarding availability of health and nutrition services in Sonitpur District.

Users and uses

Users and uses of the findings will be:

1) Local activists and actors, in particular Nazdeek and the local partner PAJHRA, who will use the data gathered through the project to develop advocacy and litigation strategies targeted towards increasing government accountability. ICAAD will be supporting the success of these strategies by engaging in international human rights reporting and advocacy (e.g. Universal Periodic Review (UPR) of India, CERD, CEDAW, etc.).

2) Community members and local leaders, who will use the findings to raise awareness of reproductive rights among the community and will be better able to articulate their demands in terms of access to maternal health services

3) The Government, in particularly local administration and Courts, is also a potential "user" in the sense that it can utilise the findings to inform policy-level choices to improve health infrastructure according to the people's needs. Therefore the Government is both the target of the advocacy activities and a direct user of the findings.

Through this pilot phase, the project team seeks to assess how the mechanism set up by the project increases community participation in holding the Government accountable for the implementation of health policies. For this reason, the project team is engaging with the DECI project in the development of an evaluation process which will serve as the basis to plan the post-pilot phase.

The engagement with DECI was made possible by the ISIF Secretariat who offered the opportunity to receive mentoring by a team of DECI consultants on Utilization Focused Evaluation and Research Communications. We decided to apply for the mentoring to; a) streamline project monitoring across the 3 partners, b) conduct and evaluation to be able to improve the project in the future, and c) understand and plan how to shape engagement with local health authorities.

A brief summary of the progress made under the UFE and Research and Communications processes:

a) UFE: Several areas were explored for Users and Uses. Since there were problems in the project implementation, it was decided that Barnabas (Project Coordinator in Pajhra) is the User and Francesca Feruglio (Nazdeek) is the facilitator for the evaluation. The Use is to learn about implementation to improve the program. Through the UFE process, the team identified areas to improve participation including:

- Increase knowledge on health rights and human rights violations
- Inclusion of training on self-confidence
- More training on use of technology
- Increased communication with participants by Pajhra and Nazdeek

The uses identified for the abovementioned issues relate to:

- Selection of volunteers
- Review of training/technology
- Review of implementation (add more activities, manage in different way, role of coordinators, other support needed)

isif asia

A list of data to be collected has been identified and the facilitator has developed a questionnaire following engagement with other stakeholders to the project. In November, the questionnaire was given to half of the volunteers through independent, third party resource persons. The next step is to analyse the data and introduce changes accordingly.

b) Research Communication

The team has carried out steps 1 to 7 of the Research Communications and is in the process of implementing the Communication strategy. The workshop held in Brisbane in September has allowed a more in-depth reflection on the situational analysis and the communication needs. As a result of this discussion, the project team has identified a communication objective to "building a relation with the Government (District and Block) so that by March 2015 the volunteers in the two Blocks will be able to hold meetings with the BPM (or DPM) every 3 months to share the cases reported."

To reach this objective, and following suggestions by the DECI advisors, the project team has identified a champion within the District level administration, which was used as entry point to set up meetings with higher authorities. The project has been formally introduced to the District Collector, Sonitpur, the highest Government representative in the District. The Collector has showed positive interest in the project and his willingness to further discuss findings of the reporting system and potentially collaborate to expand the project. Through the Collector, another meeting was held with the NRHM Joint Director of the District to introduce the project to health authorities as they are the target audience of the final report. The next steps will be to have more substantial dialogue with lower level health authorities, especially in the two Blocks, and explore opportunities for increased dialogue in lead up to the launch of the final report, which will contain recommendations to improve delivery of health services for pregnant and lactating women.

February 2015:
Both the UFE and Research Communications paths have been concluded. More specifically:

a) The UFE findings exposed specific issues with the coding system, the training materials, and difficulties in relating with frontline health workers and community members. It also revealed crucial insights to understand how information is collected and reported and what can be done to increase texting. More broadly, the different degrees of participation (=reporting) mirror existing power dynamics within the group. Social status plays an important role in allowing a participant to collect and verify information. As a result, women who are most marginalized within the group of participants also lack sufficient awareness and confidence to text reports.
    Following a discussion between the UFE user, facilitator and mentor, a number of steps have been agreed upon to address the issues identified. These include: increasing engagement with 'low reporters' through self-awareness programs and focus group discussions; engaging with frontline health workers and the community at large to sensitize them about the project and the role played by participants; revising the coding sheet and the training materials. The project team also developed a timeline for carrying out these activities, yet lack of funding poses a challenge in ensuring adequate execution.

b) The research communications strategy led to a successful engagement with authorities and to achieving the objective set out during the mentoring. After the launch of the final report (see Project Outcomes section below), District authorities committed to set up regular Grievance Forums where project participants will meet with Block level authorities to share the cases reported. The project team is currently pressurizing authorities to hold the first Forum while on the other hand is working with participants to strategize on the expected outcomes of the meetings.

Overall, the engagement with DECI mentors, especially for the UFE part, has required substantial time and efforts by the UFE User and Facilitator, and their teams, to develop adequate research tools and collect evidence. Yet, the process has been not only extremely beneficial in enhancing the project's effectiveness and impact, but also to build organizational capacity on evaluation strategies.

Indicators

Baseline	Indicators	Progress	Assessment	Course of action
1. Community members, particularly women, have little knowledge of their reproductive health rights and nutritional entitlements	Number of participants trained on reproductive health and food rights;	APRIL 2014 47 participants attended the initial 2 training sessions JUNE – DEC 14 we have conducted 1 training per Block as well as monthly follow up sessions per Block to increase rights knowledge FEB 15 – Out of 47 participants, about 30 are actively participating in the project	Participants reported gaining increased knowledge of their rights and entitlements. The awareness on and understanding of reproductive rights issues is not homogeneous across the two blocks. For this reason the project team has reinforced content of the training in the follow-up meeting, focusing on specific aspects depending on each group.	The UFE highlighted the need to ensure community members are also aware of the project and of their rights and entitlements. In the monthly meetings, we have provided additional content about the perception of rights in the community.
	Participants to the project are able to report violations;	MAY 14 – FEB 15 - Project team has been regularly calling and texting participants to make sure they have appropriate tools and knowledge to report violations As of NOV 14, about 50% of participants sent at least a text. At least half the remaining 50% actively participated to the training sessions.	Participants reported exposing and "bringing to light" issues related to reproductive rights, which would have not otherwise been addressed. Participants feel they have acquired knowledge to question unavailability of services in public hospitals From September to November 2014, the number of texts received has been slowly but steadily increasing. (This followed a decrease in reporting from a peak of July 1st, to a trough of September 1st.)	In the monthly meetings we have run sessions and activities on how to conduct fact-findings and documentation. The UFE has provided valuable insights on how to increase participation of the 'low performers.'
	Number of genuine texts (=reports) sent by participants;	DEC '14 – 70 genuine cases of violations have been texted. FEB 2015 - 75 cases have been reported	Almost all texts received are genuine reports.	
	Information texted is relevant and correct;	In more than half of the cases, information texted does not match with the one gathered at verification stage – usually texts miss some codes	This speaks to the need for a strong verification system and for redefining certain codes is a more user-friendly language. Volunteers' ability to identify violations must also be strengthened.	In the future the project team could strengthen the verification system, for instance by developing a set of fixed questions or strategies to double-check information.
2. There is limited data available on violations of maternal health rights in project location	Number of text sent by participants reporting cases of violations; Number of text verified by project team;	- As to Nov 2014, 60 genuine texts have been reported and verified through phone call. - Repeated type of violations have been reported in certain health facilities - As to FEB 2015, 75 cases have been reported and verified through phone calls. About 10 cases have been verified through fact-findings. - December 2014: the project team undertook an in-depth field research meeting volunteers, victims and their families as well as speaking with health officials. - January 2015: data collected through reports and field research has been compiled and analysed to be published in a report (see below)	The cases reported expose clear patterns of violations and identify specific gaps in the delivery of health services at facility and at Block level. This information is readily available and accessible on an interactive website platform. February 2015: A final report "No Time the lose: Fighting Maternal Mortality in Assam" has been launched in February 2015 illustrating the main findings and setting forth key recommendations to improve delivery of maternal and infant health services. (see below at #3)	As the amount of information received grows, the project team will place further attention at compiling data and verifying data with detailed fact-finding investigations and follow-up. February 2015: Data collection has been continuing beyond project completion and the team will carry out period analysis of the reports to be shared with authorities and the public.

