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Final technical report

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PUBLIC REPORT ON HEALTH

India

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Council for Social Development

53, Lodi Estate

Delhi 110013

Overview team: (in alphabetical order)

- Dr Rama Baru
- Ms Anuradha De
- Dr N J Kurian (Project Director)
- Dr Onkar Mittal
- Ms Claire Noronha
- Dr Jacob Puliye
- Dr Ritu Priya
- Ms Meera Samson
- Dr C Sathyamala (Project Coordinator)
- Mr K. B. Saxena
- Dr Ravi Srivastava

State partners: (in alphabetical order)

- Agrabamee (Orissa)
- Cehat (Maharashtra)
- Debate (Madhya Pradesh)
- HP VHA (Himachal Pradesh)
- Loyala College (Tamil Nadu)
- NKC Centre for Development Studies (Orissa)
- Sahmet (Madhya Pradesh)
- Sahyog Legal (Uttar Pradesh).
- Vaanmuhil (Tamil nadu)

Contact information:

Ms Anuradha De: hlth_report@yahoo.co.in, anuradhad@gmail.com

Dr C. Sathyamala: csathyamala@gmail.com

Dr N. J. Kurian: njkurian@yahoo.com

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***Abstract:**

The aim of this project *Public Report on Health* (PRoH) was to do a comprehensive study that would contribute to a public debate on health issues and inform public health policy. For this purpose members from different disciplines met together to form the present research team. Data was collected from six states – three states with better health outcomes and three with worse – with the help of state level partners. Both qualitative and quantitative methods were used to collect data over three years. This included a year-long study of six villages as well as a cross sectional study of 60 villages (1500 households and all health providers). Rich insights are gained through triangulation of data from different sources. This report will be used to interact and dialogue with participants in the health system ranging from policy makers at central and state government levels down to local leaders of the community, panchayati raj institutions and local health delivery personnel and of course, the common people..

Public Report on Health

The purpose of this project *Public Report on Health* (PRoH) was to do a comprehensive study that would contribute to a public debate on health issues and could inform public health policy. The idea emerged from the report of a study on education, *Public Report on Basic Education* (PROBE), which was carried out by a group of scholars and activists from 1996 to 1999. Seeing the influence of the PROBE report as an advocacy document, some individuals involved with PROBE initiated a discussion on the desirability and feasibility of a similar report on health. The group of scholars from public health and related social science disciplines met regularly for the next two years to debate on the perspective, content and study design of the PRoH and the final proposal was ready in February 2004. The Council for Social Development (CSD) (Dr. Muchkund Dubey, President and Dr. Asthana, the then Director), which held a similar perspective on public health issues, agreed to provide the institutional base for the study.

The Research problem

Health and well-being or the lack of it is the outcome of the interaction of a complex set of factors that include not just the health services and the social determinants of health, but also whether people are conceived of as rights holders or beneficiaries. The PRoH aims to meet the need of an evidence based document to help focus the attention of the nation on people's right to health which would capture people's felt needs on the one hand and what the system had to offer on the other. As the study progressed and as information from different sites was collected, the researchers were made aware of the importance of changing political and economic climate on people's health and health perceptions, and this was included in the research problem. Through the study PRoH aims to present an alternative perspective based on people's right to health care and to develop a critique of the current priorities in health care.

Objectives

The overall objective of the PRoH is to present a perspective on People's Right to Health within a holistic framework. The report will identify 'how' health, thus defined (through community perception's, health services provider's perceptions and epidemiology rationality), can be achieved and 'what' needs to be done to move towards it in the present context at a macro level through public policy. The second issue is of access to quality care across a combination of systems viz. home remedies, various folk, indigenous and allopathic systems- based on a continuum from the home, to community, to primary, secondary and tertiary level of care. This would include ensuring availability of accessible medical services, promoting rational medical management practices, promoting their rational utilization and an epidemiologically

rational health service sector policy approach with the holistic framework providing the philosophical moorings. Since there is a large body of literature on the subject, the study will place great emphasis on literature survey and learning from other evidence based approaches in the sector.

Specific objectives:

1. Exploring people's perceptions of health and well being and their determinants
 - Stratified by SES and gender
 - Focusing on interstate differences
2. Documenting illness related information-
 - Morbidity/disability/mortality patterns – and crucial variations at a point of time and changes over a year.
 - Illness management- No action/ home remedies/ self-treatment/ folk practitioners/ indigenous and allopathic systems
 - Source of treatment- Private/ Public, their profiles, Primary/ Secondary/ Tertiary
 - Expenditure on treatment- how much and how the expenses were met
 - Perceptions about illness/ treatment/ public and private health care providers/ prevention
3. Studying health Services
 - Listing of health services and service providers, public and private, across combinations of systems based on a continuum from the home, community, primary, secondary and tertiary level, from village to district towns
 - Management practices of service providers
 - Quality of care
 - Perceptions of service providers of various types at various levels
4. Analysing policy Approaches
 - Health policy in light of comparisons in health status, health seeking behaviour, access and quality of health care providers
 - To assess the problems of common people in meeting their health needs and the possible solution to these problems.
 - Specific programmes formulation as case studies- to study the determinants and process of decision making
 - Perceptions of policy makers/ planners/ administrators

These objectives were largely met. There were a few changes.

