Research for Social Action: Second Workshop

Yasser Arafat Hall, Administrative Building, Jamia Millia Islamia

(7th August- 9th August 2009)

PHRN in collaboration with Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia

Agenda:

To introduce specific themes in action research and data collection techniques to our Community Health Fellows

Resource Persons:

1. Professor Jean Dreze (Delhi School of Economics)
2. Mr. Venkatesh Nayak (Commonwealth Human Rights Initiative)
3. Mr. Ram Singh (Mazdoor Kisan Shakti Sangathan)
4. Ms. Sushila Singh (Mazdoor Kisan Shakti Sangathan)
5. Ms. Dipa Sinha (Commissioners to the Supreme Court: Right to Food)
6. Dr. Vandana Prasad (National Convener, Public Health Resource Network)
7. Dr. Ganapathy (Public Health Resource Network)
8. Dr. Archana Prasad (Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia)
9. Dr. Antony Kollanur (President, Public Health Resource Network)
10. Dr. Abhay Bang (SEARCH)
11. Dr. Prasantha Tripati (Ekjut)
12. Dr Sundaraman(National Health Systems Resource Centre)
13. Ms. Tarang Mishra (Public Health Resource Network)

Academic Mentors Present:

1. Dr. Antony Kollanur
2. Dr. Archana Prasad
3. Ms. Dipa Sinha
4. Dr. Ganapathy
5. Mr. Rafay Khan
6. Dr. Anjum Soni
7. Prof. Shakti Kak
8. Dr. Vandana Prasad
9. Mr. V R Raman
10. Mr. Arun Srivastava

Participants:

Community Heath Fellows:

1. Annie Kurian
2. Arup Abhisek
3. Arun Kumar Singh
4. Chandan Behera
5. Mahendra Behera
6. Surath Biswas
7. Fazallul Krishnan
8. Manik Mishra
9. Manas Behera
10. Enem Pravin
11. Farhat Yasmin
12. Gajendra
13. Jay Krishna
14. Jyotsna Tirkey
15. Md. Jalaluddin Khan
16. Manower
17. Manir Ahmed
18. Nazish Neyaz
19. Pooja
20. Rajeev Ranjan Singh
21. Sandip Mitra
22. Seema Kumari
23. Shah Nawaz
24. Shefali Kuntal
25. Shveta Kumari
26. Trishna Pani
27. Indu Gupta
28. Prem Singh
29. Shivacharya
30. Anwar Hussian
31. Vikram Singh
32. Vibha Upadhyaya
33. Kiranjeet Sandhu
34. Ritesh Laddha
35. Swarup Pal
36. Julee Swarukur
37. Farida Khan

Programme Coordinators:

1. Mr Alexander Kerkatta
2. Mr Haldhar Mahto
3. Dr. Anjum Soni
4. Dr. Soumya Ranjan Mishra
5. Mr Subhashis Panda
6. Mr Tanwir Ahmad
7. Mr Dinesh Bhatt
8. Mr. Arun Kumar Singh
9. Mr. Raghavendra
10. Mr. Sunanadan

Other Participants:

1. Ms. Saveetha Mahadevan (ICCHN)
2. Mr. Rabi (ICCHN)

Day 1 Friday (7-08-09)

The workshop on 'Research for Social Action' was kicked-off with a brief introduction by Dr. Ganapathy Muugan who thanked the Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia for partnering with PHRN for the workshop. He also thanked the Jawaharlal Nehru University for continued support in the Community Health Fellowship Programme (CHF). Prof. Shakti Kak welcomed the participants on behalf of Centre for Jawaharlal Studies and the technical sessions started.

Social Audit

Dr. Vandana Prasad facilitated the introduction of participants and briefly spelt out the theme and expectations from the workshop. Professor Jean Dreze began the first session with an interactive exercise where the audience got to share their prior experiences of social audits.

Session 1 (10:30-11.30): General introduction to RTI and social audits by Mr. Venkatesh Nayak

Mr. Venkatesh Nayak (Programme Coordinator, Commonwealth Human Rights Initiative) shed light on the history and relevance of Right to Information Act. He explained that RTI could be used for Jan Swasth, prison, jail reforms and so on. RTI could be best utilized when proper "fact finding" is done, problems are analyzed and appropriate action is taken (e.g. Jan Sunvai).

He stressed upon how RTI should be used so that everyone enjoys the Right to Life, which includes the Right to food, good health, and safe and clean drinking water. There are 17 types of

information which fall under the purview of RTI and these should be provided by the government to the *aam janata* upon request. However, reality presents a different picture. A written application is vital to get information for validation and further action.