Baseline	Indicators	Progress	Assessment	Course of action
3. Local activists and organisations have limited access to data on health rights violations, and thus limited ability to plan interventions.	Ability of partners to promptly verify data; Emergencies and/or serious cases are followed up by the local partner; number and type of follow-up actions done; Ability to plan and carry out broader advocacy actions	June 2014: Project partner has decided and planned 4 fact-finding investigations to follow-up on cases of maternal and infant death, and has shared a detailed report with the findings to the other organisations. June 2014: PAJHRA's project officer conducted all phone verifications within 3 days. As to February 2015 the project team has conducted 10 investigations, carrying out interviewing relatives of victims, health workers and community members. February 2015: data collected led to the launch of a report with key recommendations for local authorities on how to improve service delivery.	At the ground level, the project has seen high engagement of PAJHRA activists based in Dhekiajuli area, as well as PNJSS activists based in Balipara area. Under Nazdeek's advising, local activists are framing strategies to redress violations documented. In addition, in Tezpur's project officer has increased her project management skills and now plays a crucial role in ensuring internal communication flow among the 3 partner organisations, as well as the website update.	July 2014 – The project team has engaged with the Digital Empowerment Foundation in view of a potential collaboration July 2014 – Nazdeek has produced two external communications tools with updated activities and ad interim achievements. July 2014 The project team, together with participants, will begin to utilise existing redressal mechanisms for serious cases which have been reported and investigated Post project period, the project team will monitor and maintain pressure for the implementation of recommendations
4. Community's relation with local health authorities is poor, thereby hindering access to services	Number of meetings held with local authorities Project volunteers feel confident to approach authorities Project volunteers are able to intervene to address violations reported	May – Dec 2014: Volunteers served as a channel for victims to expose violations suffered by women. This implied approaching frontline health staff at village and hospital level, questioning poor service provision and demanding improved healthcare. November 2014: In line with the Res Comm strategy, the project team formally introduced the platform to both the District Collector (highest authority in the District) and the Joint Director, NRHM. June – December 2014: the project team has carried out monthly meetings to strengthen volunteers' capacity to use existing complaint mechanisms to redress violations. February 2015: For the first time, volunteers met with higher District authorities to hand over the report with the findings of the data collection, and directly voice their concerns over the poor delivery of healthcare	November: Local authorities, namely the District Collector, Sonitpur, and the NRHM Joint Director, Tezpur, have showed interest in the project and willingness to further discuss reports with the project team. December: As emerged during the UFE data collection, volunteers gained skills and knowledge to raise issues with health staff February: volunteers have conducted fact-finding investigations, interviewing victims and health staff. After a series of trainings, they have drafted complaints to be filed with the Departments of Health and Food and Civil Supplies February: Following the launch of the report, District authorities agreed to set up regular Citizens Grievance Forums at Block level to hear cases reported by the volunteers.	Post project period: Citizens Grievance Forums have created an unprecedented opportunity for communities to demand improvements service provision, suggest recommendations and address specific cases. In April 2015, complaints have been filed to the Departments of Health and Food and Civil Supplies leading to an proper functioning of the delivery of food supplies and health service as provided under the law. (see Outcomes section) A range of advocacy actions carried out directly by project volunteers with the support of partners organisations led to improvements in the health and food services in the two Blocks (see Outcomes section)

Project implementation: understanding the chain that leads to results

Tips: This is the most important section of the report. Here, the reader will **understand the processes and operational issues** of your project and how they contribute to the achievement of the objectives and the theory of change behind the project implementation.

Is possible that the project team's understanding of the development problems to be addressed with this project will have evolved or **changed** from those described when the project was originally submitted and approved. If that is the case, please share what motivated the change and what course of action has the project team identified.
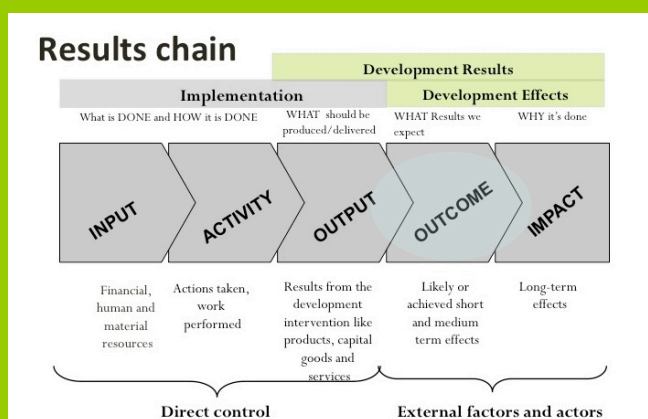

Results chain diagram provided by In Develop

Narrative - project implementation

The outputs of this project are intended to contribute to the original objectives, as follows:

> 1 - To increase awareness and participation within the community by establishing a mechanism to track and report health rights violations.

> 2 - To collect quantitative and qualitative data related to violations of reproductive rights and food entitlements in the District of Sonitpur, Assam.

> 3 - To expand access to and availability of health services for women living in tea garden areas through court litigation and advocacy.

In order to increase awareness and participation within the community, in line with objective 1, the project team identified and trained a list of participants, all of them Adivasi and most of them women. Three additional women participants were subsequently identified and trained, bringing the total to 42. This process has been carried out in cooperation with two local organizations, PAJHRA in Dhekiajuli Block and PNJSS, an Adivasi People's Organisation who has been fighting for the rights and entitlement of women in Sonitpur District of Assam. PNJSS is affiliated with the Diocesan Board of Social Services (DBSS). While the project was initially designed together with PAJHRA for the Dhekiajuli area, the second Block (Balipara) has been subsequently added in order to provide a better sampling of the gaps in the District's health infrastructure. Unlike PAJHRA, PNJSS is an informal group of Adivasi women who have traditionally focused on domestic violence and trafficking cases through self-help groups based in Balipara block. PAJHRA has maintained its role of local coordination, with the project team largely based in PAJHRA's office in Tezpur.
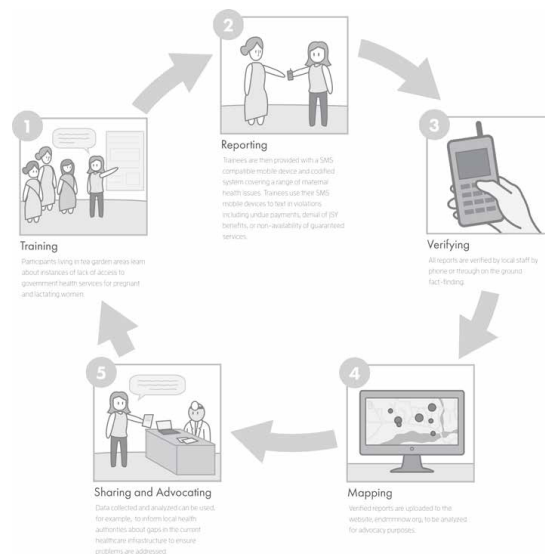
Differences in participants' background, occupation and literacy levels have resulted in a slightly different engagement of the project team during the training and workshop sessions. During the initial two-day training session held participants were provided an overview of reproductive rights and entitlements under the Constitution of India and the main national schemes guaranteeing access to maternal and infant healthcare. The trainings were developed with a participatory model in mind, seeking participants interaction and exchange through a range of activities. A translator worked with the trainers to ensure content was conveyed as clearly as possible. Participants were provided with a training kit in Assamese language, covering both the rights and entitlements session and the coding system/project overview session. In addition, they were provided a laminated coding sheet, and a phone with memory card. On the second day of the training, participants were briefed on the overall project structure, timeline and objectives. They were also trained on the SMS codes relevant to violations and respective locations, and asked to engage in simulations to test understanding and

