Fourth Research for Social Action: Rabindranath Tagore Hall, Administrative Building, Jamia Millia Islamia

(27th – 30th July 2010)

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

A Report

Agenda:

The main agenda of the workshop was to evaluate, guide and support the data collection process and data collected by Community Health Fellows (CHF) for their respective action research studies. The agenda also included continuation in capacity building of the fellows in action research and in this workshop there were sessions on research methodology with a special focus on the component of data analysis.

Resource Persons:

1. Mr. T. Gangadharan (Adviser, Kerala Institute of Local Administration)
2. Dr. Sridhar (Pediatrician and Public Health Specialist)
3. Dr. Baridalyne Nongkynrih (Associate Professor, Centre for Community Medicine, All India Institute of Medical Sciences)
4. Mr. Sandeep Sharma (Research Scholar, Centre for Social and Regional Development, Jawaharlal Nehru University)
5. Dr. Vandana Prasad (National Convener, Public Health Resource Network)
6. Dr. Archana Prasad (Associate Professor, Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia)
7. Dr. Ekta Saroha (Senior Consultant, National Health System Resource Centre)
8. Dr. Amit Mishra (Consultant, National Health System Resource Centre)
9. Ms. Sulakshana Nandi (State Convener, PHRN Chattisgarh)

Academic Mentors:
1. Dr. Antony Kollanur (President, PHRN)
2. Dr. Archana Prasad
3. Ms. Dipa Sinha (Commissioners to the Supreme Court: Right to Food)
4. Dr. Ganapathy (Senior Programme Coordinator, Public Health resource Network)
5. Mr. Rafay Khan (Convener, PHRN, Bihar)
6. Prof. Shakti Kak(Professor and Director, Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia)
7. Ms. Sarover Zaidi (ICCHN)
8. Dr. Vandana Prasad
9. Ms. Sulakshana Nandi
10. Dr. Madhurima Nundy (Senior Programme Coordinator, Public Health resource Network)

11. Mr. Haldhar Mahto (Senior Programme Coordinator, Public Health resource Network)

Participants

Community Heath Fellows and PGDDHM Interns:

1. Annie Kurian
2. Anwar Hussian
3. Arup Abhisek
4. Arvind
5. Enem Pravin
6. Farhat Yasmin
7. Gajendra
8. Indu Gupta
9. Jay Krishna
10. Julee
11. Jyotsna Tirkey
12. Kundan Shah (PGDDHM Intern)
13. Madhumita (PGDDHM Intern)
14. Mahendra
15. Manir Ahmed
16. Manish (PGDDHM Intern)
17. Manower
18. Md. Jalaluddin Khan
19. Mukund Singh (PGDDHM Intern)
20. Neelima
21. Pooja
22. Rajeev Ranjan Singh
23. Rajesh Gope (PGDDHM Intern)
24. Rashmi Mohapatra (PGDDHM Intern)
25. Sandip Mitra
26. Seema Kumari
27. Shakti Pandey (PGDDHM Intern)
28. Shefali Kuntal
29. Shivacharya
30. Shveta Kumari
31. Suchita Kumari (PGDDHM Intern)
32. Surath
33. Uttaranu (PGDDHM Intern)
34. Vibha
35. Vikram

Programme Coordinators

1. Ms Susrita Roy
2. Ms Haripriya
3. Mr. Arun Kumar Singh
4. Mr. Ajay
5. Mr. Subhashis Panda
6. Mr. S.N. Patnaik
7. Mr. Haldhar Mahto
8. Mr. Dinesh Bhatt
9. Mr. Alexander Kerkatta
10. Mr. Ajay Kumar Singh
11. Dr. Madhurima Nundy
12. Dr. Ganapathy

Fourth Social Action Research Workshop

Report of the First day of the workshop

Date: July 27, 2010

The workshop began with a welcome by Ms.Haripriya, PHRN and a round of introductions by all participants. **Prof. Shakti Kak**, Head of Department of Centre for Jawaharlal Nehru Studies welcomed everyone. She said that CJNS had been involved with the programme since its inception and was happy to see that it had come this far. She added that the objective of capacity building and action research at the grassroots was the core and essence of the fellowship programme. Since all fellows were almost finishing their data collection, this workshop would focus on data analysis.