1. The primary focus of the study was on rural areas but there was to be a small urban component in the final quantitative survey. But finally the study remained focused on rural areas, though secondary and tertiary providers in the public sector in district towns were covered. This was mainly because of delays due to logistical reasons as will be explained in the later part of the report.
2. Specific disease control programmes were not focused on as case studies. The researchers felt that this will be limited in scope when there have been sweeping changes in social and economic sector in India, particularly in public health sector. The National Rural Health Mission which was in the conception stage in 2005, has been implemented in almost all the districts since then. It was more important to use the survey to evaluate the initial impact of NRHM policies on health care provision. With this in mind the tools of the household survey in 2008-9 were adapted.
3. While analyzing situation study findings, the team realized that many changes were taking place which may critically impact health status and health determinants. The objectives were then broadened. As health status is a composite of health services and health determinants, policies related to agriculture, employment, water, land reforms, access to natural resources, directly impact the health status of people. To a limited extent the impact of these changes on health status and health policy also included in the study objectives.

Methodology

For a country as vast and varied like India developing an appropriate methodology was a challenge and evolved over time. There were variations in health status and health utilisation between states, between districts within a state, and between villages and even within a village depending on the socioeconomic background of the villagers. Health provision – both public and private - also varied widely. There was a need to triangulate information collected from different stake holders and from different sources.

From its inception it was decided that there will be both quantitative and qualitative methodology will be adopted in the study. Since one of the objectives of the study was to capture the determinants of variations in health related outcomes, states were selected to reflect this variation as also a degree of geographical dispersion and availability of state partners. Six states were selected purposively on the basis of their geographical location, and performance of the health sector (availability, access and coverage), to represent a broad variation in delivery systems and health outcomes in the country. The states chosen purposively for the fieldwork were three better performing states viz, Himachal Pradesh, Maharashtra, Tamil Nadu, and three states where the indicators of health and well-being were less satisfactory, viz, Madhya Pradesh, Orissa and Uttar Pradesh. A North Eastern state was also included in the initial proposal but was dropped due to logistical reasons. Two districts were to be chosen from each state. The choice of

districts was also guided by the principle of diversity – one district was relatively well performing according to available health related indicators and the other, one of the relatively less well performing districts in the state. In addition they were chosen from contrasting agro-economic zones in the state. A comparison of data/ information from the two districts was to facilitate in drawing inferences about the quality and quantity of health care available in a backward district vis-à-vis a developed district in the same state.

Detailed long term information was necessary, and so it was decided to involve state level partner organizations to work with the research team, rather than recruiting researchers and conducting the surveys from Delhi. These state organizations were to be involved in developing the methodology at the field level as well as collect data, and were expected to play a key role at the dissemination stage.

The methodology included both desk study and field study elements. The literature review of relevant public health literature resulted in a series of theme papers. They were very useful in developing survey instruments for the surveys. The secondary data in the six selected states were analysed to prepare the necessary backdrop for the study, and state background papers which emerged from these desk studies helped plan the fieldwork.

This was followed by a situation study of the two districts in each state. The state partner organization used secondary data to put together a brief background of the demographic and socio economic profile of the selected districts. Through group discussions and key informant interviews at district and block level as well as two villages in each district a situational analysis was done. This included a macro level rough mapping of the health services – government, private, charitable trusts (primary and secondary health care).

The project required an integrated study of the health conditions and health seeking behaviour of communities with that of health care services available to the same communities, simultaneously with provider perceptions and community perceptions of health and well-being. An intensive year long village study was considered best suited to collect this kind of data, which would have both qualitative and quantitative components. This would allow for capturing the seasonal variation in morbidity patterns and health needs as well as for developing an in-depth and comprehensive understanding of life context and worldview of the various sections. So it was decided to access in depth information about people's perceptions about health and wellbeing the changing contexts of public health, and process of healthcare in selected villages in each state under study.

Due to time and budget constraints only one village in each state was selected for this purpose. from the villages visited during the situation study. Information on socio-economic and demographic profile of village population, their livelihood details, source of water, nutrition and major illness and information about health care facilities accessed by villagers were used to develop the methodology and

tools of the intensive village study. This included a baseline survey and four rounds of morbidity survey of the entire population (including heights and weights), a longitudinal study of selected households regarding their food intake, morbidity and work and a survey of all health providers to the villagers, both inside and outside the village. In addition qualitative data from the communities were collected regarding their health and well being, and perceptions regarding health providers/ health facilities.