usability of the coding system. Also, upon their request, participants have been provided a personal ID card to recognize their role as women leaders within their own communities. For about a third of the women participants, the training was their first exposure to using SMS functionality on phones, which highlighted the lack of exposure and access to technology and communication.

Following the first training, the project team sent all participants a SMS text officially launching the project and since then maintained consistent engagement with participants on a weekly basis through phone contact done by PAJHRA staff from their main office located in Tezpur. To facilitate communication flow and ground-level interventions, a coordinator has been identified for each block among the staff of the two local organisations. The coordinator is contacted weekly by the local project team and updated on the number and content of texts received as well as on the follow up required. The project team has better defined the coordinator's tasks after an assessment meeting held in June in Tezpur.

Differences among participants in the two blocks are also reflected in the challenges encountered at the ground level. In Dhekiajuli Block the group of participants are health workers or young activists living in/near tea gardens, and therefore were quite familiar with the health system and the entitlements under some of the government schemes. In Balipara Block participants are mostly farmers or housewives living outside tea garden areas, and were therefore much less familiar with reproductive health issues and rights. Consequently, the main challenge for the Dhekiajuli participants relate to employer-employee power relations within tea gardens, with some participants hesitating to report violations because they are afraid it may have negative on the tea garden hospital health staff. In Balipara Block, the challenges speak to the need for strengthen participants' capacity to understand and adequately identify reproductive rights violations. For these reasons, following an assessment meeting held in June, the project team decided to hold a second workshop with participants in each block.

A second workshop was held in June, to reinforce the content of the initial training, and from August onwards the project team has been meeting the volunteers monthly to discuss outstanding issues with the reporting (both technical and content-related). In particular, the meetings have been crucial to address a number of issues that volunteers faced, and which were hindering the ability to report cases of violations. For instance, in both Blocks the issue of whether to report about violations occurring to non-Adivasi patients emerged, such as women belonging to the Muslim community. In this case, it was agreed that the focus of the project is not restricted to Advasi community, although it represents the vast majority of beneficiaries.

Upon requests of project volunteers, monthly sessions also provided tools and built skills to better identify violations, conduct fact-finding and use existing grievance mechanisms to address violations. This decision was also supported by UFE data showing that the challenge in obtaining reliable information regarding cases identified is a major hindrance to reporting. Volunteers engaged in activities during and between training sessions to build their advocacy skills. This effort was particularly important since increasing capacity of participants to undertake fact-finding investigations will, in the long term, ensure sustainability and reduce workload for the local staff. Indeed, by the end of the project, volunteers acquired sufficient knowledge and skills to seek redressal of cases at Block level (Objective 3). The project successfully created a pool of 'paralegal' women activists who can obtain positive change for the entire community. Complaints filed by volunteers with relevant authorities, such as the Departments of Health and of Food and Civil Supplies, led to significant improvements in the delivery of health and food services (see 'Outcome' & 'Impact' sections).

A final and crucial step has been taken in the development and launch of the report 'No Time to Lose: Fighting Maternal Mortality in Assam through Community Reporting' containing a quantitative and qualitative analysis of the over 70 cases reported from May to December, including key case studies, maps and visual representation of data. The report offers tangible and time-sensitive recommendations for Block and District level health authorities and tea garden management to improve service delivery and save mothers' and infants' lives. On 17th February 2015, about 30 project volunteers met District authorities, namely Deputy Commissioner, Sonitpur, Shri. Lalit Gogoi, District Joint Health Services Director, NHM Sonitpur, Dr. M. H. Saikia and Medical Inspector of Plantations, Dr. P.K. Lahkar who praised the initiative and promised to submit the findings and recommendations of the Report to higher-level authorities. Dr. Lakhar further stressed that lack of adequate infrastructure in the tea gardens was a major barrier in accessing health services. No Time to Lose identified a significant gap between

patients and healthcare providers. In this regard, Dr. Saikia committed to establishing a Citizens Grievance Forum at the Block level to address maternal health violations reported through the End MM Now system, with time-bound action from the State. (Objective 3)

After project completion, volunteers and partner organisations will maintain pressure on authorities to implement report recommendations and address individual cases through the Citizens Forum.

Technical aspects:

As to the technical operations of the project, in order to collect data in line with objective 2, texts sent by participants reach a smartphone located with PAJHRA's staff in Tezpur (Sonitpur District, Assam). The office is located at equal distance between the two blocks. Through a phone application, texts are sent to the online system, which de-codifies the texts and converts them into reports through a plugin installed on the website. In order to become publicly visible on the map, each report needs to be manually approved by the local staff, who follows-up on each text received by calling the sender and asking additional information. Once the case reported has been verified by phone, and additional details are collected, the report can be published on the website's map and database.

As to the challenges faced in this process, one of the main issues is that the repeated power cuts occurring in Tezpur make it difficult for the local staff to timely update the website. Since electricity shortages are due to the excessive heat, this problem is likely to be solved once the monsoon season ends. In the meanwhile, the information can be conveyed by telephone to the Nazdeek staff based in Delhi, who have access to better internet connection. Another technical issue involves the transfer of data between the smartphone and website. The website, running on Ushahidi, has been synced to the smartphone through the application SMSsync. However, the plugin installed on the Ushahidi platform did not initially communicate properly with SMSsync, thereby creating repetition of texts on the website back-end. This negatively impacted the data collection, making it more difficult to timely update the website with the recent information of the reports received.

The customized Ushahidi plug-in used for the project was adapted from a Open Health Networks (OHN) (http://cegss.osf.parsons.edu/) program designed in conjunction with Parsons the New School. The setup of the plug-in was handled in-house by ICAAD, and certain problems experienced at the outset of the project were fixed in-house with advice from the OHN team in Guatemala. However, there were two remaining problems that both the OHN team and our in-house team could not solve; the primary being the duplication of SMS issue. The team went through two separate technology consultants, one of whom fixed a database problem and the site redirect issue but was unable to make any real progress on the duplication issue. ICAAD began working with an external consultant, Michael Kahane, who originally designed the customized Ushahidi plug-in used for the project was adapted from the Open Health Networks (OHN), who was finally able to resolve the duplication issue. The prior duplicate reports were then cleared from the system.