He shared cases from Panchmahal in Gujarat where the villagers filed an RTI application and made the MOIC and ANM visit the village regularly, repaired the X-ray machine staying idle in Chandrapur district in Chattisgarh and so on. He pointed out that much ground work is required to appropriately use RTI. He pointed out that one needs to frame the right questions to get the desired information. (Reference Material: "The Right to Information Act: A Primer" by Suchi Pande and Shekhar Singh)

Session 2 (11:30-12:30): Experience of NREGA social audits and presentation of "100 Tips for an Effective Social Audit" booklet by Professor Jean Dreze (Honorary Professor, Delhi School of Economics)

Professor John Dreze started the lecture with building the perspective about the goal of social audit. He stressed on the importance of integrating both action and research. He pointed out that it is usually believed that activism deviates from objectivity while the researcher remains obsessed with objectivity. He emphasized that in the pursuit of objectivity, one needs to note that so called neutral grounds are closely interwoven with power structures. Hence, in this pursuit one needs to protect the cause of the poor and at the same time ensure that action be guided by objective findings.

From this perspective he explained the experiences of NREGA social audits. According to him social audit is a multipurpose activity. It should be taken up as a community process involving the community right from the planning phase through monitoring and evaluation. The NREGA has provided a wealth of experience in social audit. He informed that the “nexus” between private contractors, corrupt government officials and political leaders is evident. This nexus is to extract profit by various means like 1) extracting heavy work from the workers 2) by showing less attendance. Corruption has become a norm. He termed it as culture of corruption where corruption is a way of life.

There can be a number of activities under the ambit of social audit like muster roll verification, meetings, awareness generation, worksite inspections, cultural programmes, yatras, *shramdaan* at NREGA worksites, etc. For social audit one may need to obtain certain government documents and if required these may be obtained under RTI. Form a core group for this purpose, with adequate representation from disadvantaged groups. Make sure to facilitate the participation of disadvantaged groups, and ensure in particular that women are actively involved in good number in the entire process.

Training is very important for a successful social audit. One needs to address communication skills during the training. Collect important testimonies in writing (or record them on video). Make sure to record all relevant details including dates, people’s names, place of residence, etc. Whenever possible, record testimonies on video (video-recorded testimonies are much harder to “retract” than written statements).

The NREGA has been reduced to a scheme. There has been rampant corruption in the states in the name of NREGA as with other welfare schemes. He pointed out there can be different ways to check corruption like 1) compensation, 2) fine, 3) charges under the act. Going to court is the real redressal mechanism. Social audit is a part of the system of transparency. Under NREGA, social audit has been adopted differently in different states. As far as NREGA is concerned, SA has to be conducted by Gramsabha but in practice none of the Gramsabha has the capacity to do so. Though there is much to be desired with the implementation of NREGA, the situation is not bleak since there is enough legal recourse and scope to remedy the situation. (See Annexure 1 for "100 Tips for an Effective Social Audit" booklet)

Session 3 (13:30-14:00): Sharing experience of social audits of Integrated Child Development Scheme (ICDS) and Mid-Day Meal Scheme (MDMS) in Andhra Pradesh by Ms. Dipa Sinha (Member, Working Group for Children Under Six of the Jan Swasthya Abhiyan and Right to Food Campaign)

She shared the experiences of social audit in Andhra Pradesh. It is the responsibility of the state to take care of the rights of its subject but in many places it is not happening, she pointed out. She identified that there were three stakeholders in this social audit, namely State, Community and the NGO (Non-governmental Organization). The process of social audit is required when the state fails to take care of its responsibility and the situation demands mobilization. From the experience of social audit of ICDS and Mid-day meal schemes in Andhra Pradesh it is evident that NGO should play the role of a facilitator and should not replace either state or community. The NGO should work with the community. They should prepare the community to take up the issues. MV foundation never took up the issue directly but rather involved themselves in all meetings and exercises conducted by the community with relation to issues of their rights. In this context she pointed out that elected members should not be involved in delivery of services rather the service provider should be accountable to them. MV foundation did social audit in 111 schools of two gram panchayats and saw how this can strengthen the community.

The social audit involves understanding of the schemes, e.g. Midday meal Scheme. One needs to understand at micro level. One should review the records maintained. It also requires the creation of a team. The team formed should be trained to conduct social audit.

They found that the members of gramsabha are usually not proactive and this poses difficulty in having a proper social audit. She suggests that members of the social audit need not necessarily be from the gramsabha . The findings show that there is no salary for cooks and menu is given without budgetary bifurcation of the amount sanctioned. Many schools maintain two attendances register namely 1) kaccha and 2) Pacca registers. Purpose is self evident. It is interesting to note that these lacunae in the mid-day meal scheme which never came up earlier could be seen during the social audit. Hence it could bring out different forms in which the poor women (cook) got exploited. Social audit also initiated discussion and community involvement. In the forum questions on how to conduct follow-up was also raised. GramSabha was asked to suggest solutions. Suggested solutions include writing on walls about the process, menus were suggested.