Finally there was a larger quantitative study of 10 villages from each state. This included a sample survey of households and a survey of all health providers in the village, as well as government providers at the district/ block level. The intensive village study gave the variations in health status and utilization over a longer period of time, and provided insights to the possible interrelationship between health determinants and outcomes. Through the quantitative survey it was possible to capture and quantify crucial variations in people's experiences with regard to health at a point in time. It gave a quantitative dimension to the data that enabled comparison and contrast among states at different levels of development. The providers survey gave a clear picture of the functioning of the health services and the user perceptions of these services. On the basis of the larger sample the quantitative survey served to validate or contradict some of the important findings of the intensive study.

Sample selection:

A multi stage sampling was done at the district and village level to arrive at a representative sample of villages.

Two districts from each of the six selected states were selected - one district above average and the other below average in terms of certain health related indicators. It was decided to rank districts according to health indicators. There were discussions about the appropriate indicator/s. Infant Mortality Rate (IMR) was thought to be most appropriate. But in the absence of current reliable figures, an index was built from several indicators like rural female literacy, infant mortality rate, safe delivery and total vaccination. A composite ranking was built from these figures and the districts were stratified into four quartiles. The sample districts were chosen purposively from the second and fourth quartile. It was thought best to leave the final choice to the state partner NGOs. This was because the state partners NGOs work at the grassroots in the states in which they are the PROH's partners. It was felt that their acceptability by the villagers in districts they have been working in would facilitate collection of quality data. They would also be aware of contingencies, such as political or geographical issues that might help/hinder research work in the area. The final selection of the districts was thus purposive, within the quartiles, based on contacts, special features and identification of partners¹.

¹ For instance, in Tamil Nadu, Virudunagar district was chosen as it has one of the highest MMR (rural) in the state despite a higher female literacy (Ref: Government of Tamil Nadu, Tamil Nadu Human Development Report, 2003, p151).

The selected districts, state wise are given below, the first one being the poorly performing district and the second one being the better performing district.

1.	Chamba (H.P)	2.	Una (H.P)
3.	Shahdol (M.P)	4.	Hoshangabad (M.P)
5.	Jalna (Maharashtra)	6.	Pune (Maharashtra)
7.	Rayagada (Orissa)	8.	Dhenkanal (Orissa)
9.	Allahabad (U.P)	10.	Meerut (U.P)
11.	Virudungar (T.N)	12.	Kancheepuram (T.N)

Situational Study Villages

The district wise list of villages from the 2001 Census was used as the basic sampling frame. Very small and very large villages i.e. those with population less than 500 or more than 4000 were excluded from the sampling frame. Fifteen villages were randomly selected from this sampling frame, and from them two villages were chosen from them purposively. These villages were not to be the one the partners worked, yet should be convenient for the situation study.

Village for intensive year long study

The situational study was followed by an year-long intensive village study of one of the two villages of the poorly performing district in each state, which were initially selected based on the assumption that the NGO which was working in nearby villages would be able to gain the trust and the willing cooperation of the respondents for a year long survey. Though attempt was made to select villages of similar size for the study, Orissa and Himachal Pradesh had villages of much smaller size. So in these two states two neighbouring villages were chosen for the study, while only one village was studied in other states.

Table below lists the selected states, the districts and the villages for *Situation Study* and the IVS. The selected villages are referred to by code names to protect their identity.

Selected states, districts and villages for the *Situation Study* and the IVS

State	District	Village code	Village selected for the IVS
Tamil Nadu (TN)	Kancheepuram (better developed)	KDV1	
		KDV2	
	Virudunagar (not so well developed)	VDV1	
		VDV2	√
Maharashtra (MH)	Pune (better developed)	PDV1	
		PDV2	
	Jalna (not so well developed)	JDV1	√
		JDV2	
Himachal Pradesh (HP)	Una (better developed)	UDV1	
		UDV2	
	Chamba ²	CDV1	√
		CDV2	
Madhya Pradesh (MP)	Hoshangabad (better developed)	HDV1	
		HDV2	
	Shahdol (not so well developed)	SHDV1	√
		SHDV2	
Orissa (OR)	Dhenkanal (better developed)	DDV1	
		DDV2	
	Raigada (not so well developed)	RDV1	√
		RDV2	

Within the selected village all households were selected for the survey. In addition, using the baseline survey data the households were separated into five separate socio economic categories and in all 15 households were selected from them (3 randomly chosen from each category) for the longitudinal survey (6 rounds of 7 day log of data on food intake, morbidity and work).

Selection of Villages and Households for Household Survey in Phase II

In order to broad-base the findings of the study, in Phase II a random sample of five villages was selected from each of the twelve districts for a survey of households and health providers. In each district three independent random samples of five villages each were drawn without replacement. This was because if

² Initially, Sirmaur was chosen, but with the change in state partner, this was dropped and Chamba district chosen.

the partner NGO ruled out survey in some of the sample villages in one sample due to some reason such as political disturbance or inaccessibility, it could implement the survey in the second independently selected sample. In this fashion, sixty sample villages were selected from the twelve study districts.

The number of households to be selected from each of the sample villages (for Phase II) was decided after estimating the sampling error for household estimates at the district level. It was felt that a sample size of forty households in each village would provide a total sample of 400 households (or about 2000 individual observations) at the district level and that this would be adequate to provide reasonably reliable estimates of the qualitative and quantitative variables being studied.