Since the start of the collection, 2 facilities were added to the coding sheet, and 2 were deleted as irrelevant, thereby bringing the number of total facilities covered to 18 (see box on the left). Codes cover all types of facilities, both public (7 Primary Health Centres, 1 Community Health Centre, 1 District Hospital, 2 Medical Colleges) and private (7 tea garden hospitals).

The website was eventually modified so that upload of reports on the front-end of the website is now easier through a drop-down menu with the names of the facilities covered by the codes (See picture above). This has facilitated manual upload of reports by the local staff and, more importantly, has ensured more accurate mapping of the cases reported. Based on preliminary research, we anticipated that reporting using an SMS based reporting system would likely result in some loss of information. This was proven to be the case as when verifying reports local staff often records additional information that could have initially been reported by code, or gains much more information through verbal conversation than can be reasonably expected for an SMS/code based report. However, in addition to a number of other positive ancillary affects an SMS system provides (such as increased use of technology by participants), a particular value is the initial alert to the incident and the start in a chain of investigation.

EndMMNow

English (US)

SUBMIT A REPORT

HOME   REPORTS   SUBMIT A REPORT   GET ALERTS   PROJECT   ABOUT US

Submit a New Report

Select A Form Type Default Form

Report Title *

Description *
Allowed HTML tags: "a, p, img, br, b, u, strong, em, i, iframe".
Iframes are only allowed from: %^//(www.youtube.com/embed/, player.vimeo.com/video/, w.soundcloud.com/player/.

Date & Time: Today at 10:34 pm (Asia/Kolkata)   + **Modify Date**

Categories *
- Health Facility Conditions
- Availability of Services
- Undue Payment
- Food Rations
- JSY Entitlements
- Emergency

Optional Information

First Name

Last Name

Email

Find a location near you
Select a City

-31.89147, 110.20463

AFRICA
SOUTH AMERICA
Indian Ocean
AUSTRALIA
ANTARCTICA

5000 km
2000 mi

Scale = 1 : 222M
Terms of Use

DELETE LAST   DELETE SELECTED   CLEAR MAP

City, State and/or Country   **Find Location**
* Search for your location using a location name OR latitude,longitude coordinates (format: 38.19, 85.61), OR click on the map to pinpoint the correct location..

Location Name *
Example: Corner of City Market, 5th Street & 4th Avenue, Johannesburg

News Source Link   +

External Video Link   +

Upload Photos
Browse…   No file selected.   +

Submit

Facility	Block/Location
Dhekiajuli Primary Health Centre	Dhekiajuli Block
Dhekiajuli Community Health Centre	Dhekiajuli Block
Sapoi Tea Estate hospital	Dhekiajuli Block
Tinkharia Tea Estate hospital	Dhekiajuli Block
Dibrudarang Tea Garden hospital	Dhekiajuli Block
Panbari Tea Garden hospital	Dhekiajuli Block
Narayanpur Tea Garden hospital	Dhekiajuli Block
Dhirai Tea Garden Hospital	Dhekiajuli Block
Rakashmari New Primary Health Centre	Dhekiajuli Block
Balipara Block Primary Health Centre	Balipara Block
Haleswar Primary Health Centre	Balipara Block
Dipota Primary Health Centre	Balipara Block
Dekargaon Primary Health Centre	Balipara Block
Panchmile Primary Health Centre	Balipara Block
Sonabeel Tea Garden hospital	Balipara Block
Kanaklata Civil Hospital	Tezpur
Guwahati Medical College	Guwahati
Tumuki Medical College	Tezpur

More comprehensive information is outlined in the table below:

Input	Project activities	Outputs	Outcomes	Timeline	Status	Assessment
Entire project team	Development of criteria for selection of participants/volunteers; Field research and identification; Meetings with potential volunteers held	Output 2. Building of network of volunteers	A network of 44 participants in 2 Blocks has been set up 3 additional participants have been added, bringing the total to 47	February 2014	Completed	Participants feel they are positively impacting their communities, as they are part of a large-scale programme and they feel more confident to raise concerns on health rights violations. Progress made on Objective 1. During this phase a partnership has been developed with PNJSS, a women rights group in Balipara Block. As to December 2014, there were about 30 volunteers actively participating
Purchase of cell phones with memory cards, laptop, projector and office supply.	Distribution of equipment among stakeholders	Output 1 and 2. Online platform (endmmnow.org) and SMS code developed and building of network of participants.	Project stakeholders are better placed to implement the project and have gained improved access to key equipment.	April – May 2014	Completed	Equipment was purchased from different sources to find better deals, but that incurred in additional costs (i.e. custom fees). December 2014: Reflection by team that decision to purchase basic cell phones for participants enabled easier functionality and use, however may need to purchase a 2nd smartphone for GPS purposes.
ICAAD staff and external consultant	Project website and SMS code developed	Output 1. The code system covers about 30 types of violations and 18 health facilities December: Codes have been added to include 2 (and clear 2 previous ones) more facilities and feedback has been gathered on how to better phrase existing codes.	Participants have access to a mechanism that tracks reported violations and populate them on a single platform. Data collected is verified, mapped and displayed on a public website	April - May 2014 December 2014 – re-designing Post project period: revising coding list	Completed	June: Participants and partners have asked to expand list of codes to include location of food ration shops. December 2014: the website has been rebuilt to allow for easier reports upload Post end of project: list of codes will be revised based on the codes to be able to collect more nuanced information. Codes that have not been found relevant will be deleted. On the website, filters for search will be revised to reflect most commonly reported issues.
Nazdeek staff	Development of training materials by project team	Output 2 and 3. In April, 2 Training toolkits have been prepared: 1) on maternal health rights under Government laws and schemes; 2) on the coding system (list of codes and how to use them) and 4 Training sessions held (2 per Block) June-December: Monthly meetings to address technical issues and build capacity to identify, document and address violations.	47 participants have acquired sound understanding of their legal rights under the Constitution and various Government schemes Participants function as hubs of information to report on incidents occurring to women living in their respective areas. February 2015: the project successfully created a pool of women activists who can obtain positive change for the entire community	April 2014 26th - 27th April (Dhekiajuli Block) 3rd - 4th May (Balipara Block) Monthly meetings from June until December	Completed	May: Training toolkits have been prepared and translated into a local language Assamese. Due to technical limitations, the translation process has made the toolkit more basic both as to content and visuals. Understanding of maternal health issues and confidence in utilizing the phones was initially not consistent within the 2 Blocks. December: Through UFE data collection, feedback has been gathered on the content and methodology of the initial training, which allows for improvement of the training module. December: UFE data has also shown the need for smaller-scale level meetings with participants and peer-to-peer sessions. Post project period: UFE revealed need to translate training materials into another local language (Sadri) to ensure they can be understood by a wider audience
Project team	System testing	Output 1, 4 and 5 Comprehensive monitoring and tracking of project implementation (circulated internally) August: Technical issues have been solved by consultants hired ad-hoc	Initial assessment of system testing, identification of gaps and readjustment of strategies	5th May 2014 onwards Technical issues were solved in August June-December 2 part-time interns have been working carrying out verification and website management	Completed	- Some participants are not used to send SMS texts and therefore require more assistance. - Other participants hesitate in reporting cases of violations because they fear adverse repercussions from tea gardens management. December: The UFE survey has suggested a number of issues in terms of project implementation that can help ensuring more consistent participation of volunteers. February: the project team is consulting with other organisations running ICT projects to improve case tracking and systematize communications with victims and their families to improving assistance to victims.
ICAAD and Nazdeek staff	Production and dissemination of communications/advocacy materials on the project	Output 6. Production and dissemination of communications materials Article on the Guardian Video/pictures Online launch September: Production of one short project presentation and a more detailed project brochure. Project was very positively featured in a local newspaper article, which included interviews with volunteers and local staff. February: Production and dissemination of extensive report used for advocacy with local authorities	The details of the project were shared among over 4000 contacts and reported on international media February: after the launch of the 'No Time to Lose' report, the issue of maternal and infant health was raised in 5 national and local newspapers, and presented in 3 international human rights forums.	13/3/2014 (article) April – brochure 3-4/5/2014 (videos and pics) 12/6/2014 (online launch) September (brochure and project overview) November (newspaper article) February: launch of report through press conference and meeting with authorities	Completed (I phase) June - Sept Completed (II phase) February 2015	The project was very well received by the general public and was welcomed by international and local organisations (such as Awaaz, White Ribbon Alliance, National Foundation of India) September: Thanks to the participation to the 2014 APNIC Conference held in Brisbane, the project team has began to build relationships with other stakeholders working in the ICT area, such as the Digital Empowerment Foundation. More collaborations to strengthen the system are planned in the post project period