It clearly shows that there are diverse possibilities from social audit in terms of making the system accountable. (See Annexure 2 for EPW article by Ms. Dipa Sinha on "Social Audit of Midday Meal Scheme in AP")

Session 4 (14:00-14:30): Sharing of experience of social audit of a PHC in Jawaja, Rajasthan by Smt Sushila and Mr. Ram Singh
Smt Sushila started by stating,

> "Social audit should be there every where"
> "It exposes a lot and it is good for common man'
> "If someone opposes social audit every body knows why?"
> "Even if it is not successful every where still it has given hopes"

She gave an account of a sarpanch who could bring in all the difference just by utilizing the Right to information act. A system which was quite indifferent to the health needs of the community could be made accountable by the simple action which includes awareness, making use of the available RTI act and regular follow up of the matter. It was the simple but formal query under RTI act by the sarpanch about the staff posted for the village and the services which they are supposed to provide to the villagers that resulted in stimulating the system. Initially the authorities tried their best to avoid answering the questions raised by the sarpanch. But the sarpanch pursued the matter and insisted on a formal reply. This resulted in the authorities responding accordingly and at present the villagers are getting visits from the health worker posted for the village. The taste of success only raised the hopes among the community.

She gave vivid narrations of interaction between MKSS and the staff of PHC in District Ajmer with regard to general mal functioning of a public health institution and how the collective efforts of the community could bring in the difference over a period of few years. They gave an account of successful application of social audit in Rajasthan.

Mr. Ram Singh said that what came out during the social audit was that there was general dissatisfaction across the board with the health services offered in the PHC. The general problems with the PHC were access was difficult, irresponsible staff, lack of services at PHC, etc. But once the social audit gained success people gained faith in the movement or the organization.. In fact there were instances when medical officers have refunded the money taken illegally by them earlier. In turn the community helped regarding budget, tube well, generator and could even get back the medical officers who were attached else where. At present the same PHC is having 5 medical officers and functions well.

Session 5 (Day 1) 15:00-16:00 Overview of data collection techniques /Describe various data collection techniques and state their uses and limitations by Dr. Ganapathy (PHRN)
Chair: Dr. Archana Prasad

Dr Ganapathy described that Data-collection techniques allow us to systematically collect information about our objects of study (people, objects, phenomena) and about the settings in which they occur. He further reminded the participants on the various steps of research and pointed out details on the data collection techniques like:

- Using available information: Usually there is a large amount of data that has already been collected by others, although it may not necessarily have been analysed or published. Locating these sources and retrieving the information is a good starting point in any data collection effort.
- Observing: Observation is a technique that involves systematically selecting, watching and recording behaviour and characteristics of living beings, objects or phenomena.
- Interviewing (face-to-face): An interview is a data-collection technique that involves oral questioning of respondents, either individually or as a group.
- Administering written questionnaires: A written questionnaire (also referred to as self-administered questionnaire) is a data collection tool in which written questions are presented that are to be answered by the respondents in written form.
- Focus group discussions: A focus group discussion allows a group of 8 - 12 informants to freely discuss a certain subject with the guidance of a facilitator or reporter.
- Projective techniques, mapping, scaling: When a researcher uses projective techniques, (s)he asks an informant to react to some kind of visual or verbal stimulus. Mapping is a valuable technique for visually displaying relationships and resources. Scaling is a technique that allows researchers through their respondents to categorise certain variables that they would not be able to rank themselves.

He described these techniques with the help of examples. He pointed out the distinction between techniques and tools applied in data collection. He summarized the advantages and disadvantages of various data collection techniques. When discussing the advantages and disadvantages, he also brought out the importance of the combination of different techniques so that they can complement each other and reduce biases in research. He also explained that both qualitative and quantitative research techniques are often used within a single study.

He also described the biases which affect the research. He explained with examples:

- Defective instruments
- Observer bias
- Effect of the interview on the informant
- Information bias

He concluded the session with a discussion on the ethics in research. He explained various ethical considerations that go in while designing a research at every stage. He also circulated the ethical guidelines document, “Ethical guidelines for research in social sciences and health (1998 -2000)”. These ethical guidelines are framed through a national initiative which was coordinated by CEHAT.

During the discussions the importance of ‘case studies’ as a technique was highlighted and it was suggested it be included in the list. (See Annexure 3 for the power-point presentation on Data Collection Techniques)

Day 2 Saturday (8-08-09)

Session 1 (9:30-11:00): Case studies of research at the grassroots by Dr. Abhay Bang (SEARCH, Gadchiroli)
Chair: Dr. Anthony
Dr. Abhay Bang started his lecture by acknowledging the importance of institutes like Jamia Mila University in the field of "Nai Talim" and considered his visit here as pilgrimage. He raised a question to the participants –Why research? He then gave two examples of grass root studies.