Dr Vandana Prasad, National Convenor, PHRN thanked CJNS for the support. She said that this fellowship was an innovative programme and the idea was to link academics to real life situation. She explained that it was a process of building academics, research and activism together. Since this was the last quarter of the fellowship programme it was time to analytically consolidate all learning. It was time for fellows to think and write and bring their work to a logical conclusion. She also added that it was a time also for reflection on how the programme had strengthened them and what had been the limitations of their work. She also briefly explained the concept of a fellowship and contrasted it from being a regular employee.

The next session was on *'Decentralisation and Health Reforms'* that was taken up by **Mr. T. Gangadharan**. Mr. Gangadharan is a pioneer in decentralised planning in Kerala and has done extensive work on planning and natural resource management at local level. He began his session by relating the health sector reforms brought about at global level and an increase in commercialisation and privatisation. He went on to discuss how decentralisation could react to the challenges of commercialisation and privatisation. Major part of his presentation then focused on experiences from Kerala. Local government in Kerala is very vibrant. Even before public health movements started, there were small local movements taking place in many parts of the developing world. In the context of the present world economy, the need for such a movement was more and more critical. Decentralisation in India had mostly

happened in southern states. In health too, a lot had been achieved as basic health indicators of Kerala show that it is doing much better than the rest of India. Kerala is very near to total immunization, total water supply, housing and sanitation. Gram Panchayats in Kerala have played an active and vibrant role in realising many of the achievements.

There are three types of devolution of functions to the Gram Panchayats:

Mandatory functions include - Maintenance of Traditional drinking water sources, Collection and disposal of Solid wastes, Regulation of Liquid wastes, Maintenance of Environmental hygiene, Maintenance of Public markets, Vector Control, Regulation of Slaughtering and sale of meat, Prevention of Food Adulteration, Adopt Immunization programmes, Effective Implementation of National and State strategies for prevention and control of diseases being the important ones.

General Functions include- Awareness building on Social evils like liquor drinking, narcotics etc.; Environment awareness building and;

Development Functions on Health and Sanitation - Running of PHCs and Welfare centers (All disciplines); Running Mother and Child care centers; Control of diseases and preventive health activities; Family Planning activities; Implementing Sanitation works.

Health related functions of the Panchayats include - Running Community Health Centers and Taluk Hospitals; Running of PHCs and Welfare centers (All disciplines); Running Mother and Child care centers; Control of diseases and preventive health activities; Family Planning activities; Implementing Sanitation works.

Mr. Gangadharan then went on to give different experiences on decentralisation of activities to Gram Panchayats. What came out as a major point in decentralisation from the Kerala experiences was that there was a lot of financial freedom where the gram panchayats could be given from a minimum of 35 lakhs up to maximum of Rs 2 crores and along with it, the power to prioritise activities according to local needs. This has helped in innovating different activities at the local level.

It is not that Kerala did not face hurdles as there are issues linked to corruption and some of the present challenges have arisen in the form resurgent communicable diseases and double burden of diseases.

Several questions came from the participants. Some of them were: what is the difference between devolution and decentralisation; how is Kerala able to retaining human resources in health services in the villages; how is corruption tackled? Is there any capacity building done for the gram panchayats? Kerala experience showed that there was a holistic approach to address people’s needs and thereby addressing all determinants that were important to a better health system. In this context how does the PDS function in Kerala? One question that repeatedly came from the participants was that how the process of decentralization or strengthening PRIs could work in different state contexts.

Mr. Gangadharan started by responding to the question on PDS stating that Kerala has a strong PDS and every village has a Neeti Store where groceries were available at a standard price even when market prices are high. Mid-day meal programme was for all children till

class VIII and local governments' monitored distribution and quality of the food. Panchayat periodically examined the ration shops and school mid-day meal programme.

Kerala Institute of Local Administration (KILA) provided cascading training periodically and this was part of capacity building. Three important components were finance, function and functionaries that were given in decentralization. The Gram panchayats controlled as many as 7-13 departments and the community had its own monitoring systems in place to make things transparent.