Input	Project activities	Outputs	Outcomes	Timeline	Status	Assessment
Project team	Reporting and tracking of health rights violations	Output 4. As to the end of November there were 57 individual cases reported. By February 2015, about 75 cases have been reported	June 2014: Initial sense of the most common forms of violations (lack of blood, transport, undue payment) and the facilities that are responsible for larger share of violations. February 2015: Data analyzed led to identification of main factors leading to maternal and infant health rights violations and formulation of recommendations tailored at facility level.	May – Dec 2014	Completed	The reports reveal a pattern in the type of violations communities are facing within the 2 blocks, and the locations where a majority of such violations are stemming. The reports identify 2-3 facilities that are responsible for a large share of the violations reported, with the lack of availability of blood and access to transport central to cases of maternal and infant death. This information makes demands for greater accountability from the public officials much more nuanced. Dec: Reporting of cases has fluctuated due to a host of factors (need for more trainings, expectations of greater immediate intervention by CBOs…).
Nazdeek staff	Assist local staff to carry out ground coordination of the project (follow up with participants' reports)	Output 5. Capacity Building and networking February 2014 - June - Nazdeek staff delivered one-to-one sessions to PAJHRA staff on website management and how to follow-up on reports - A volunteer program has been launched to find a project assistant. June - Dec: - Two interns were trained to assist in the phone verification and fact-finding - Additional training provided to participants to build their skills in conducting fact-findings and use existing administrative remedies to address violations. - Support in M&E and research communications received through DECI-2 mentors	Strengthened capacity of local partner to make best use of the project outputs. For instance, the local staff has received training on how to conduct follow up actions (phone and on the ground) on each report received. February 2015: Project volunteers became effectively 'paralegal' activists, thereby easing the workload of local partners and carrying out grassroots advocacy	May 2014 – February 2015	Completed	June 2014: One of the challenges encountered initially was to maintain a flow of internal communication among the three organizations involved (ICAAD, Nazdeek and PAJHRA). December: This has been addressed by identifying a more efficient division of tasks among the three partners involved, with Nazdeek coordinating with Pajhra aspects related to the ground implementation of the project, while separately engaging with ICAAD on aspects related to technical development and future funding opportunities. More attention needs to be placed on the questions asked at the time of phone verification of reports.

Project outputs, communication and dissemination activities

Tips: Take into account that the reader of your report has not being involved in project implementation, so readers do not have any further knowledge besides the information you are providing here.

This section of the report will allow you document the communication and dissemination efforts that the project team has conducted, which might be part of a specific communication strategy design as part of the project, or in place for the organization as a whole. When possible, please provide information about strategies in place and the rationale behind them.

Lessons can be learned from many aspects of project implementation, covering a wide variety of aspects such as technical, social, cultural and economical. Taking the rationale behind the project and its objectives can serve as a framework to draw your conclusions. Lessons can be identified by project partners, beneficiaries and general staff from the organization. A project diary and other activity records can serve as a tool to reflect during project team meetings and immediately after project activities are conducted.

> ***Outputs are immediate, visible, concrete developmental change that is the tangible consequence of project activities, under direct control of the project team.***

Example of possible outputs to report are:
- *New products and Services (software, online platforms, applications);*
- *Information sharing and dissemination (publications, conferences, multimedia, social media);*
- *Knowledge creation (new knowledge embodied in forms other than publications or reports, such as new technologies, new methodologies, new curricula, new policies);*
- *Training (short-term training, internships or fellowships, training seminars and workshops) and*
- *Research Capacity (research skills; research management capacity and capacity to link research to utilization of research results).*

Project outputs	Status	Assessment	Dissemination efforts
Output 1. Online platform (endmmnow.org) and SMS code developed The code system covers about 30 types of violations and 18 health facilities	Completed on 5th May 2014 December 2014 – re-designing Post project period: revising in light of feedback received	The technical issues previously faced have been addressed through the help of external consultants. The coding system has been revised adding codes upon requests of participants. Feedback has been collected to improve both the website and the codes list.	See output n. 6
Output 2. Building of network of participants	Completed	Building of network is completed but key activities to strengthen it and maintained engagement will be carried out throughout the project	The existence of the network of participants is fairly known among local communities as participants shared the project details. Since November 2014, the network is known also to local authorities (District Commissioner and NRHM Director). In February 2015, women volunteers met with local authorities to present findings of the data collection and demand better delivery of health services.
Output 3. Design and delivery of trainings and workshops	Completed	4 sessions have been carried out (2 per block) in April. Specific modules have been developed for the other 6 meetings carried out between June and December. From June to December, we have carried out skills-building sessions on fact-findings and documentation, complaint drafting and use of administrative grievance mechanisms to address violations.	Video and photos of the sessions have been collected and will be compiled together to track the development of the project. After the end of the project the training materials will be translated in another local language and disseminated again.
Output 4: Knowledge creation: identification of gaps in the delivery of healthcare in the project area, including patterns of violations and systemic issues at facility level.	Completed but will continue after project period	The data collection through SMSs allowed identifying and mapping systemic issues leading to lack of access to basic maternal and infant health services. In addition, field research and analysis of data collected led to the formulation of key recommendations for local authorities and tea garden managers to improve service delivery in the area covered.	Findings are illustrated in a final report "No Time to Lose", submitted to relevant government authorities in February 2015. The report visualizes findings through maps and infographics. It also presents concrete recommendations, both 'policy-related' and 'service-related' in line with government policies and schemes.
Output 5. Capacity building and networking	Completed but will continue after project period	The organisations involved have strengthened their capacity by acquiring crucial skills, such as management and communication skills by coordinating day-to-day work and developing communications and monitoring strategies. Networking and building of relations with external stakeholders, including civil society and government actors.	By February, local partners presented the project to, and developed relations with a range of government authorities/department, including District Collector, Sonitpur District; Disaster Relief Team, Sonitpur District; National Rural Health Mission, Assam; Health Department, Sonitpur District; Child Welfare Committee, Assam Partners also developed relations with other stakeholders including Department of Mass Communications, University of Tezpur, Digital Empowerment Foundation, Awaaz, Change.org, Centro de Estudios para la Equidad y la Gobernanza (Guatemala), Ushahidi
Output 6. Production and dissemination of communications materials	Completed but will continue after project period	March - June 2014: blog article, online launch of the website through newsletters and social media (Facebook and Twitter). June - November: development of presentation materials and briefings. December - February 2015: Publishing of Final report with findings of data collection and key recommendations; press conference and press release launching the report; video describing the project; production of online newsletters	Press Coverage: The Guardian, The Hindu, The Assam Tribune, The Telegraph Newsletters reached over 3,000 contacts Presentations about the project were delivered at a range of national and international foras, including: 'Sexuality and Social Justice: What's Law got to do with it?', held by the Institute for Development Studies in Brighton, UK 'ICT for social accountability,' held by Centro de Estudios para la Equidad y la Gobernanza en los Sistemas de Salud in Delhi UNICEF Consultation 'Mobile Phones: A tool for Social & Behaviour Change', held in Guwahati, Assam 'Assam Digital Innovation Summit 2015', held by DEF in Guwahati Assam