Dr. Bang began by giving an account of his journey as a junior resident in the department of pediatrics. He had witnessed the death of a young female child of 8 years. She had been admitted with complaints of fever by her mother. As she was not developing fever for last 2-3 days medical officers decided to discharge her. Unfortunately she collapsed before receiving the discharge sheet. Later in the enquiry it became evident that as the thermometer was not working there was normal temperature charting for her. This could come to light only when one tried to review the records. That is research was done. Here the problem was identified as to why a child died even when she was admitted to hospital. And this quest to search for the answer resulted in knowing the fact.

Dr Abhay compared this situation with district or state reporting on infant mortality rate for a given district or the states. This is usually much lower than what is available from Sample registration system data or NFHS data. He views this as the failure of the health intelligence and is analogous to the thermometer which is not working to detect temperature correctly. In fact this was identified as the problem by him and they did a study in four districts of Maharashtra to catch the burden of infant deaths. The results were clearly showing that the state govt. reporting system is not able to pick up all the deaths and are thus under-reporting. This in turn hides the real situation. Once the research was done and the report was prepared and submitted it only resulted in various actions at different levels to address this. It was not easy as it appears here.

He pointed out that performance audit is a useful tool. Here he also highlighted the importance of correctly framing the statement of the problem, design of the study and the objectives of the study. He also underlined the importance of network of NGOs in coordinating the study. In their study they took 13 sites, 226 villages and 6 slums covering a population of 2 lakh. This study took two years. The period of study was 1999 to 2000. To rule out bias, the author had compared age wise mortality data from the study with that of SRS/NFHS data. Since SRS data comes every three years while NFHS data comes in every five years. Further this gives values for the state or district. He pointed out the importance of having knowledge of IMR figures of district rather than for the state.

He says a child has no political voice they can only cry or die, the only two ways of protest they know. Not recording has become the systematic way of solving the problem. The effect of independent audit is immense as it influenced the behavior of the health system. The IMR got reported which in turn resulted in the committee, chaired by Chief Minister. Thus, as said by Brian McCarthy – Measurement can itself bring major change.

He showed the photographs of the places where more than 80 % of new borns in India are delivered and argued that it directly means that our new born care has to reach there if we really want to make any dent in the IMR. He showed the delivery room conditions in case of home deliveries. He presented the socio-cultural conditions of these delivery rooms and unhygienic conditions influenced by tradition. It is important to note that no health care reaches here where it is really needed. So here again the author showed how the problem was identified at the grass root level and the questions were raised as to how to give home based care to the new born and who will give this care. He pointed out the difference in the stand they took as compared to that of UNICEF and WHO, who were advocating that sick child should reach hospital for care. With classical evaluation design, they compared the data for intervention village and the control village. Intervention was ***home based new born care by Dai or AROGYA DOOT (literate women who were given training) rather than neonatologist/MO/Nurses as they are not available in rural areas.***

They found in their study that 95 percent of the deliveries take place at home. Four percent receive no medical care, 26 percent receive attention from doctor. The three primary cause of neonatal mortality was 1) Sepsis, 2) Asphyxia, 3) Premature birth. They decided to attend these three causes of mortality by five pronged approach through HBNC. The five approaches were

1) Trained birth attendant
2) Care of baby at birth
3) Management of new-born sick baby
4) Intravenous injection
5) Health education
6) Health workers were trained through chart books.

Arogya doots were trained to use mucus sucker, ambu-bag, intravenous injection and sleeping bags for low birth weight babies. In fact their skills were evaluated and approved by a group of senior pediatrician like Dr Meherban Singh, Dr. Ramesh Poddar etc. They had a comparison between the control area and the area where intervention was done. In the intervention areas IMR came down to 22 while in control are it remains around 60.

Here, his stress was on the design of the study while planning a study at the grass root level. He explained how they did in their study in brief. In order to see the effect of the new intervention adopted one needs to design the study in such a way that one should know the baseline information on the indicators which are of importance. There has to be control and intervention areas designed in the study. He also gave the understanding to the participants that to see the effect of an intervention adopted one needs to wait for some minimum duration. In his case they took ten years to see the effect on infant mortality.

He identifies four key persons for new born care in the rural/ Indian setup and they are mother, grandmother, dai and arogya doot. The instruments which he taught to arogya doots includes syringe, Vitamin K, Gentamycin beside Ambu-bag and reports. The mortality rates in this area matching with that of the 2nd level neonatal units. Even this comparison he used to show the concept of checking the results by different ways (triangulation) research design. He informed

that this package had been repeated in another 7 villages of Maharashtra (Ankur). ICMR has adopted this to be implemented in other states. He said that this can be adopted in any area which is having the IMR more than or equal to 45.

