



Report of the Fifth Workshop on Research for Social Action

Dates: 13th -15th December 2010

Venue: Dayar-e Mir Taqi Mir, Jamia Millia Islamia, New Delhi

The fifth and final workshop in the series of workshops under the Community Health Fellowship (CHF) programme was organized from 13-15 December 2010 in the Rabindranath Tagore Auditorium, Mir-Taqi-Mir Building, Jamia Millia Islamia University.

Agenda:

Final presentation of Action Research by Fellows and to give a grand finale to the first batch of fellowship programme

Resource Persons:

1. Professor Rama V Baru (Centre of Social Medicine and Community Health, JNU)
2. Shri Keshav Desiraju (Additional secretary, Ministry of Health and Family Welfare, GOI)
3. Dr. T. Sundararaman (Executive Director, National Health Systems Resource Centre, GOI)
4. Professor Nimesh Desai (Head of the Department of Psychiatry and the Medical Superintendent at the Institute of Human Behaviour and Allied Sciences, Delhi)
5. Professor Dileep Davalanakar (IIM, Ahmedabad and IIPH, Gandhinagar)
6. Mr. Arun Srivastav (Consultant, National Health Systems Resource Centre)
7. Mr. Samuel Philip Matthew (CJNS-ICSSR project)

Academic Mentors Present:

1. Dr. Antony Kollanur (President, PHRN)
2. Dr. Vandana Prasad (National Convenor, PHRN)
3. Ms. Shilpa Deshpande (President, ICCHN)
4. Dr. Archana Prasad (Associate Professor, CJNS, JMI)
5. Ms. Dipa Sinha (Supreme Court Commissioner's Office, Right to Food)
6. Dr. Ganapathy (Executive Director, PHRN)
7. Dr. Madhurima Nundy (Senior Programme Coordinator, PHRN)
8. Mr. Haldhar Mahto (Senior Programme Coordinator, PHRN)
9. Mr. Rafay Khan (State Convenor, PHRN Bihar)
10. Prof. Shakti Kak (Professor, CJNS, JMI)
11. Mr. V R Raman (Board Member, PHRN)
12. Mr. Arun Srivastava

Participants:

Community Health Fellows:



1. Annie Kurian
2. Arup Abhisek
3. Surath Biswas
4. Farhat Yasmin
5. Gajendra
6. Jay Krishna
7. Jyotsna Tirkey
8. Manower
9. Manir Ahmed
10. Pooja
11. Rajeev Ranjan Singh
12. Sandip Mitra
13. Shefali Kuntal
14. Shveta Kumari
15. Shivacharya
16. Anwar Hussian
17. Vikram Singh
18. Vibha Upadhyaya
19. Kiranjeet Sandhu
20. Swarup Pal
21. Julee Swarukur

PGDDHM Interns:

1. Madhumita
2. Manish Mani
3. Rashmi Mohapatra
4. Rajesh Gope
5. Uttaranu Choudhary
6. Mukund Singh Munda
7. Sanjay Kumar
8. Kundan Lal

Programme Coordinators:

1. Mr Pratik
2. Mr Haldhar Mahto
3. Ms. Susrita Roy
4. Mr. Satya Patnaik
5. Mr Subhashis Panda
6. Ms. Madhurima Nundy
7. Mr. Dinesh Bhatt
8. Mr. Arun Kumar Singh
9. Mr. Haripriya
10. Mr. Sunanadan
11. Mr. Ajay
12. Mr. Ajay Kumar Singh
13. Ms. Sucheta



14. Ms. Sharmishta

Other Participants:

1. Dr. Bency Joseph
2. Ms. Sunita Singh (CHSJ, New Delhi)
3. Mr. Aravind Pulikkal (Triosdev, New Delhi)

Day One

The first day of workshop started with a song followed by brief introduction of the participants.

The inaugural session was on **“Public Health and Nehruvian Vision of Welfare”** by **Prof. Rama Baru**, Chairperson, Centre of Social Medicine and Community Health, Jawaharlal Nehru University. The session was chaired by Dr. Vandana Prasad.