Project outcomes

*Tips: This section should be completed **ONLY** for the final report.*

*ISIF Asia expects you to report about the **outcomes** of the project as defined in the table below, based on the project implementation section of this report. Project team is encouraged to discuss the questions provided below to guide the reflection:*

Can you identify and describe the relationships between the activities implemented and the social, economical, cultural and/or political benefits of your project implementation?

> **Outcomes can be defined as:**
>
> - *Medium-term effects*
> - *Effect of a series of achieved outputs*
> - *Should capture the changes for the beneficiaries*
> - *Take place during the life of project/strategy*
> - *Influence but not direct control*

The project contributed to creating positive change in a number of ways:

1. **Community members gained awareness and knowledge of their rights:** An immediate outcome of the project was the increased awareness on maternal and infant health rights, including knowledge of Government schemes and policies mandating basic healthcare standards for pregnant and lactating women and children. During the workshops held, the participants demonstrated a clear shift towards a rights-based perspective: issues that so far were seen as a fatality, such as lack of health services in a government hospital, are now labelled as violations of women's rights and entitlements under the law. This has generated not only a shift in the understanding/knowledge of rights, but also in rights-holders' behaviour (see below). According to UFE data, most of the participants are 'more aware about health issues like maternal and infant mortality' and 'learned facilities and services should be available at hospitals.'

2. **Community members gained confidence, skills and knowledge to address violations:** The project has successfully established a pool of women activists who are able to advocate for increased access to health and nutritional services. Increased awareness led to increased confidence to act for demanding better service delivery. Once volunteers familiarized with the concepts of the training sessions, they began to challenge the status quo, questioning the lack of availability of services (especially ambulances) to frontline workers in their respective villages and tea gardens. The move is an initial and necessary step towards demanding greater accountability to the government and private garden managers. UFE data showed that nearly 70% of participants interviewed "gained courage to speak up more and now feel confident to talk to health officials." Similarly, on the access to technology front, participants have become much more familiar with the use of SMS. Data collected through the UFE shows that 40% of participants gained first-time access to a phone and 50% of them increase the use of phones beyond the scope of the project. Upon requests of volunteers, the project team developed and delivered additional training sessions on how to conduct fact-finding and documentation and how to draft and file formal complaints with relevant government departments. This led to significant achievements soon after the end of the project period, with a number of complaints filed and pressure put on local health authorities to ensure access to services.

3. **Improved access to maternal and infant health services in the area covered:** In terms of actual improvement in the delivery of health services, UFE data shows that 60% of participants perceive an improvement in the quality of treatment received at public hospitals, and in the maintenance of records by health and social workers (for instance earlier registration of pregnancies which ensures women have access to nutritional supplements and check-ups). Significant and longer-term achievements have taken place after the project period and are discussed in the 'Impact' section below.

4. **Local NGOs and advocates are able to collect data for advocacy and litigation:** For the first time, civil society in Assam can rely on solid data on the lack of access to maternal health services. Thanks to this data, the project team formulated key recommendations to curb the appalling number of maternal deaths among Adivasi women. Key recommendations include the immediate appointment of a hematologist for the Dhekiajuli Community Health Centre, and the establishment of a more efficient referral system. The findings are essential to build strong advocacy and litigation strategies and fight maternal mortality. Moreover, the project piloted a mobile and web technology to systematically track maternal health violations through community reporting. By the end of the project period, the technology has been tested and tailored to the local context on the basis of the feedback gathered. The system is an invaluable tool for local partners as well as for the community to track and monitor delivery of health services.

5. **Community members have access to a mechanism to redress violations:** Community members have access to a mechanism to redress violations. A major outcome of the project is the establishment of Citizens Grievance Forums in each of the two Blocks. Data collection and field research identified a significant gap between patients and healthcare providers. A first attempt to close this gap was done during the report launch, where about 30 women volunteers submit the final report to District level authorities. One of the report's key recommendations concerned the establishment of a system for volunteers to regularly meet with local health authorities to discuss and address the cases reported through SMSs. In that circumstance, authorities committed to holding Citizens Grievance Forums every 3 months, and to take time-bound actions to address the issues reported. For the first time, women will have the opportunity to bring their concerns directly to the attention of Block Programme Managers who are in charge of ensuring adequate delivery of health services.

Project management and sustainability

*Tips: Please comment on the general project **administration, staffing, procurement**, etc. specially those aspects contributing to the fulfilment of the project objectives as well as those that have delay project implementation.*

*Indicate **how the project team has strengthened its capacity** and work towards sustainability with the support provided by ISIF Asia? (new equipment, training, improved administrative skills, lessons learned from the project). Has the organization increased its research or administrative skills of the team involved? Has the project allowed for a particular contribution to capacity building of women or marginalized social groups? Special attention should be paid to the expected or unexpected impact on marginalized social groups.*

*Have you done **anything different** to provide administrative support for this project **besides your "business as usual"** processes and procedures? Has the project inspired change inside your organization?*

> *Sustainability is to be examined not only in terms of staff retention and financial stability of the organization supporting the project but about the communities' appropriation of benefits perceived from project implementation.*

The ISIF Asia Secretariat is very interest to learn if this project has generated opportunities for future development (new funding from partnerships, sponsorships, investment or other funding mechanisms), please provide details.

Please explain if the ISIF Asia grant has helped to consolidate your organization and how. If any of the project activities will continue after the end of the ISIF Asia grant, please describe how your organization is planning to support future developments.

June 2014:

The project team is composed of staff from three different organisations, namely Nazdeek, PAJHRA and ICAAD.

One project coordinator from Nazdeek and one from PAJHRA have been appointed to coordinate the overall project (Nazdeek) and its ground level activities (PAJHRA). ICAAD has been providing key technical assistance

as well as strategic insights, especially in the initial stages of the project (selection of web platform, development of coding system and communication strategy). Additionally, a desk officer based in Tezpur has been appointed within PAJHRA under the oversight of Nazdeek. The desk officer is in charge of the phone verification, data management and website updates. The project has so far been a great opportunity for the desk officer to increase communication and organisational skills, as well as gain a right-based approach to the work. This latter piece will require further effort, in particular by improving drafting skills and the reports verification carried out over the phone.