So with the help of two studies
1) One was of measurement of the infant mortality which brought impact on the policy
2) Another was the example of intervention—HBNC

For intervention study it is important to define goal and how to measure it

He asked the participants five questions

1) What was the objective of the study?
2) Was the study based on the real life problem how was it discovered?
3) How was the problem studied? – Methodology
4) Was the inference valid and did it make any change?
5) Can I use this method?

The author explained how research design is done and highlighted the importance of correct measurement. He quoted Noble laureate Neil Bohr "One accurate measurement is infinitely superior to a thousand intelligent opinions". He informed the participants that they should start by counting. They should know how to measure. One should learn the relevant methods for measurement in their study. For example,

1) How to measure malarial deaths, malnutrition?
2) How to do survey, sampling?
3) One should also know to check confidence interval of the measurement.
4) One should know to use the measurements obtained.

He stated that truth/knowledge is a powerful tool to change the societal perception. Since knowledge gives empowerment. So poor can become empowered by themselves if they have knowledge. Hence public health research can be a tool for this. (See Annexure 4 for the seven questions raised by Dr. Abhay Bang)

Session 2 (11:30-13:00): Appreciative Inquiry by Dr. Prasanta Tripathy (EKJUT, Jharkhand)
Chair: Dr. K. R. Anthony
Dr. Prasanta Tripathy, member of the Jharkhand PHRN and founder of Ekjut, conducted the session on Appreciative Inquiry (AI). In the previous session, Dr. Bang spoke about the importance of measurement and how 'measurement is a very powerful method of change'. Before introducing the topic of Appreciative Inquiry, Dr. Prasanta too echoed the same point and mentioned that Public health action-research demands - proving (repeatedly) what is already known to people on the ground, but denied by the powers that be, and the importance of quantitative methods and measurements to prove existence of inequities in health care. He mentioned that qualitative methods too can be equally powerful adjuncts.

He began by screening a film that captured the spirit of Appreciative Inquiry. The film was about the interactions between an elderly teacher and students from diverse backgrounds in an outdoor setting. CHFs were asked to reflect on the positives. This set the tone for the rest of the session.

He stressed that AI can be a positive revolution in leading forward. One of his slides read – 'Words are like tool', 'to a hammer everything is a nail'. He elaborated on the power of "proactive language" and as an example, he sighted Barack Obama's election campaign and his constant references to 'Yes we can' in his speeches...

"The problems of the world cannot be solved from the same level of consciousness that created it". It was discussed, as an example, how the problems of "global warming" is the result of a level of consciousness that believes that the earth and its resources are for plundering and that these are "infinite" and the only way to deal with this problem will have to be by looking at things differently and replacing this paradigm with Gandhiji's- "There is enough for everybody's need but not enough for some people's greed".

Dr. Tripathy suggested that AI can be used as a method to bring about change in culture and environment of a workplace and presented its eight assumptions-

1) In every human situation something works
2) Where we focus on becomes our reality
3) Reality is created in the moment and there are multiple realities
4) The language we use shapes our reality- proactive language vs. reactive language. Examples were cited...
5) Act of asking questions influences the outcome in some way.
6) People have more confidence going into the future (unknown) by carrying something from the past (known).
7) If we carry parts of the past into the future they should be what are best about the past.
8) It is important to value differences.

Appreciative Inquiry was first defined by David L. Cooperrider and Dr Suresh Srivastava in 1987. He mentioned about a number of principles that guides AI for further reading. These are:
The five phases of an Appreciative Inquiry journey are:

1) Define
2) Discovery
3) Dream
4) Design
5) Destiny

Once the organization has "defined" the overarching issue as the theme for the future sessions the participants are taken through the "Discovery" phase.

As an introduction to the Discovery phase he cited an example of a positive question by citing Albert Einstein who began by Inquiring

"What the universe would look like if he was to sit at the end of a light beam and travel." This apparently led to his discovery of theory of relativity.

As a demonstration of how the "Discovery" session should be conducted, participants were asked to talk about their positive past achievements. Dr. Tripathy emphasized the need for any good team to value different opinions of its members and how any outstanding work should be appreciated. The Community Health Fellows shared their personal experience of team work and the recognition of their work by some of the teams which they have been a part of in the past.

There was a quick round of experience sharing about being in a team and the following attributes got tabulated.

1) Appreciation
2) Creativity
3) The ability to make a difference.

He also elaborated on "sphere of concern" and "sphere of influence" in our lives and how the expansion of one leads to the constriction of the other. To be effective one may decide to expand ones sphere of influence and these needs to be done ethically.

At this point, Dr. Antony shared an example. He had once visited a Government hospital in Lalit Nagar, Uttar Pradesh. The hospital was in a dismal condition like most of the Government facilities. But to his surprise he found a bright and well tended garden in the middle of hospital which was a sole effort of the *dai* who worked in the labour room. The garden serves the example of the difference which one can make even in a very adverse environment by using one's sphere of influence, taking very well into account the sphere of the identified concern.