Dr. Baru stated that design of public health system of India was based on Nehru’s vision of welfare which was influenced by Keynesian economics wherein role of welfare state was to promote economic development and build state institutions to support market. Following this approach to welfarism, state institutions were built, however, there were many contradictions. Firstly, the state institutions focused on health service system to improve health status of the country. The First five year plan, and also the Bhore Committee Report, identified levels of determinants of health, but in reality, the investments were more in building institutions for health service delivery and less for food, water, hygiene and sanitation. The situation has further deteriorated with little or no convergence between various levels of determinants. Secondly, while the focus was on development of state institutions for health service delivery, the role of private players in providing health services was not contested. The private sector was accommodated and allowed to thrive. The poor investments in the public health system have weakened the public sector and have given impetus to growth of private sector. In the Sixth five year plan, private sector in health services assumed even more authority because health was no more seen as state’s responsibility; instead it was identified as an individual responsibility. This also triggered a shift of trust from public health services to private health services. Today, India’s public health system is fraught with a challenge of revival of the trust in public institutions and potential to improve under NRHM.

The session ended with an extensive discussion on the situation in the field, ways and means to improve the trust in public system by increasing accountability, re-socialization of the providers in public system; re-socialization of the middle class who have more or less exited from the public sector and most importantly by improving investment and strengthening the public health system.

The second session was on **“Issues in improvement of Public Health System”** by **Shri Keshav Desiraju**, Additional Secretary, Ministry of Health and Family Welfare.

Mr. Desiraju focused on National Rural Health Mission (NRHM) and said that NRHM had initiated various positive changes in the public health system, but despite the positives, there were many unresolved issues in the way of achieving health outcomes, for example:

- “NRHM has been able to leverage money but the expenditure is still not as much.



- JSY scheme has improved institutional delivery, but infant mortality is not coming down.
- ASHA has been deputed in every village, but the community is still far away from understanding the public health needs.
- Bachelor in Rural Health Services course has been designed, but debates are still going on. The debates include contents of the course; course being centrally funded may not be accepted by all states, sustainability of the scheme and also altercations with Medical Council of India.”

Mr. Desiraju also released a book on Urban Health--the latest in PHRN series.

The third session was on “**Differential Planning and Financing under NRHM**” by **Dr. T, Sundararaman**, Executive Director, National Health Systems Resource Centre

Dr. Sundararaman highlighted some crucial aspects in the health services, under NRHM, that are yet to be strengthened:

- District planning and budgeting- The mismatch between the district plans and amount allotted is one of the gaps in systematic planning for NRHM.
- Non- expenditure of allocated untied fund is another gap. It is difficult to plan and utilize, as per one single plan because the facilities across the country deal varied problem and issues. It was shared, that while some sub-centres were not able to use their respective funds, there were some sub-centres which have utilized the funds effectively and were requesting for more funds.
- Health Management Information Systems (HMIS) has been launched to collect facility level data but data collection in the required way has not yet been possible. The HMIS is a change from the existing form of data collection, so it is taking some time and effort on the part of the system to accept and follow it.
- Human resource management aspect which includes, putting the right person for the right task is yet to take place.
- ASHA’s role and nature of supportive supervision and training that she requires for proper service delivery also needs to be clarified.

The fourth session was a presentation by **Samuel Mathew Philip**, Research Associate for the ICSSR Project on documenting the research work of all fellows. This project is housed at the Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia and is a collaborative project with PHRN. He presented the findings that he had analysed from three of the schedules filled by the fellows at several points during their fellowship. These were the socio-economic profile schedule, exit interviews of fellows who had left mid-way and a questionnaire that was filled by the fellows documenting the reasons for joining the programme, experiences with the fellowship programme and future goals and plans. He shared the data collection tools and also some preliminary findings. Some of the major findings highlighted were as follows:

From the socio-economic profile:

- Most fellows were between the age group of 25-44 years.
- There were 20 male fellows and 11 female fellows
- 22 from the General caste, 6 OBCs and one each from SC and 2 from ST category.
- Most have worked prior to joining the fellowship programme



- Less than one third of the fellows are principal bread winners

From the exit interviews:

- All fellows who left the programme mid-way were males
- 1 left for personal reasons another for pay and three for organizational reasons
- Fellows who left did not have any issues in returning or being associated with PHRN in the future.