In terms of organisational capacity, through the project implementation all organisations have so far gained A) visibility, exposure and connections with other organisations interested in learning about the project and exploring opportunities for collaboration; B) unique opportunity to strengthen monitoring and evaluation, as well as research and communication skills by engaging with the DECI-2 project and be able to carry out an effective evaluation throughout the project lifetime; and C) better equipment, crucial to carry out project activities.

November 2014:

Some of the participants have taken a very proactive role in seeking information over conditions in health facilities and availability of services, and at times even facilitating access to services; for instance accompanying pregnant women for medical check ups and ensuring that medicines are given free of costs. This has been a somewhat unexpected outcome which the project coordinators will build upon by intensifying engagement with participants and focusing on existing mechanisms to redress violations. Indeed, through additional capacity building activities, the responsibility for following up on the cases reported has gradually shifted onto participants. While this strategy implies more ground efforts by Nazdeek and Pajhra to develop and deliver training sessions, it will on the long run ensure sustainability and local ownership since community members will not depend on NGOs and advocates to seek violations redressal.

In light of the achievements reached so far, project activities are likely to continue after termination of the ISIF Asia grant, and the project team is planning to seek funding opportunities. This process will take place over the next few months, after the project implementation is consolidated at ground level.

On the project management aspect, the improvements have regarded two aspects: 1) increased ground-level activity through the help of interns. Two interns, both students of the Mass Communications Department of Tezpur University, have been assigned to the task of phone verification and fact-finding, firstly through a full time one-month internship and subsequently through a once a week engagement with the local staff; 2) more efficient division of tasks among the three partners involved, with Nazdeek coordinating with Pajhra aspects related to the ground implementation of the project, while separately engaging with ICAAD on aspects related to technical development and future funding opportunities.

Furthermore, the 2014 APNIC conference in Brisbane has afforded the opportunity for the project team to develop relations with other organizations working in the ICT sector in the region. This has been particularly beneficial since the project partners have not undertaken ICT project before, and are looking forward to receiving inputs and share ideas with other civil society groups. Following the APNIC conference, the project team has engaged with the Digital Empowerment Foundation, which also works in the Northeast of the country. This engagement has opened a series of opportunities for the future, including building technical capacity of local staff, a larger dissemination of the project findings, a potential application to the Vodafone Foundation, and the Annual ICT Manthan Award.

February 2015:

Arguably one of the main issues with project management related with human resources at local level. Cases verification and follow-up and website management has been carried out by multiple staff members, leading to inconsistencies in the way information is uploaded and, in turn, challenges during the data analysis. Additionally, transferring of technical knowledge from Nazdeek and ICAAD to PAJHRA has been insufficient, resulting in low capacity of local staff to ensure proper functioning of both the website and the smartphone application. While the project has consistently seen 2 to 4 people involved at local level, it would be ideal to designate one staff member to work full-time on the project and conduct verification, ground engagement with volunteers and website management.

The UFE process has been very useful to identify gaps and seek to improvement project management and planning. For instance, the project team should work towards better inclusion and higher participation of 'low-reporting' volunteers, since those are likely to be particularly marginalized. Overall, future management of the project will require sustained ground-level engagement to consolidate outcomes achieved, particularly to ensure effective functioning of Citizens Grievance Forums.

Impact

*Tips: This section of the report does not refer to the project activities, but about the **"bigger picture"**. It will be desirable if the project team can reflect on the **impact that the project has contributed to as part of other actions implemented by your organization and/or your partners**.*

> *Impact refers to the influence the project may had on the way people does things through the use or adoption of the project outputs; changes in the context the project was implemented; changes in the community the project has been working with; and/or changes inside the organizations that have participated in the implementation or the relationships established through the project's implementation.*

Impact is often impossible to measure in the short term and is rarely attributable to a single activity. Impact can be linked to a vision or long-term development goal that your organization might be working towards.

It can be identified as a logical consequence of achieving a combination of outputs and outcomes.

Impact is usually measurable after the project life and is outside the direct control of the project team and the organization.

Nazdeek's mission is to bring access to justice closer to marginalized communities. We believe that community members are best placed to demand justice, while civil society organisations can facilitate the process but not drive it. For this reason, throughout the project period, Nazdeek, together with local partners PAJHRA and PNJSS, engaged with project volunteers to build their capacity to document, report and address violations. This effort led to volunteers filing a number of formal complaints with relevant government departments to address cases reported through SMSs:

Balipara Block

Complaints filed to strengthen delivery of food and nutrition to pregnant & lactating women & children under the National Food Security Act:

1. Complaint filed against Doinogmirpothar Anganwadi for failure to provide mid-day meal to approx 40 children and 10 pregnant and lactating women
2. Complaint filed against Agarbasti Anganwadi of irregular and insufficient quantity of mid-day meal proved mid day meal to approx 40 children and 10 pregnant and lactating women
3. Complaint filed against Khonamukh Anganwadi for failure to proved mid-day meal children, pregnant and lactating women to approx 40 children and 10 pregnant and lactating women
4. Complaint filed against Mansaripanchayat Anganwadi for failure to proved mid-day meal pregnant and lactating women to approx 40 children and 10 pregnant and lactating women

Dhekiajuli Block

Complaints filed on a range of health and nutrition issues arising in the health facilities and local food distribution shops.

1. Complaint filed against the Panbari Public Distribution Shop (PDS) for failure to provide consistent and timely access to food rations as per the National Food Security Act. The PDS shop is only open once a week (should be at least 6 days) and beneficiaries are provided less then their legally allotted amount.
2. Complaint filed against the Sapoi Tea Estate for not appointing a doctor at the Tea Garden Hospital per legal requirements.
3. Complaint filed against the Tinkhuria Public Distribution Shop under the Food Security Act. The complaint highlights the unavailability of subsidized food grain and irregularity of shop hours.

4. Complaint filed against Raikasmari Primary Health Center for unlawfully charging pregnant women for blood tests.
5. Complaint filed against the Narayanpur Tea Estate for unavailability of ambulances.

In addition to complaints, due the strengthening of legal capacity of the trainees volunteers have taken actions such as surveying population in their respective areas to demand increased staff of frontline health workers (Sapoi), formed women committees to secure better functioning of food distribution schemes and appointment of skilled medical personnel.

Grassroots advocacy and filing of formal complaints led to significant improvements such as:

- Appointment of doctor at Panbari Tea Estate (around 1,500 families)
- Appointment of Accredited Social Health Activist (ASHAs, frontline health worker) at Sapoi Tea Estate (around 1,500 families)
- Better service delivery of food rations in Balipara Block
- Reduced waiting time for ambulances in Balipara Block
- Strengthened relationships between volunteers and ASHAs for e.g. more consistent communication, and volunteers invited to ASHA meetings to provide suggestions on better implementation of maternal health schemes
- Doctors have visited Anganwadi nutrition centres to weigh children and pregnant/lactating women and assess health status in Balipara. Reported as first time this is happening in the area.
- General manager in Tinkharria tea estate held a meeting with workers and assured them that hospital's facilities and services will be upgraded soon.

Local media covered one of the cases reported through the platform, triggering a debate within Tezpur District Hospital about the lack of sufficient blood supply (one of the main issues highlighted in the final report)

Overall Assessment

Tips: This section of the report is extremely valuable for the ISIF Asia secretariat as it provides evidence about the role and relevance of ISIF Asia contributions in the Asia Pacific region.