Dr Prasanta mentioned that this is also an example of – "how in any given organization there is something that "works" – 'the positive core'. The Discovery session attempts to capture this positive core through "appreciative questions".

"Dream" session-The participants learnt how a team can co-craft a dream taking the identified positives from the "Discovery" session and that the dream statement has to be a "provocative proposition".

An outdoor game (exercise) helped understand the factors that go into the "Design" stage for actualizing the "dream". (He got the participants to take a drill using a ball. Four teams were formed. One team was to observe the other three teams who were asked to pass the ball in a fashion that it touches the hand of each person in the team. Then they were supposed to repeat it again with the aim of reducing the time to do it. The team improves its performance with time, and learnt about the need to design "Doing the right things (the value paradigm) right, first time and every time (the efficiency paradigm)".

Discussion on the "Delivery" stage dealt on the need for proper sequencing of activities.

A quiz on what goes first (in a sequence) into a beaker to fill it without spilling was used as an illustration.

Dr Prasanta emphasized that Appreciative Inquiry (5 D) session was to help develop an interest in the topic and a full discussion and internalization can only happen through longer well designed programs and readings. His team (Ekjut) conducts such sessions for interested organizations as well as for the government. (See Annexure 5, 6, 7 for more information on AI)

Session 3 (14:30-16:00): Issues involved in planning, designing and evaluating large studies. by Dr. Prasanta Tripathy
Chair: Dr. K. R. Anthony

- Dr Prasanta Tripathy began this session with a quote from H.G Wells that Statistical thinking will one day be as necessary for efficient citizenship as the ability to read and write. He also hastened to add that" Provided the researcher has a vision of the pros and cons, and appreciates the limitations to what can be concluded, good quantitative research need not require advanced statistical knowledge" This quote was from The Good Research Guide, Martyn Denscombe, Open University Press, 1998

  And that one can always seek help from experts.

- For planning a study the need for formulating a good research question was discussed. He mentioned that an approximate answer to the right question is worth a great deal more than a precise answer to the wrong question. And finding the right question may be harder than finding the right answer

- He reiterated that the relevance of the research questions should always be kept in mind while framing the same. He suggested following steps to ensure that the research questions framed are of relevance to field reality-

1. Justify the need to undertake the research by reviewing published and unpublished data.
2. This review will also identify the confounding factors.

After this brief discussion he shared a number of trial designs that he had picked up for discussions with the group. The main objective was to help the participants to begin to learn to critique published evaluations and trial results and to be able to evaluate the evaluations through their own analyses. These studies were from Australia, Bangladesh, Scotland and Haiti.
Each offered a valuable lesson that ranged from ethical considerations to "who gets left out", ethics of doing or not doing an evaluation etc.
Some of the lessons are equally applicable for qualitative methods.

.

The need to be unbiased about quantitative and qualitative research methodologies was also discussed in this session. Dr. Tripathy spoke about the inherent values of each of these methods. He explained that the Quantitative method explored the what, where and when questions, while the Qualitative method explored the why and how questions. He then gave examples of "good and bad" study in terms of its design and ethical position. He informed that there are different types of studies like:

1) Exploratory study
2) Operational study
3) Formative study
4) Process evaluation

Dr. Tripathy also spoke about Kolbe's 'Learning cycle' which explains the interactive connection between experimenting, theorizing and the process of simultaneous experimenting and reflecting, while the evaluating process remains a key component to the learning cycle.

The concept of Equity Gauge was also discussed and he used the example of Ekjut's model, where while addressing health inequities, empowering, monitoring and advocacy become the three foundational pillars of the gauge. He described the collobrative work of Ekjut with organisations such as PRADAN and Centre for International health and development - University college of London.and how the "equiry gauge frame work" that Ekjut used got transletd into a trial design.

The Ekjut trial involved 18 cluster of villages as intervention and another 18 as control.. Women's groups in the intervention clusters opened up (to non members) during the monthly meetings facilitated by local women facilitators. She took them through an innovative participatory learning and action cycle(PLA)meetings focussed on addressing undrrlying and immediate causes of maternal and newborn mortality. The gains of this PLA cycle has been quantified through a rigorous and robust surveillance system that has been set up in about 385 villages spread over three distructs of Jharkhand and Orissa. There was some discussion on the preliminary analyses during this session but can not be presented (in this document) here because this is yet to be published. He also mentioned that the results were disseminated first to the partnering communities and for ethical reasons benefit extended to the communities in the control clusters.

This presentation was followed by a brief discussion about the need, advantgages and disadvangtages of RCTs on the whole, as a technique adapted from medical trials to use in communities and how care needs to be taken to adapt it keeping ethical considerations in mind.. Dr Tripathy explained that there will be sitiuations when it was possible to do ethical RCTs involving communities and that it could be a powerful advocay tool since this is considered as a robust method for evaluating effectiveness of interventions.