For questionnaire on experiences of fellowship:

- The most common answer on why they joined the programme was learning about public health, and for many it was a short term engagement
- On relationships with colleagues and superiors they said that it was friendly and cordial while many said they had made friends and professional connections because of the fellowship programme.
- Many had acquired several training skills – ASHA ToT, training in research methodology through the workshops that they attended. Many were also part of the Fast Track capacity building training.
- In future, most want to continue studying and working in the field of public health. Some even want to start their NGOs or be part of big NGOs.

Day Two

The second day of the workshop began with a brief welcome and recapitulation of the previous day's sessions by Mr. Subhasis Panda (Programme Co-ordinator, PHRN, Odisha). Ms. Mukund from Bihar gave a melodious start to the day with a prayer song and was joined by the rest of the participants. Thereafter, Mr. V. R Raman formally welcomed the first guest speaker of the day, **Prof. Nimesh Desai**, Director, Institute of Human Behaviour and Allied Sciences (IHBAS) for a session on “**Mental Health**”.

The session started with a brief introduction to the development of psychiatry and the history of institutions for the mentally ill. Reference was made to the fact that till the eighteenth century, the mentally ill were supervised by an untrained person, usually jailors and kept in shackles. Phillippenelle was the first person to advocate and successfully influence the institutional behavior for the mentally ill, which resulted in the beginning of change; for the first time in human history, they were kept without chains. In the late nineteenth century and the 20th century, Freud's idea of human psyche highly influenced the world of professional psychiatry, especially in Europe. The practice and acceptance of psychiatry evolved to a great extent in the post second world war era, especially after 1957, when the first anti-depressant came into the market.

The first mental health hospital to be established in India was Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) in 1925 A.D. The process of mental health reforms started tangibly only post-Independence in India. The issue of exploitation of mentally ill, especially women, both in and out of institutions, was discussed. A brief introduction was given to creation and journeys of IHBAS. It was also mentioned that NIMHANS (Bangalore), IHBAS (Delhi) and RINPAS (Ranchi) are the three resource centres for treatment and research in mental health in India, as recognized by the Government of India. In the middle of 1980s, the District Mental Health Programme was started under the National Mental Health Programme with a view that every district should have a mental health unit for diagnosis and management of common mental illnesses and referral for more intense cases.



There was discussion on the gap between existing services and the need of mental health services in India. In Jharkhand, a total of three mental hospitals have a capacity of treating around 300 in-patients, while the total burden is of around 48,000 to 60,000 patients per year. In response, it was brought to light by Dr. Desai that mental illnesses are primarily in two categories; psychosis and neurosis. Of which, psychosis (mostly cases of severe illness) affects about 1% to 2% of the population and neurosis affects around 6% to 8% of the population. So, on an average, 10% of the population is in need of services related to mental health. In the same thread, it was discussed that the treatment gap for mental illness is in the range of 80% to 90%. According to a survey, in metro cities, this gap is around 77%. On an average, less than 1% of the total patients need to be admitted. And hence, the existing infrastructure can be easily utilized to address the mental health requirements of our population. OPD services should be focused on identifying and addressing mental illness at the primary level. This can contribute to managing the total disease burden in a significant manner.

There was a discussion on the inclusion of mental health focus in DHAP, in the agenda of CBOs and motivated individuals working at the grassroots level. For inclusion of a mental health mandate in the DHAP, it might be an effective strategy to persuade the district nodal officer to implement the District Mental Health Programme mandated under the NMHP. While planning for community intervention, it needs to be borne in mind that depression is the most common mental illness and it affects about 3-5% of the population. With a brief training, the general practitioners in the desired location can be easily equipped to handle the ground level situation. Under the Urban Mental Health Programme, two training modules have been prepared; one eighteen hour module on psychiatry (overview) and a 3 hour module exclusively on depression. Even if only the second module is taken into consideration and doctors at the PHC or CHC level are persuaded to be part of the programme, it will make a huge difference to the community well being. Primarily two issues have to be tackled on the primary level, one is suicide prevention and the other is building support groups comprising of care-givers and families of the mentally ill. There is also a need of sensitization regarding the difference between “mental illness” and “mental retardation”. Stricter implementation of the Disability Act, which recognizes both the above mentioned conditions, is needed.