*Tips: Briefly provide **your own views** on the value and importance of the project relative to the proposed innovation, investment of time, effort and funding involved. Include the strengths and weaknesses of the project and the steps taken to strengthen the credibility and reliability.*

*This is your opportunity to conduct a **team reflection about the value of the project for the organization**. The following questions might help you to prepare a substantive overall assessment.*

- *To what extend the project meet its objectives?*
- *What were the most important findings and outputs of the project? What will be done with them?*
- *What contribution to development did the project make?*
- *Were certain aspects of project design, management and implementation particularly important to the degree of success of the project?*
- *To what extend the project help build up the research capacity of your institution or of the individuals involved?*
- *What lessons can be derived that would be useful in improving future performance?*

June 2014:

As a legal capacity building organisation with a mission to bring access to justice closer to marginalized communities, Nazdeek sees this project as an important innovation in the way communities gain access to grievance redressal mechanisms.

The challenge lies in ensuring smooth implementation of the project in a result-driven way, so that violations reported are "mechanically" followed up by the local staff and, when possible, by other activists and community leaders. Due to the time restrictions associated with the pilot project, while it allows for setting up a mechanism to identify and report violations, it does not fully address how the follow-up actions can take place. The project has been designed with the main purpose of collecting data to be used in advocacy and litigation at the end of the project period. However, our learnings have shown that certain high-priority cases reported from participants warrant ground interventions to be carried out during the project period. For this reason, a major adjustment by the project team involved identifying a range of actions taken by grassroots activists and facilitated/advised by the project coordinators. This resulted in the development of more activities than those originally planned at the design stage, and has therefore led to more resources (financial and human) to be put in place. However, the inclusion of this particular aspect is crucial to fully assess the potential of this project in providing access to justice, and to do it in an innovative through direct community involvement.

The grant has expanded our access to resources available (both financial and human) and provided avenues to obtain crucial data to substantiate advocacy strategies. More specifically, the findings that began to emerge over the first two months of data collection (May – June), have allowed us to already identify major gaps in the health infrastructure at Block and District level. As an example, many cases belonging to the Dhekiajuli block, some of which have resulted in maternal and infant deaths, concern the lack of an available blood bank in the area. And while the lack of blood availability is a known fact for local activists and health rights organisations, it has so far been challenging to demonstrate its direct impact on women's health, particularly in tea garden areas. In this sense, the project is playing a crucial role in filling an information gap, which has hampered the ability of civil society groups to advocate for a systemic change in the delivery of maternal and infant health services in tea garden areas.

As to direct impact for the organisations, the grant has infused essential support to 3 fairly small organisations, and allowed us to take a design idea to fruition. Since launching the project, we have learned how unique and innovative the project is within the digital and legal space and believe that there is real opportunity to scale. These learnings would not have been possible without the support from ISIF Asia to pilot our model of fusing SMS technology, community monitoring and legal empowerment to advance maternal health in India.

November 2014:

Through discussions with the participants, the project team observed that the improvement in the delivery of health services which is taking place at grassroots level is due to the pressure built by the reporting mechanism on the frontline health workers. In this sense, the system is beginning to function as a community platform to raise instances of malfunctioning of public health services. In an isolated and marginalized setting, like the one of the tea gardens, the mere fact that information is being sent outside the garden, and is received and analysed by civil society advocates, can be enough to build pressure on the relevant health workers to perform better. In doing so, the reporting system is turning into a community-led monitoring system.

Some project participants, who have first noted this change, have also asked to expand the issues covered by the coding sheet to include, for instances, cases of trafficking or child labour. This could be potentially done in a second phase of the project, once the system has been piloted and adjusted. It is however important for the project team to catalyse on the pressure built so far to push for larger-level change.

Lastly, a very promising trend is the interest expressed by participants to take up a more active role in demanding improvement of health services delivery. Indeed, during group discussions, volunteers have raised the need to approach local authorities, directly or through representatives, and some participants, who could facilitate this process, have gradually emerged as leaders in each Block. For this reason the project team has placed consistent effort in the past few months to equip participants with the skills and tools to conduct fact-findings interviews and surveys of health facilities. The next stage would be to ensure that participants are able to compile information on specific cases and submit it to local authorities.

February 2015:

Overall, the project has been a great opportunity for the organisations involved to se the potential of the use of technology for social accountability. The organisations involved invested additional financial and human resources (such as the additional trainings provided) to improve project implementation and ensure longer-term achievements. This was done in the recognition that the project opened many doors for strengthening our work in other areas. For instance, Nazdeek will utilize a similar technology for building a reporting mechanism for women living in slum areas in Delhi. Additionally, the project has been selected to be part of a research study conducted by the Columbia University, Department of Population and Family Health, looking at the use of ICT for maternal health accountability.

This project also has increased the capacity of the local organization (PAJHRA) in understanding maternal health rights better, engaging with the government at the district and lower level authorities and in advocating for reproductive health rights of Adivasi women in larger civil society platforms. The use of ICT and legal mechanism through the project in addressing maternal health rights violations particularly in the tea garden setting has added new dimension to the work being done at the grassroots.

Lastly, through the support of ISIF Asia, part of the project team attended the Responsible Data Forum and the RightsCon 2015 event held in Manila. The events have been a great opportunity to engage with the international ICT community, granting Nazdeek visibility at international level and, more importantly, access to new resources and tools to strengthen its impact.

Recommendations

Tips: Include any recommendations in this section that you and your project team, the organizations supporting the project and the community you worked with, would like to make to other practitioners or researchers on the field facing similar problems or implementing similar solutions.

Please take a minute to share recommendations with the ISIF Asia secretariat that might help to improve the support provided.

While the use of SMS technology to advance human rights and development has grown exponentially in the last decade, our experience suggests that the fusion of technology with community monitoring and legal advocacy is a new and burgeoning form of activism. We would recommend that a platform or network of practitioners working in this space be established so that learning can be shared across disciplines and regions.

As to the ISIF Asia support, we are grateful for the consistent communication on upcoming events, potential opportunities for support and networking opportunities provided via the ISIF secretariat. The flow of information is essential for 3 small organizations like ourselves who are deeply embedded in the work and seeking avenues to share our work and build linkages to support the project beyond the pilot period.

Bibliography

Tips: Include complete bibliographic references to all sources (printed, on-line, quotes, etc) used to prepare the different sections of this report. The APA style guide offers examples about how to reference a variety of sources. http://www.apastyle.org/learn/quick-guide-on-references.aspx(as accessed on 3/7/2013).

(1) *Poverty, child, maternal deaths high in India: UN report*, the Hindu, 8th July 2014, http://www.thehindu.com/news/national/poverty-child-maternal-deaths-high-in-india-un-report/article6188227.ece

(2) *Health Indicators,* National Rural Health Mission, State of Assam http://nrhm.gov.in/nrhm-in-state/state-wise-information/assam.html

(3) *Rapid Appraisal of NRHM implementation – District: Sonitpur*, University of Guwahati, Population Research Centre, Department of Statistics, 2009

(4) Article 14 and 15 of the Constitution mandate "equality before the law or equal protection of the laws", and expressly prohibits discrimination on the basis of sex.

isif asia

(5) India is also signatory to a number of international treaties that mandate States to protect the right to life, food and health, including the UN International Convention on Economic, Social and Cultural Rights, the UN Convention for the Elimination of Discrimination Against Women, the UN International Covenant on Civil and Political Rights.

(6) *Brief industrial profile of Sonitpur District*, Micro, Small and Medium Enterprises Development Institute, Government of India, Guwahati, 2013