The methodology for selection of households at the village level was circular systematic sampling with a random start. This was done after ensuring that the lists of households in the selected villages conformed to the requirements of such a sampling scheme.

Changes in Methodology

The methodology was formulated through regular meetings of the research team at PRoH over a period of two years preceding the study. Many of the overview team members and advisory team were part of these meetings. The methodology continued to evolve as different phases of the study was completed. It was originally proposed that for the year long village study there will be at least two researchers per team who will stay in the village, and collect information over the year. A part-time medical doctor was also to be involved – in addition to self perceived morbidity, there were to be regular health check ups too.

However in the project inception period, when the project state partners were identified, they felt this model was difficult to achieve as few good researchers would agree to stay and work in the village continuously for one year. So instead the model used was to have several rounds of surveys over the year with four or more researchers.

There were discussions around the role of a doctor in the survey – the researchers were in a dilemma. While a doctor would medically diagnose diseases as opposed to data regarding self perceived morbidity, it appeared unethical if the doctor diagnosed illness and did not ensure that the patient had access to health care. Yet if the research team were to provide medical treatment it would not be feasible from the point of view of costs and may lead to creating tensions in the village. Moreover, it may influence the health seeking behaviour of the people.

Later a similar dilemma was faced when a prescription study was suggested in the third round. Finally it was decided that no medical doctor will be involved in the survey. And though the survey team was not to intervene in health care seeking behavior of the respondents, they would assist critically ill patients to access health care in the government institutions.

The research design involved looking at a more developed and a less developed district in every state. While this design was maintained in the situation study and the larger village survey, a major compromise was made for the year long village study due to resource limitations. It was decided to study only one village from the less developed district in each state.

Project Activities

The team met regularly for almost two years before the inception of the project to develop the methodology. The team members were now separated into the overview team and the advisory team. The overview team continued to meet every month to coordinate and take decisions. Dr. Asthana who was the exofficio project director of CSD had retired by this time, and Dr. Kurian the new director of CSD was the exofficio director of the project. PROH had its office in CSD and two SRFs and later 1 one JRF was appointed for the work. The inception phase of the project required identifying partner organizations in different states. The team wanted to follow a participatory model where the partners were involved from the outset and inform the very design of the survey. One member from the overview team was made the nodal person for a state and was expected to guide and coordinate with the partner organization regarding the research activities. Each organization was to have a state level coordinator and two researchers.

It was decided that for ethical clearance an ethical committee will be set up, which will meet before every phase of the field work and give clearance for that phase. The Ethics committee that was convened for the purpose of the project met on October 24, 2005. The committee consisted of R. N. Gupta (Emeritus Medical Scientist, Indian Council of Medical Research) who was the chair of the Committee, Amar Jesani (Coordinator, Center for Studies in Ethics and Rights), Narayan Banerjee (Director, Center for Women's Development Studies), Ratna Sudarshan (Director, Institute of Social Sciences Trust) and Somen Chakravarty (Human Rights Lawyer) were other members of the committee. In the meeting of the ethics committee all research tools were discussed and their comments were incorporated. There were separate consent forms for individual interviews and group discussions and a separate for the researchers were made to ensure confidentiality. It was also decided that the village names will not be used in the reports. **(Annexure 1)** The committee gave clearance to the methodology of the phase.

The ethics committee raised certain questions regarding methodology. There were questions regarding the collection of detailed data of aspects which usually are not included in health survey. There were questions regarding the size of the qualitative sample as well. Ethics review is a serious institutional mechanism which is required for all public activity. This project was different from the others in the sense that the methodology of the different phases was to be finalized before each phase and the committee members had information about the first part of the project.

The study team agreed that there was a need to produce a document that captured the process of the evolution of the project over the earlier years. The researchers involved were individuals with diverse theoretical frameworks and methodological perspectives and the evolved methodology was different from the usual morbidity and providers survey. This document was thought to be useful not just in the current context of getting ethical clearance, but also in the future for other questions that may arise from other quarters about the evolution and methodological decisions of the PROH. Several team members worked together to draft the process document (**Annexure 2**).

There was a workshop with all members of the PROH Delhi team and the partner states were trained in the methodology of situation study. Situation study was by two organization – one the one in Kanchipuram by Loyolla College, Chennai, and the work in Virruddhanagar was done by Vaan Muhil based in Tirunelveli. AS the IVS required work in Viruddha nagar the work continued with one partner – Vaan Muhil. For the work in each state there were two fieldworkers and a state coordinator. In addition one person from Delhi project office and one member from the overview team worked closely with each state team. The training workshops in Delhi were usually followed by a state level training of investigators. There was also a communication workshop with a state level advisor team in some states.