The next session was by **Prof. Dileep Mavalankar** of IIM Ahmedabad (now on deputation to IIPH, Gandhinagar). The session was chaired by Mr. V. R. Raman. The topic of the session was “**Issues of Governance and Reforms in Public Health**”.

The session started with a discussion on the diverse nature of our country, demographically and culturally. More specifically, also in relation to the different systems of medicine that is prevalent in different parts of the country, which makes it a challenge for the public health system to provide a standardized and uniform system of healthcare. A brief mention was made to the historical development of the public health system in India. Its initial structure was highly influenced by the British health development pattern. One of the first Acts to be passed in India was the Epidemic Act of 1897. In consonance with the British influence were the posts of sanitary inspectors, the process of birth and death registrations and the degree of MBBS. The current system of health delivery system is like a “*jugaad*” which has a makeshift approach and is a mix of everything. Major points discussed are as follows:

- Mega Trends in healthcare
 - Gross underinvestment
 - Poor management capacity
 - Mainly driven by the private sector
- Mismanagement in professional councils

- Unregulated and corrupt
- Norms are mostly structure oriented and not process oriented
- Domination of representatives from the private sector
- Curricula of medical education is not in sync with the current public health needs
- Problems with the government system
 - It is highly fund starved
 - Has bureaucratic restrictions
 - Has to deal with political interference
 - Lack of management capacity
- Major issues in governance
 - Lack of role clarity of various cadres
 - Political interference in day to day administration
 - Lack of clear policy on transfer, posting and security of tenure
 - Problems of corruption and nepotism
 - Misuse of existing assets and lack of accountability
 - Absenteeism (esp. in health sector)
 - Centralization of powers

The second part of the session focused on the reforms introduced in the arena of public health and the problems these are fraught with.

- Structural reforms (creation of Health Societies under NRHM)
- Financial reforms (provision of pool funding, insurance cover, user fees, differential financing under the aegis of NHSRC etc)
- Public Private Partnership (handing over, EMRI, franchisee)
- Supply system reforms (example of Tamil Nadu Medical Services Corporation)
- HMIS (helps in efficient management of data and has improved decision making)

Problems encountered

- Lack of political will
- Lack of public health leadership
- Interest in physical infrastructure building rather than services (Taj Mahal syndrome)
- Vested interests overshadow public interest
- Lack of dialogue on health and health related issues
- Operational issues: no separate cadre on public health administration and utter lack of standardization and lack of focus on community mobilization.

Possible solutions

- Imparting information to public
- Negotiations with the community and higher authorities to ensure monitoring of service delivery and provision of facilities



- Flexibility of timings/part timing according to the convenience of the health staff; the idea is to ensure efficacy and minimization of absenteeism
- Developing leadership in public health

Presentations by the CHF's

In the first two days of the workshop all fellows had to present their research work. This was the final presentation they made where the focus was on the findings and the analysis of the data. Fellows from Bihar (5), Orissa (3), Jharkhand (7) and Rajasthan (4) presented their research studies. Each state had a panel that gave feedback. Most of the comments were on linking up findings and analysis to the overall objective of the study. It was crucial to make that link and see if the research questions that the fellows had in mind were being answered.

Day Three

The first session of the day was on **“Potentialities in Social Sector”** by **Mr. Arun Shrivastava**, Consultant, NHSRC. Mr. Rafay Khan chaired the session.

In his presentation, Mr. Arun talked about broad meaning of the social sector, the different types of organizations that are called as social sector organizations, their history and evolution in the different periods, changes that it had undergone and the opportunities for establishing our own organization.