At the end, Mr. Gangadharan emphasized that one had to attempt in decentralization. It was not that it was a smooth sail in Kerala. Kerala too faced a lot of challenges and still faces but the merits in decentralization are far more. Therefore, all states given their specific contexts need to attempt and devolve power to local administration and the community. So it was important to start working in smaller areas and small groups. One has to be political to bring about any change or reform.

In the next session, three of the Orissa fellows presented their on-going research work and received comments from the panel in order to strengthen their work. The panel included – Dr. Vandana Prasad, Dr. Archana Prasad and Mr. Haldhar Mahto

Post lunch there was a technical session by **Dr. Sridhar**, a pediatrician and public health specialist. He took the session on some concepts in quantitative research. His main focus was on highlighting some basic concepts in quantitative research and why and how sampling is important. The research question has to be defined very clearly then the remaining work was just to collect data and answer the questions. In most public health questions one started with a question where the denominator was important. In an equation X/Y – Y was the denominator; it was also important to see whether Y was representative of the population; who did they represent and this depended on the question asked in the first place. The responses to any question regarding any population, the answer was an estimate as one could not say that this was the truth as it was a sample that was studied and not the entire population when conducting research.

He went on to discuss what determined a sample size. Why did we not take a small sample? How did one know that it was a good enough sample? The session was made interactive by asking the participants for answers. Through the use of the statistical software Epi Info he showed the structure of a bi-variant table and through results generated by the tables showed how to interpret Odds ratio and Relative risk. He also used Epi Info to show that how the minimum sample size that was needed could be calculated.

Report of the Second day of the workshop

Date: July 28, 2010

The session started with a motivational song by one of the participants. In the first half of the day there were two session. First was on sampling methods and data analysis in quantitative research. This first half of the session was conducted by **Dr. Baridalyne Nongkynrih**, Associate Professor, Dept of Community Medicine, AIIMS. In the session, Dr. Bari discussed the need for sampling using different examples. One example was about selecting

sample for studying incidence of malaria using data from state hospital, district malaria office and from PHC/AWC. In this example, she shared how collecting data from any one of the sources may be misleading, and hence there was a need for sampling.

In the session she also explained terms like sampling frame, sampling interval. She also explained the different types sampling like Random, Systematic Random, Stratified Random and Multistage sampling, along with their advantages and disadvantages. She discussed the Probability Proportionate Sampling (PPS) in details as this is one of the most commonly used techniques for nationwide studies.

The next part of the presentation was on quantitative analysis. In this session, some important points of quantitative data was briefly touched upon like type of variables, measure of variables like central tendency normal probability curve and skewedness of normal probability curve.

Following this theoretical session, there was a session on analysis of data in MS Excel. **Mr. Sandeep Sharma**, PhD Scholar in JNU took this session, in which he demonstrated functions like sort, calculation of mean, median and mode, frequency and also on the use of pivot table to do multivariate analysis.

The second session before lunch session was devoted to presentation by Community Health Fellows from Jharkhand. The fellows presented in front of panel comprising Dr. Vandana Prasad, Dr. Archana Prasad and Mr. Rafay. Eight community health fellows from Jharkhand presented their work in social action research and received comments from the panel in order to strengthen their work. One media fellow presented his work during the last one year, mostly related to filing of RTI. It was suggested that the fellow should work with PHRN teams in other states also so that fellows in other states also learn about Right to Information and how to use it. Though the presentations were supposed to be over before lunch, some of the presentations were also carried out after lunch.

Following the presentation, was a session on Qualitative Data Analysis which was jointly conducted by **Dr. Vandana Prasad** and **Dr. Archana Prasad**. This session was participatory in nature where the participants were facilitated to think about the purpose of qualitative data and also its differences with the quantitative data. Most important and crucial difference was that, qualitative data was largely those that cannot be measured, like behavior, perceptions etc while quantitative data can be measured. The qualitative data was about developing in-depth understanding about a phenomenon and its intention is not to generalize. The qualitative data just tries to analyse questions like why and what, and not how many? The presentation gave an understanding of how to exercise rigor in analysis of qualitative data. As shared in the session, maintaining transparency at every step of the research and sharing of biases was the best way to ensure rigor. There were some ways of qualitative analysis like audit trial, thematic content analysis and grounded theory which was briefly discussed in the session.