Two types of outputs emerged out of the first years' literature surveys. It was envisaged that the literature survey would feed into the research design for the fieldwork as well as provide the basis for the policy analysis framework of the report. One type of output was the theme papers written by different members of the project team. A writers' workshop was organized on April 24th and 25th, 2006. These papers were to be revised on the basis of received comments. These papers have been sent to IDRC earlier (**Annexure 3**). The other set of outputs is in the form of State Background Papers. Though these papers borrowed from the state Human Development Report, the latter was examined critically. These papers have also been sent to IDRC (**Annexure 4**).

A five day intensive interactive workshop was held at Indian social Institute, from 13th to 17th may, 2006. The drafts of the situation studies were presented and discussed in the workshop. This was followed by a training of the research team for the first two rounds of IVS survey. As the methodology was evolving over time the agreements with partners were made for specific periods. The Himachal Pradesh partner Sutra could not want to continue working in the project due to their inability to find a field level coordinator. So their agreement was not renewed. Later

another organisation HPVHAI was identified. They started their IVS later than others but it was possible for them to complete in different rounds in the right order.

By the end of two rounds of morbidity survey tools for the last two rounds were finalized. These included a schedule for Economic survey of households, including cost of health care, and a schedule focused on women's morbidity. The group felt that the villagers will be familiar with the researchers after meeting them for six months, and will not be reticent in giving correct information on their private matters. There was meeting with the Ethics committee to get clearance. This was followed by a training workshop in Delhi, and then individual state level workshops.

With the completion of intensive village survey, the project office, along with the state partners, was busy with data cleaning, data entry and data analysis. A major problem was the multilingual nature of the model and all the tools had to be translated. However in the data entry and analysis time one realized the enormity of the task – need for translating all qualitative interviews from handwritten schedules. Ideally this should have been done at the partner organizations, but there was limited availability of good bilingual people and a large part had to be done in the Delhi office. Himachal Pradesh started their rounds later, and so phase II of the project was delayed till the HP partners completed their work.

In the last phase new agreements were required with the partners. At this time two of the partners wanted to discontinue – as the project had got delayed and they had prior commitments with other work. So in the states of Orissa and Madhya Pradesh two new partners were identified.

The various survey instruments and sampling methodology were approved by the Ethics committee. Researchers from the project office field-tested the survey schedules in different state with the help of partner organization before finalization. This was followed by a two-days training workshop in September 2008, at Delhi which was attended by the principal investigators and supervisors of all the partners' organization. The logistics of the field work were also finalized in this workshop. A hands-on training on actual selection of sample villages and households was also carried out in this workshop. Before the actual field work was started in October, researchers from the project office visited the states and trained the field investigators of partner organization in the actual canvassing of the schedules. During the survey period also

frequent field visits were made by them to closely monitor the field work to ensure quality of data collected.

At the same time the draft report based on IVS was completed. After the Phase II survey, the data was cleaned, entered and analysed. In March 2010 in a final workshop all members came together and the findings of the IVS and phase II survey was presented. At the same time a detailed outline of the Public Report on Health was finalized.

Activity	Time
Agreement signed :	March 2005
Project office set up	May 2005
Workshop 1 (meeting new partners)	July 2005
Workshop II (training for situation study)	November 2005
Situation study fieldwork	December 2005, January and February 2006
Workshop III (presenting situation study, training for 2 rounds of IVS)	May 2006

Time Schedule of IVS

States	Baseline	Morbidity Round I	Morbidity Round II
MP	August-2006 September,	October 2006	December 2006- January 2007
UP	August-2006 September,	September – October, 2006	January 2007
Maharashtra	September – October, 2006	September – October, 2006	December 2006- January 2007
Tamil Nadu	August-2006 September,	September – October, 2006	January 2007
Orissa	August-2006 September,	September, 2006	December 2006- January 2007
HP	May – June, 2007	July – August 2007	October 2007

S.No	States	Morbidity Round III	Morbidity Round IV
1	MP	April – May 2007	August- September 2007
2	UP	April – May 2007	September 2007
3	MH	April – May 2007	September – October 2007

4	TN	May 2007	September 2007
5	OR	April – May 2007	August- September 2007
6	HP	January 2008	May 2008

Activity	Time
Workshop IV (interpretation of data collected, training of last two rounds of survey)	November 2006
Workshop V (Training for 60 village survey)	September 2008
Village survey	October 2008 – March 2009
Final workshop	March 2010

As discussed in the following section the project has been delayed unexpectedly. As a result some of the data has not been analysed fully, and in one case, not analysed at all. This is the longitudinal data collected as seven-day household logs from 15 households in each IVS village. The methodology was devised to capture the linkages between nutrition, work and morbidity, and was to be related with the household's socioeconomic background. One member from each household was given the task of recording the data for each of the seven days, and where all members were illiterate the researchers met them every day to record these details. Good quality data was collected from most villages. But entering the data and then its analysis was a time consuming task, and there were several deadlines to meet. So this set of data has not been entered till now. The team realizes the value of the data and report based on its analysis. They plan to look for additional resources to enter and analyse this data after the PRoH report is submitted.