The presentation was followed by a discussion in which the fellows raised some pointers as well as some doubts. In the discussion, Mr. Rafay Khan said that, “if the present structure of government is working efficiently, then we need not have an alternative structure but if it is not so, then an alternative structure is needed (e.g. the present social sector)”. Mr. Khan added that in any case, our role could be complementary, supplementary or sometimes in opposition to government structure. There were different roles that we needed to adopt. But we also ought to understand that, the main responsibility lay with the government.

One of the fellow asked that, the people in the nongovernmental organizations are contractual in nature and because of some other reasons; they find it difficult to establish their positive image in the society. What should they do to change this situation? In response to this, the facilitator Mr. Rafay said that, there is no other way but to constantly work and create a positive image. He talked about his own example of building credibility in the government structure. He talked, how it took 3 long years to create the situation where the government officers and the people in the society want them continue with their work which necessarily complementary to the government’s efforts.

Dr. Vandana Prasad further clarified and said, “one’s livelihood and one’s work for society should be different as far as possible. If you are in the social sector, then it is necessary to keep your livelihood aspirations low. The other important step to create your credibility is to give back equal service to what you are getting paid for. It is necessary to pay back something genuinely to the society. One should not forget the spirit of voluntarism in this field”.

The next session was titled **“Reaching the Unreached”** where fellows had to do role plays on given situations. The fellows were divided in to four groups and had been given one situation on the very first day. On the third day they performed a 20 minutes play based on which there was a 15 minutes discussion.

Group 1

Situation:

“Ram Babu works in the fields as a hired labour. He had been very ill and has recently been diagnosed with tuberculosis. The nearest DOTS provider is located in a PHC that is 7 kilometers away. In these circumstances how does Ram Babu receive his treatment and daily dose of TB medicines?”

There were some of the important issues that the role play presented by the fellows reflected upon. Those issues were the loss of livelihood due to the TB. There were comments on it such that, there should be support provided for the TB patients when there is no earning member in the family.

There is no social security in the informal sector and this has the worst impact on the people working in it and some getting affected by TB. The other issue that was raised was about the stigma related to the disease. For that, the Behavior Change Communication (BCC) should be imparted.

There was another suggestion from the participants that if it possible, in the District Health Action Plans, nutritional supports for the TB patients having no other financial back up should be incorporated.

The fellows pointed out that in the first phase of the RNTCP, there was provision of the nutritional support for the diagnosed patients. The possibility of using the funds at Panchayat Level, such as, VHSC fund to support the TB patients, should be explored and advocacy should be done around it. One of the fellows gave example of the Kerala Government, where under the NREGS; the TB patients are given not so heavy work to do and exceptions have been made for them.

There can be ICDS level intervention, in which the children of TB patients can be given extra nutritional supplementary food. One of the fellows, talked about the temporary Antyodaya Card to support the TB patients with provisions of food grains and other necessities.

About the role of the ASHA that was projected in the role play, the facilitator commented that, the role play demonstrated that, ASHA was capable of playing the role of a link worker as well as an activist.

Group 2

Situation:

“Sita is 10 months old. During the VHND her mother got her along where she was weighed. Her weight was 6 kilograms. Perform a play around the interventions that would be necessary to bring her to a normal weight so that she becomes a healthy infant. How would one sustain the intervention?”

After the presentation, Dr. Vandana Prasad observed that one should not forget the technicalities of any matter at any point. Like in the role play presented, the fellows did not talk about the severity of malnutrition and how to address a case of severe malnutrition. The intervention should have been around these points but the role play did not highlight it.

Group 3



Situation:

“Mariam is a young tribal woman of 20 yrs. She is in the first trimester of her pregnancy. Her hamlet is farthest from the sub-centre which is in another hillock. Do a role play around Mariam’s situation that covers her entire pregnancy and the delivery. Build it around the interventions that would ensure a healthy pregnancy, safe delivery and care of the new born.”

The third group presented the delivery of the tribal women who is in first trimester of her pregnancy living in the remote area where the sub centre is in the other village which is difficult to access by any vehicle.