RCT trial data analysis needs also to be backed with qualitative process evaluation. Social programmes are unlike medical interventions, in which the treatment is usually well designed and straightforward and the implementation environment well defined. Hence a good evaluation needs to do a detailed analysis of what are often called

process-evaluation questions about management and implementation. Such analysis is done by adopting a theory-based evaluation design that traces the whole causal chain through which inputs lead to outcomes. Relevant factors in this approach include coverage, targeting performance, and changes in knowledge and behaviour in the target group. Ekjut trial paper and related documentations promises to do that. (See Annexure 8 for an article on "Process Evaluation for Community Participation")

Session 4 (16:30-17:00): Introducing **'**30 **x** 7**'** cluster survey method by Dr. K. Antony (President, PHRN) [1]

In this session Dr Antony explained the concept of representative sample of the universe under study. While studying the immunization coverage in a district, he stated that based on the certain statistical calculation one needs to have a sample of 210 children, who had completed infancy in a district with the population 2lakhs. The current convention is to have 30 clusters of towns or villages and as to visit as many house holds as necessary in each cluster until 7 children are selected in each.

Then he explained the method of selecting the 30 clusters. For this he guided to have the list of villages from the census office with village population along with the cumulative population figures. Then he explained the ***cluster interval and sampling interval*** which is calculated by dividing district population (2 lakhs) by 30. Hence the cluster sample comes to about 60000. Then one needs to select the first village from the list which is having the population of the size of cluster interval. Within this selected village or ward one need to randomly select the first house with eligible child and then next 6 continuous houses (without skipping) till one gets total 7 eligible children.

It is ideal to have two investigators per team. So in order to cover 30 sites we may need 60 person days. So if each team covers five sites at the rate of one site per day at least, we need twelve teams to complete the work and it will take five days. It is always better to have a manageable number of personnel.

Dr Antony also described about the lot quality assessment method (LQA). Here if the sample selected is not of proper quality then the whole lot is discarded.

[1] Also see PHRN book 10, lesson 8 for 30 cluster sampling details.

Session 5 (17:30-18:30): The importance of citing references by Dr. Vandana Prasad

Dr Vandana discussed about the references with regard to research writings. She enquired from the participants why they feel it is required. When this should be done? Why it is done / not done? She informed that this requires skill and one need to practice it. A document further explaining techniques and styles for citing and referencing was circulated for self study during the evening. (See annexure 9)

Day 3 Sunday (9-08-09)

Session 1 (10:00-10:30): Change management by Dr Sunderaraman (NHSRC)

Dr. Sunderaraman began the session by quoting Archimedes "Give me place to stand and I can move the world"; the principle of leverage. In the context of the challenge and our attempts to achieve district level change to improve the health system, he outlined nine steps of change management.

These are:

STEP 1: To define who 'we' are. We need self awareness of one-self and the place one is situated in with regards to the system we are attempting to change. Change can come from both inside and outside the system. What is important is to realize the potential and limitations of one's own positioning.

STEP 2: Define what changes we are asking for and who is demanding the change. One should be very clear about the changes that are asked for. Also one needs to define the legitimacy to ask for the said changes. For example if any change is required in the official policy then it calls for a political process. At the level of implementation, the official agenda has to be respected and spaces sought within that it-self. One has to be careful while listening to an outsider for the change concerned for various reasons like sustainability of efforts. If one is part of the official system then one can demand for such change and then one needs to be aware of the process.

STEP 3: Build Understanding of the agenda and perception of various stakeholders. Making of policy is a negotiation. For example for a programme like ASHA, the final decision is negotiated based on what the political system is asking for, what the medical fraternity is looking forward to, what people are looking for in terms of benefits, what ASHA herself is looking for and what the poor or the marginalized may ask for (given the chance). Interaction between all these stakeholders will decide the purpose of the instrument. We should understand various players and their roles and accordingly position ourselves to direct change.

STEP 4: Imagining and posing the alternatives. Under the prevailing weaknesses and strengths, one needs to imagine alternatives and for this it is essential that one continuously 1) Reads 2) Discusses 3) Learns theories 4) Utilizes experience in the light of theory. This should be a key are of strength for a group like PHRN.

STEP 5: creating and detailing the process to achieve the posed alternative. It includes various things like budget line, note sheet, guidelines, and instructions. This skilled follow up is a critical part of achieving change.

STEP 6: Building confidence and optimism that change is possible through demonstration and positive feedback.

STEP 7: Networking. This helps in building the critical numbers that are interested in positive change and creates an enabling environment and builds strength for the negotiation that is required.

STEP 8: Persistence and Negotiation. Staying power is one of the most important elements of success as change takes time and patience.