Learnings from implementation and management of project activities

This had been a very complex project which involved several rounds of fieldwork in six states. However the partners were not thought of as data collectors only – the proposal envisaged them as equal partners of this project. During implementation one realized several types of problems in coordination, and in maintaining data quality. It was really very difficult to coordinate fieldwork in six states, and the project had to go in for several time extensions.

1. Partners were at different levels in capabilities. While some like Anusandhan Trust of Maharashtra had years of experience in research and interventions in Public Health, there were groups who had never worked in this sector before. So some needed a greater degree of support and guidance.

2. Initially the Report was thought of primarily as an advocacy tool and partner choice was made with advocacy in mind. However the team felt later that it was essential to have a report based on a reliable data base and rigorous research and so the nature of the project changed. This led to some problems as the partners were not always able to meet the demands of this rigour, and some of the tools – like the verbal autopsy of deaths, or the repeated rounds of height and weight data – yielded faulty information in a few states.
3. As the partners were identified after the proposal was approved, they felt less involved and accountable to the project. It became clear over time that some partners viewed this project as an opportunity to add health to the areas of expertise – and as a source of funds essential for their survival. Hence there were problems in maintaining time schedule, and some left the project when it became clear that the work was demanding. This delayed the project considerably and a lot of energy was wasted in identifying and training new partners.

For good quality of data it was important to have the same group working in the area and with the different stakeholders. The analysis was expected to be enriched with their knowledge they have gained about these areas. This was not achieved in all states.

The partners found it very difficult to identify capable researchers and retaining them. Firstly the Tsunami aftermath saw an influx of development funds and a rapid rise in remunerations in the voluntary sector. There had been a serious underestimation of salary levels. The budget should have built in an inflation markup over the years of the project. The work was strenuous and required documentation and analysis skills. So often city educated researchers were keen to leave and left in the middle of phases for higher salaries. The Delhi office had to be involved in identifying researchers. In three states even the state coordinator left in the middle of the project. The problem of continuity was experienced both at the PROH office and at the state levels with the researchers discontinuing when they received better prospects. This, along with difficulties in finding qualified personnel led to the delay in completing the work

4. The FCRA rule of the Indian government changed in 2006. Under this rule all organizations who are funded by foreign currency has to have FCRA clearance from the government – even when they are not directly funded. This became a problem for several organizations, and was one of the reason the MP partner had to discontinue.

Some of these problems could have been avoided if the partners were identified before the project was finalized. But unfortunately this process requires time and money. For such long programme

involving multistates and multi-organizations the funders could use a model where a small amount is sanctioned to the leading research group to identify partners – the final agreement should be jointly with all partners. The state level organizations would then be an equal partner of the project and directly accountable to the funders in delivery of outputs.

5. There were frequent changes in the project team too – leading to several problems and unnecessary delays. When the project was sanctioned Dr. Asthana, Director of CSD, was the project director, and Mr. Amarjeet Sinha, IAS, was the coordinator for all practical purposes. But due to delays arising from the project approval process Dr. Asthana retired and the new CSD director Dr. Kurian became the new project director. Mr. Sinha was appointed director of National Rural Health Mission in the same year and had to leave the project.

While capable researchers took over these positions, their ideas about the project were not necessarily the same. This created many management problems – originally the budget and time line was proposed on the basis of certain extent of fieldwork. Advocacy component was quite large. However in the project a lot more (and good quality) data was collected but it required a much longer than estimated time to collect and analyse them. This delayed the process considerably and did not leave time for advocacy. More detailed and rich analysis of the data, particularly the qualitative data, is possible.

There was an element of voluntarism in-built in the project proposal. Both the overview team members and the project partners were expected to give part voluntary inputs. In particular whole time project team staff was kept limited and at a low salary. Though the voluntarism element remained with most of the overview team members – it meant very few could give a large chunk of time to the project. For the partner states, sometimes survival issues became very important and they could not devote the required time to the project work. Later in the project more staff had to be recruited, but implementation would have been smoother if more fulltime staff were associated from the first.

5. Several problems arose from the evolving of the methodology. Every time the methodology was finalized at the overview team level, there had to be a clearance process from the ethics committee and then fresh agreements with state partners. The state partner Cehat had its own ethics committee which had different take on the issues. These processes delayed the project every time. This again suggests that delays could be limited if the state teams were part of the research team before the project received final approval.
6. A major problem in the project implementation was to get the necessary permission to interview government doctors and health department staff. This was in spite of interventions from the overview team – some of whom are ex- or present bureaucrats.

Project outputs

This group came together to produce an evidence based document - the Public Report on Health. This is expected to be the most important output of the project and will be disseminated among different groups. It will be a short (around 100 pages) and easily accessible document and will be used to focus people's attention on the current health policy and its implementation. The detailed outline of the report was sent on April 2010 and the first draft is expected by May end. The report will be shared in early July, 2010

This report is based on several research reports on different phases of the survey. These research reports were part of the deliverables in the proposal, and have been sent to IDRC. They are also being sent as annexures. The details are given below.