While commenting the role play, the fellows said that the group did not show counseling on the dangers during the pregnancy. There was no depiction of the inaccessibility of the village and the sub centre. The defining factors for the delivery of the women were the drunkard husband, the decision making at the right time and the role of ASHA.

Dr. Vandana spoke about the contextualization of situations. She said that unless we contextualize we would not be able to think of solutions applicable to any situations. For example, in this situation, the home delivery could have been an alternative.

Another issue that the national convener highlighted was of the rest that should be given to the pregnant women. In the present role play, the drunkard husband had nothing to do with wife’s pregnancy. In other cases also in rural areas, the pregnant women hardly get much needed rest.

She said that the solution for it lies in group formation. The facilitator talked about importance of cultural context. He said that while implementing the solutions we need to understand the cultural context. The interventions should be culturally sensitive and socially acceptable.

Group 4

Situation:

“Kachar is a tribal village and is severely affected by Malaria after every monsoon. There are many cases of death. During monsoons this village becomes inaccessible and there is no health sub-centre in this village. The villagers feel there is a need to intervene. Do a role play on the formation of a VHSC and tackling the malaria issue as a priority. (This should be with the help of block and district representatives).”

The fourth group presented the scene of the village affected by Malaria - that affects the village in every monsoon and the formation of VHSC on this backdrop.

The fellows commented on the role play saying that there was no clarity on the formation process of the VHSC. The other suggestions were that the prophylaxis treatment and also slide collection could have been shown in the role play. That ASHA can treat the patient symptomatically, could also have been shown in the role play.

Dr. Vandana reiterated the fact that in order to work in difficult situations and suggest solutions one needs to go into that situation and then think. Unless we do that, we would not be in a position to suggest interventions and solutions.



The third session was the session which was to be coordinated by the Community Health Fellows themselves. The idea was to bring forth the positive and negative points of the fellowship programme and experiences shared by the fellows in different states. It was further thought that, the fellows would suggest how to move ahead after the fellowship programme for themselves and also for PHRN as an organizing and coordinating agency.

The third and final session of the workshop was on the **Way Forward** and was coordinated by the fellows themselves. For that, the fellows divided themselves into different groups according to the states and discussed amongst themselves what could be the way forward from here. They selected representatives from their group who expressed the groups' view in front of everyone.

- 1) **Jharkhand:** The team from Jharkhand said that, they have got exposure within the state but did not get exposure outside the state. If it is possible for PHRN, to organize such an exposure in other states then it would be great.

The suggestions by them were as follows:

National Core Group of Community Health Fellows should be formed and active
Alumni Meet should be organized once in a year
They will remain in contact with each other through e-group
They will support capacity building in their states wherever possible
They will support in the studies conducted by PHRN in different states wherever possible
They will support as resource persons

- 2) **Bihar:** The feedback and suggestions from Bihar team was the same as the Jharkhand team but they raised two different points. They were :

The fellows expressed that, if PHRN could support the fellows till they got jobs then it would be really great. The second suggestion was about linking current fellows with the future Community Health Fellows, to learn from them as well as to guide them wherever possible and required.

- 3) **Orissa:** Apart from the common points expressed by the other two groups the Orissa team talked about following points;

The Orissa fellows expressed their plan to hold a Press Meet to sensitize the media about the issues of community health and the fellowship programme.

Orissa fellows had planned to develop a model village which would be a PHRN model village - emphasizing on the community processes.

- 4) **Rajasthan:** Rajasthan fellows expressed their resolve to be in contact with each other. They informed that some of them had registered their organizations and they would need support from PHRN for their capacity building and other technical matters.



They expressed need for some space within PHRN office to hold meetings at state and national level. They also expressed a need to form a collective identity as “PHRN Resource Group” at the national level and also within Rajasthan.

The Fellows have also thought of an organization named ‘Community Health Forum’ as a formal organization of PHRN fellows from Rajasthan or at national level. They need guidance on policy issues and strategy formulation. The Rajasthan group also suggested forming the district units of the PHRN.

Rajasthan Team felt that hitherto PHRN had been at the academic level and so they expressed their willingness to join and support PHRN if it wanted to go for mass mobilization in Rajasthan.