The latter half of the day was devoted to presentation by Bihar fellows. The fellows presented the progress on Social Action Research. A panel comprising Dr. Vandana Prasad, Dr. Archana Prasad and Dr. Ganapathy gave comments on their work. By the end of the day, only four fellows could finish their presentation. Presentations of remaining two fellows were postponed for the next day.

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Report of the Third day of the workshop

Date: July 29, 2010

Dr. Amit Mishra and **Dr Ekta Saroha** conducted the sessions on **"**HMIS in the district health action plan". The session started with a basic introduction to HMIS. Dr Amit stated that, as per WHO, HMIS can be defined as an information system that is especially designed to assist in the management and planning of health programmes. In the context of NRHM, he said that HMIS had become indispensible for effective planning, monitoring and management of various health programmes. Over the years it had been instrumental in achieving the basic thrust of decentralized health planning and management in NRHM.

During the course of his presentation he focussed on the following points.

- The management processes of HMIS included a systematic approach to information, the subsequent decisions, allocation of resources, monitoring and achievement of the desired objectives
- The flow of information had to be from the level of sub-centre, PHC, CHC to the block level. Subsequently the information of the block and sub-district/district HQ hospital reached the DPMU and there after it reached the state HQ and ultimately to the national web-portal
- The implementation of HMIS in NRHM had different stages including:
  - Establishment of overall system across states in the country
  - Improvement in data quality & information use
  - Ensuring sustainability
  - Developing advanced skills
  - Review of overall implementation
- The basic building blocks of HMIS are data, information and knowledge. Through an example he clarified the difference between data, information and knowledge.

Following Dr. Amit Mishra, Dr. Ekta Saroha conducted a session named "Conversation over data". Dr Ekta had circulated a hand out "Murshidabad district HMIS data analysis 2009-2010" to the participants and mainly focussed on the analysis. The analysis was found to be very interesting as it was being transacted through the hand outs. She justified the significance of HMIS in the context of health planning and management of our country. She clarified that earlier health planning and management was driven by the donors, primarily

World Bank and WHO, on the basis of their perception. However with the advent of our own system HMIS we had been able to make our need based health planning, monitor the programme efficiently and manage the health programme very effectively with a definite outcome.

While stating the limitations of the HMIS she stated that at this stage HMIS was only effective in having uni-variate analysis and it will take a considerable degree of time for bi-variate and multivariate stage of analysis. She also spoke on the differences between a survey, surveillance and registry. She explained that HMIS was nothing but a registry which had been put electronically (taking stock of the demography). The session on HMIS also continued on day 4 where the fellows could experience HMIS through hands on presentation by Dr. Amit Mishra. Dr. Ekta Saroha also continued her session on "conversation with data" through the data circulated on Murshidabad district. The primary data tables were already extensively commented by Dr. Sundararaman and Dr. Ekta explained the rationale behind his comments and she encouraged more comments on the data. The session was very interactive and explained the limitations and scope of HMIS data.

The latter half of the day was devoted to presentation by the remaining Bihar fellows and Rajasthan fellows. The fellows presented the progress on Social Action Research. A panel comprising Mr. Arun Srivastav, Dr. Madhurima, Mr. Rafay, Dr. Archana Prasad and Mr. Haldhar gave comments on their work. Dr. K. Antony, Ms. Dipa Sinha and Ms. Sulakshana Nandi were also present and gave their comments.

In the post lunch session, **Ms. Sulakshana Nandi** made a presentation on comparative study of public and private service providers under RSBY in Chhattisgarh. This study was undertaken under the guidance of Ms. Nandi by two post-graduate student interns from Jamia Hamdard University.

The key highlights of the presentation were as follows.