STEP 9: Recognizing Game Changers. Taking advantage of opportunities and problems that arise: From time to time new developments take place that could dramatically alter the nature of the negotiation or even the objectives. Such a factor could be a change in governance or in management which is much more supportive, even proactive, to lead this change. It could be game changers in the opposite direction is the new leadership is hostile to this change. Or the game changer could be the introduction of some new technology. Or is could be a change in the policy environment. Every crisis can be taken as opportunity. Though all the circumstances cannot be controlled by us we can always be in control of the situation and can make best use of chance and possibility.

Session 2 (10:30-11:30): Responses of Public Health System to the referrals made by Mithanins: A case study of Chhattisgarh
Ms. Tarang Mishra (PHRN, Chhattisgarh)
Chair Dr. Archana Prasad

Ms Tarang presented the pilot study done in the Raipur and Kanker district of Chhattisgarh to understand how referrals by the Mitanins are working. This study was actually part of field work of a student named Laurel from Oxford University. She was guided to PHRN and SHRC, Chhattisgarh as she had to submit her project work on Community health worker. For this study Ms Tarang, from PHRS, CG got associated with Ms Laurel for designing, conducting and analyzing the data obtained. The objectives of the study were: to evaluate the referral process of the Mitanin programme and to analyze the different components of the system and to asses the

response of the public health system to Mitanin referrals using data collected from the perspective of the Mitanin, patients/villagers and other health service providers at the sub-center, PHC, CHC levels.
The main findings and limitations of the study are as follows:

Major Findings:

- Mitanin's knowledge about criteria for referral is good.
- Non-Incentive based referral high at 75%
- 85% patients referred to the government facility and 15% to private practitioners
- Out of referrals to government facilities, 39% referred to HSC 21% to PHC, 40% to the CHC.
- Patients of all age groups- children, adolescents, adults and aged are being referred by Mitanins
- 90% of the patients follow through with the referral.
- Reasons for not following the referral given by patients–
    - 50% of them said they don't trust the services provided by the referred facility.
    - 25% of them said lack of transport
- More than half of the patients were accompanied by Mitanin to the facility.
- 89% patients received follow–up visit by Mitanin after seeking treatment.
- 90% of the Mitanin never received any kind of feedback from the health care provider.
- 80% of them are not currently using the referral slip and major reason for not using them is they never received it back from service provider.
- 21% of the patients were referred again from the facility where they went to seek treatment
- None of the patients or Mitanins reported having utilised the Mitanin Help Desk at CHC

Limitations of the study:

- Recall bias
- Lack of Records
- FGD was not included as a tool.

- More sensitive and appropriate tools are required for some of the indicators used.
- Comparison of felt need and actual need should have been made.

(See Annexure 10 for power-point presentation of the study)

Session 3 (13:30-14:00): Launching PHRN Website Dr Vandana Prasad (Public Health Resource Network)

Then PHRS official website was formally launched.

Session 4 (14:00-17:00): One-to-One meeting: Fellows working with Academic Mentors (Finalizing tools of data collection)

In this session all the available mentors discussed with there community health fellows about the projects they have finalized. Mentors did review the write up particularly with stress on the research methodology. In many instances it is realized that the CHF need to rework their topics. New mentors were allocated to the newly inducted CHF.

Session 5 (17:00-18:00): Concluding Session: Research action plan for next three months

Dr. Vandana thanked all the participants and asked them to focus on field visits and publication of initiatives adopted in the field to influence change. The workshop concluded after Raman, Arun Srivasatav and Rafay briefed the participants on the tasks and challenges ahead in the quarter. They emphasized that the time for orientation is over now and now action must be evident and focused. Thus action research must be used as a tool for negotiating change.

Other specific actions required were as follows:

- In the forthcoming quarter the fellows are expected to finalise the tools of data collection, complete the pilot study and if possible complete the data collection process.
- Individual initiatives need to be taken to maintain close contact with academic and field mentors, government functionaries and the state PHRN team
- Time management has been noted to be a challenge for some of the fellows and it is important to plan carefully to be able to meet the objectives of the fellowship programme which is sharply deadlined.
- An evaluation process for the fellowship programme as well as the fellows is being evolved by the national PHRN team and will be communicated shortly.

- All efforts to be made to 'mainstream' Rajasthan fellows. For a start, all fellows will be brought into the PHRN e group so that they remain in contact with the larger forum. Additionally, PHRN-NHSRC-SEARCH to plan for a coordinator based in Jaipur to facilitate the process further.

At the end, feedback was taken from the participants (Annexure 11 Feedback power-point presentation) which indicated a fairly well appreciated workshop. The post workshop individual evaluation was deferred to the following weeks and the questionnaire for that would be developed by the national team (Annexure 12 Questionnaire for Evaluation).