Another suggestion that the team made, was regarding more rural fellowships at local level. They felt that if it was possible to launch such fellowships at local level, it would really be helpful and they would support it.

The Rajasthan Team raised the issue of individual v/s collective action and said that they would need institutional support to make an impact. Because if approached individually, it would be very difficult to make an impact.

In responding to this, Ms Susrita Roy from Rajasthan said that, while talking about collective action we must take into account difficulties involved in the process. She said that differences of opinion were bound to arise while taking on collective action. Despite that, we must be united and that was important.

She further said that, while involved in such processes, it was important to consider importance of collective wisdom as well.

While responding to the feedback given by the fellows, Dr. Vandana said “normally one looks for security and stability. But we are in PHRN now, which is an NGO and is thus not stable. NGOs are always unstable and dependent. That we need to keep in mind and everybody in PHRN is aware about that.

She emphasized that “Fellowships are not jobs. There is distinction between jobs and fellows. The fellows necessarily lead life of a learner as they are in learning phase. Presently, PHRN does not have plans to continue with Fellowship Programme. In January 2011, there will be a meeting of the national core committee (NCC) where a decision will be taken on the same.

PHRN will be in a position to share resources such as space and other basic facilities in the office. All the community Health Fellows can join General Body and have the voting rights in the general elections. She informed that there would be a national convention of all the alumni in 2011.

She informed that, the PHRN can support the fellows in using its identity and taking research projects. Further, she informed that, PHRN is not thinking for mass mobilization.

In his comments, the Arun Shrivastava said that there can be a link for the alumni on the website of the PHRN, where the Alumni can post their opinions, news, material etc. He further added that, the networking is a difficult



process and keeping the spirit alive is necessary. For that the members of the network have to have shared belief and shared identity.

While talking to the fellows, Mr. Dinesh Bhatt informed about different types of memberships and how can fellows be in touch with PHRN through these memberships. He informed that, there were 4 types of memberships –

- Student membership: this is the basic level of membership
- General membership: voting rights will be there and membership fees will be Rs. 200
- Life membership: Rs. 3000/- will be the fees and this will be onetime payment
- Associate membership: this is the membership for the NGOs and different institutions

Mr. Subhasis Panda from PHRN Orissa suggested that programme coordinators from different states should take immediate steps to materialize the ideas given by the fellows otherwise the same would be further delayed and nothing would come out.

Ms. Shilpa Deshpande from ICCHN congratulated all the fellows on their success and reiterated that there was quite a shortage of people working at the district level and having essential knowledge and tested skills. She said that Public health was not just a management issue but it had socio economic and political aspects attached to it, and that ICCHN wanted to fill this gap of people having right orientation towards this. She congratulated the fellows again and credited all fellows who had worked sincerely for successful completion of this unique programme.

Mr. Haldhar said that it would be useful to upload short CVs of all the fellows on the website after their placement in different organizations so that people would come to know whereabouts of alumni of this programme.

In the end, Mr. Rafay told that, everybody including the fellows must achieve mastery over at least one PHRN module so that people would look up to him/her as a resource person for an area specific to him or her. He wished all the best for the future to all the fellows.

Feedback and Evaluation

A feedback was taken from the fellows as has been taken in preceding workshops too. Everyone mentioned that overall it was a good workshop. There were some issues like the venue being a little far from the accommodation; some mentioned that the programme schedule should have been sent in advance. About the sessions, some fellows mentioned that some simple reading material could have been circulated before each lecture so that they were more prepared. Some fellows also felt that nothing was covered in this workshop on research methodology.

There were four guest speakers this time who covered a wide range of topics in public health. A questionnaire was prepared covering all the four sessions. The fellows were evaluated on the answers that they gave. The questions were subjective and not factual hence there were varied responses and the fellows did not score high marks. Out of 26 fellows, 7 scored more than 50 percent, 9 scored between 40-50 percent and 10 scored less than 40 percent. Shefali Kuntal from Bihar and Madhumita from Orissa scored the highest score of 60 percent.