- (i) Two sets of research papers were generated from the overview of literature undertaken for policy, morbidity and perception studies – these were in the shape of a series of theme papers, and six state background papers.

➤ **List of theme papers (Annexure 3)**

- a. Ideology and Health Sector Reforms: A State Level Analysis by Rama Baru
- b. Health Perception Studies and Their Role in Public Health Policy and Planning: Some Theoretical And Methodological Issues by Ritu Priya and Mita Deshpande
- c. National Rural Health Mission: A Critique (work in progress) by Onkar Mittal
- d. Governance in the Health Sector by K. B. Saxena
- e. Recovering From A Disaster: An Ethnographic Study Of Post Tsunami Relief, Rehabilitation And Reconstruction Activities In The Coastal Districts Of Tamil Nadu by Pavananthi Vembulu, R. John Suresh Kumar, C Sathyamala.

➤ **List of Background paper (annexure 4)**

- a. Background paper of Himachal Pradesh
- b. Background paper of Madhya Pradesh
- c. Background paper of Maharashtra
- d. Background paper of Orissa
- e. Background paper of Tamil Nadu
- f. Background paper of Uttar Pradesh

These papers have already been sent to IDRC. The theme papers will be edited and published later in this year. Two have been published so far (details given below).

1. Saxena, K. B. (2010): “*Health Policy and Reforms: Governance in Primary Healthcare*”, Aakar Books, Delhi
 2. R Pavananthi Vembulu , R John Suresh Kumar , C Sathyamala (2008): Post-Tsunami Housing in Tamil Nadu in *Economic and Political Weekly*, Volume 43, Number 16, April 19 – 25.
- (ii) Data analysis and write-up on the situational analysis: Separate reports for the state of Himachal Pradesh, Madhya Pradesh, Maharashtra, Tamil Nadu , and Uttar Pradesh were written and sent on November 2008. (**Annexure 5**) .
 - (iii) Report on the intensive village studies in the six States: The report on the Intensive Village study in six villages was sent in April 2010 (**Annexure 6**).
 - (iv) Data analysis and write-up on the result of quantitative survey – A two part report has been sent in April 2010: First part is based on the findings of the household survey (**Annexure 7**) and second part on the Providers survey conducted 60 villages in six states (**Annexure 8**).

Three types of written outputs are expected in this year.

Firstly there will be the Public Report which will be used for advocacy with policy makers and with other stakeholders.

Secondly there will be a more detailed report which will allow the different advocacy groups to use part of the evidence for their own advocacy. This would be somewhat in line with the report based on Intensive village study but will included information from different phases. There may possibly be separate reports for each of the six states to be used for state specific advocacy purpose.

Thirdly there will be a short summary of the public report which will be translated and used even at the grassroot levels.

Apart from these reports several academic papers can emerge from the data. They are in the pipeline and can be planned only after the Public Report is finalised. It will then be possible to identify issues on which data has been generated and which needs to be analysed in greater details.

Technology

Collecting health related information is a very time intensive method. So usually health surveys are either focused on large scale providers surveys or are collected in specific areas as case studies. In this study an unique attempt was made to collect year- long information of selected areas as well as from a cross section of villages in six state. The collected data was not confined to morbidity information and interviews with health providers alone, but detailed information of socioeconomic background, livelihood

issues, nutrition living conditions and village facilities like water and sanitation were collected to capture the perceptions of the respondents. NSSO had collected morbidity data in the past while NFHS has regular rounds of surveys focused on women's health in particular. But this study looks at public health issues in a holistic manner, and attempts to triangulate actions and perceptions of different stakeholders.

Through quantitative and qualitative methods information has been collected from 12 districts in 6 states over a period of three years. This was a unique opportunity to compare the efficiency of different methods in collection of different types of data. For example comparisons of responses from the IVS and the quantitative household survey indicates where the cross section surveys yield more reliable data and where more long term surveys are required. These findings will be very useful for planning health surveys in future.

There have been innovative attempts to triangulate information from different sources. This was attempted for the household survey where their perceived health status was related to their socioeconomic and geographic context. The perceptions of and about health providers were also examined in the broader context. The analysis gives a fresh insight about the needs and availability of health facilities.

Capacity building

The project has been led to improved capability both at the individual as well as institutional level. The several training workshops trained the researchers in both quantitative and qualitative surveys. The overview team members are well known academicians, activists and professionals. While many of the researchers knew the basics of quantitative survey, they were trained over the years, in the principles of random sampling, and different types of qualitative survey and documentation. These included interviews, group discussions, and verbal autopsies of deaths. They were taught to take heights and weights accurately. Most of the state level researchers came from social work background and though they were good at interacting with the respondents their ability to document were limited. They became more skilled in these.

The organizations which are the state partners came from varying backgrounds. Some of them have been working at grassroots level in different arenas of service delivery or advocacy, while others are primarily research and training institutes. Except for CEHAT in Maharashtra, none other were directly involved with health sector. But they all felt the need for interventions since health was a major problem in the areas in which they work. When asked how they felt they can gain from the project their responses were varied from “developing a better understanding of health issues”, “develop an understanding of research accountability and design”, explore health issues in detail to enable them in evidence based

advocacy". In general the state level organizations felt they could develop a new understanding and skills by working closely with a larger team consisting of a pool of people with different specializations, and would be able to improve their skills in qualitative and quantitative analysis.