- Objectives, what RSBY exactly was
- Who were the stakeholders/partners
- The methodologies, sampling, selection of beneficiaries, and the major findings of the study
- From the study it became apparent that there was a huge gap in the following areas as far as RSBY in the state was concerned
    1. Status of enrolment in RSBY in Chhattisgarh
    2. Hospitals empanelled

3. District drug profile
4. Details of claims in public hospitals
5. Details of claims in private hospitals
6. Awareness and enrolment procedures
7. Knowledge of RSBY in the community
8. Nature and type of illness covered under RSBY
9. Information about the hospital and the experiences in the hospital on claim settlement
10. Diagnostic tests and procedures, out of pocket expenditure in private sector, guidelines for utilization of claim amount by public sector

The areas of concern in RSBY in the context of Chhattisgarh are

- Enrollment rate was only 44%
- Utilisation rate was abysmally low at 0.5%
- Claims ratio was highly adverse at 2.8%
- Awareness on choices and entitlement was very low
- Out of Pocket expenses: Still continued to be quite high
- Transparency: Case wise data not available, hospital wise data also kept secret, receipts not given to beneficiaries, reasons for rejection not disclosed
- Private sector discrimination against the poor – fixing quotas of beds
- Accreditation: Hospitals with highly inadequate facilities accredited (usually CHCs)
- High percentage of False claims (people with no illness)
- Institutionalizing Conflict of Interest - Incentives to Health staff and Rogi Kalyan samitis

The suggestions for further research was as follows

- Larger sample
- Prescription analysis
- Community survey to know issues related to coverage, utilization etc.
- Interviews of service providers (awareness, problems faced)

The final session for the day was conducted by **Dr. K. Antony**. In his session he focussed on the action plan for next 3 months for the CHFs. The session was very interactive and at the end of it a plan for the next few months was finalised.

The proposed action plan is given below:

- **Completion of primary data collection latest by 15th August 2010**
- **Data analysis and interpretation by reaching out to local biostatisticians.**
- **September and October to spent on writing the report.**
- **Simultaneously, the documentation of the activities in the field should also take place.**
- **Developing a write-up on how the research study relates to the public health scenario in the country and what are its implications with reference to health policy and planning.**

Presentations by CHFs

The main agenda of the workshop was to evaluate the data collection process and data collected by Community Health Fellows (CHF) for action research studies. All the presentations were structured to cover the following: theme of the research, hypothesis, objectives, questions, methodology (tools, sampling, respondents etc.), and data collected, data to be collected and tentative timeline to complete data collection.

There were four sessions spread across three days of the workshop for CHF presentations from four states. At the end of each presentation, feedback was given both by the panel and the other fellows on improving/sharpening their data collection. Feedback included suggestions like

- **Having a better link between topic, question, hypothesis, objectives and the tools.**
- **To be careful with the design like the case and control area, experimental study, usage of terminologies and the relevance of scientific research tools.**
- **To discard the action part and complete the research even if that meant to be just a situational analysis.**

The suggestions and comments were insightful and helped the CHFs to look at their work more critically and make necessary amendments so as to give a holistic picture in terms of the research output. Soon after the last session on the fourth day the fellows had one to one

discussions with their respective research mentors to develop a more specific direction to their research studies incorporating the feedback and suggestions provided by the panel.