In this project a multidisciplinary approach is taken, and a mix of qualitative and quantitative methods is being developed. So it is a learning experience for all researchers involved. In addition the state partners are mostly very skilled at advocacy at different levels – a rare opportunity for the academicians in the team.

The project staff was mostly from qualitative research background. They were exposed to quantitative methods. Interacting with different state teams and providing training, support and supervision when necessary improved their skills in project management. They also were gained skills in health related fieldwork and data analysis.

The overview team members were exposed to different types of research methodology and the qualitative researchers were exposed to quantitative methods and vice versa. Similarly public health experts were exposed to other social science concepts, while several doctors and social scientists were trained in public health concepts.

Those handling the project management and coordination found the coordination a major challenge, and felt their capacity to work with people from diverse disciplines, and motivation have increased considerably.

Of the six partners only one (Anusandhan Trust) had prior experience in research on health. However all outputs reflect their improved understanding and capacity in conducting research on health issues. Several of them have since then become involved in health related interventions and advocacy.

The project team members had close interactions with members of the ethics review committee. This led to the members having a greater understanding of ethical issues related to social science research. This has led to a vibrant debate in the project team and with the state partners on the ethics of research. It has led to more thinking about the ways of operationalising research sensitively.

Project outcomes

Necessarily, such a report will involve interaction and dialogue with participants in the health system ranging from policy makers at central and state government levels and the bureaucratic apparatus involved with the health system down to local leaders of the community, panchayati raj institutions and local health delivery personnel and of course, the common people in their perceptions, their experiences, and their interactions with the health system. Such dialogue occurring at multiple levels is crucial to a

complete presentation of the problems of the common people in meeting their health needs and the possible solutions to these problems.

The dissemination will be at the state level as well as the national levels – we intend to present it not in one big workshop but in several small ones with targeted audience. The final report will be disseminated in the printed form as well as through e-networks. All the team members are actively involved in different networks (such as (JSA) Jan Swasthya Abhiyan, MFC (Medico Friend Circle, NAPM (National Alliance of People’s Movements), Right to Food, Right to Livelihood, BPNI (Breast Feeding Promotion Network in India), IBFAN Asia (International Babyfood Action network) and others) and will disseminate the outputs. This report will be an useful tool to strengthen these networks and generate public debates on important issues. For example in May 2010 the newspapers have focused on starvation among children in Sankargarh block in Allahabad district in Uttar Pradesh. The children were seen to eat mud and silica in hunger, and it was being contested by state government as to how it arises from habit and not hunger. In the present project there is detailed information about malnourishment and food habits in villages in these areas and PRoH members expect to add to the ongoing debate using their data.

Several of our members are associated with policy making process and will disseminate the report to relevant officials in related ministries, members of the Parliamentary committee on health, and trade unions. Our government is keen on having evaluations of NRHM and our report will be add to that. Hopefully the report will also generate discussions and re-examination of health policy to ensure that people are looked at as right holders and not beneficiaries.

There have been several micro-level outcomes at the state level – some of them have revised their interventions based on their research. Several of them have organized health camps in their villages. The UP partner had tried to ensure that recruitment be done properly under NRHM.

Overall assessment and recommendations

A study of this nature and scope is challenging to say the least. The major conflict was the tension in the study was whether it was to be an advocacy report or a research report. Since initially the advocacy part was emphasised the partners were chosen with that in mind. However, the need for a evidence base for advocacy pushed the study towards a more rigorous methodology. This shift led to working with state partners who were not either well versed or inclined to carry out a rigorous study design. The problem was also compounded with the disciplinary tensions within the Overveiw Team between qualitative and quantitative methods, differences in the understanding of ‘public health’ and ideological thrusts. That the study was completed is a mark of the perseverance of the team which believed in the value of the output

despite all such constraints. We can say with confidence that the data collected and the insights gained would add to the discourse on public health particularly from a rights perspective. So in that sense it has been worth it, in terms of the money, time and effort. However, were such a multi-centric, multi-state and multi-disciplinary RESEARCH study is to be attempted again, it may be better that academic institutions with a track record of implementing high quality research be involved as partners. The study protocol, methodology etc should be evolved with the partner organizations. The involvement of a good Ethics Committee is important and this should be independent (not institution based) from the research organization; PROH gained greatly by the Ethics Committee members who while being critical were also supportive.

Some of these problems could have been avoided if the partners were identified before the project was finalized. But unfortunately this process requires time and money. For such long programme involving multistates and multi-organizations the funders could use a model where a small amount is sanctioned to the leading research group to identify partners – the final agreement should be jointly with all partners. The state level organizations would then be an equal partner of the project and directly accountable to the funders in delivery of outputs.