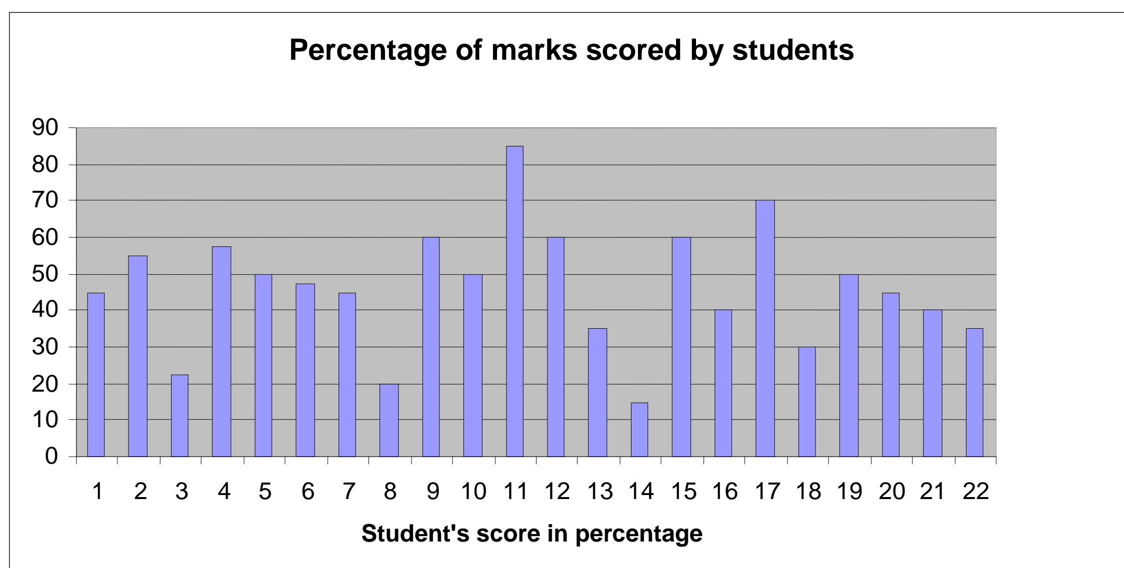
Feedback and evaluation

The four days were full of learning and at the end of the workshop the fellows had more clarity to their research, got a direction for their study by interacting with their mentors. The process of data collection by the fellows from all the states were behind the time line due to involvement in other organizational activities they now felt that with the given inputs they can assume greater responsibility and align their efforts accordingly to fill the gaps. They all left with a new enthusiasm to finish the data collection and to begin their report writing.

The logistics were well arranged and managed. The sessions were rich in content and facilitation was well coordinated with inputs coming from various sources.

At the end of the valedictory session, the feedback and evaluation of the workshop was facilitated by **Ms. Haripriya** and **Mr. Haldhar Mahto**, who had developed questionnaire for evaluation and a form for feedback where the participants were asked to write their feelings on what was good about the sessions. Everyone was appreciative of the session taken by Shri Gangadharan on Decentralised planning, Dr. Baridalyne Nongkynrih on sampling methods and the session on HMIS by Dr. Amit Mishra & Dr. Ekta Saroha. And similarly the fellows overwhelmingly felt that the session by Dr. Baridalyne Nongkynrih would have been very useful in their research had it been presented in one of the earlier workshops. The feedback on the sessions was based on what they felt about each session and how much they understood in each session. The responses actually did not reveal any trend and it was very mixed in nature.

The evaluation of the students consists of a set of 13 questions which carry a total of 20 marks (each point/ key words carrying one mark). The graph below shows the score of the students in percentages.



The least score is 3 out of a total of 20 marks i.e. 15 per cent (scored by one CHF) and the maximum being 17 i.e. 85 per cent. Ten CHFs scored 50 per cent and above out of which seven were female and three males. Twelve CHFs scored less than 50 per cent. The highest score of 85 per cent and second highest of 70 per cent were both scored by women. The evaluation was not confidential as it was thought that feedback and assistance to the weaker students will be necessary. The questions tried to encompass objectively all the sessions covered during the contact classes.

The workshop was concluded with a valedictory session presided by a panel consisting of Dr. Antony, Dr. Ganapathy, Mr. Arun Srivasatava, Mr. Rafay and Dr. Archana Prasad. The panel at large appreciated the efforts of the fellows but at the same time warned against complacency since plenty of work on action research had to completed within the limited time frame.

List of Annexure

1. Programme outline
2. Presentation made by T. Gangadharan
3. Presentation made by Dr. Baridalyne Nongkynrih
4. Presentation made by Dr. Vandana Prasad
5. Presentations made by Dr. Amit Mishra and Dr. Ekta Saroha
6. Presentation made by Ms. Sulakshana Nandi
7. Presentations made by the CHFs, Odisha
8. Presentations made by the CHFs, Bihar
9. Presentations made by the CHFs, Jharkhand
10. Presentation made by the CHFs, Rajasthan
    (The annexure on presentations would be uploaded in the PHRN webpage)