# IDRC supported 'Closing the Gap' Project on Health Equity

End of Project Evaluation

**Introduction**

The "*Closing the Gap: Health Equity Research Initiative in India*", implemented by the Achutha Menon Centre for Health Science Studies, the Public Health Wing of Sree Chitra Tirunal Institute for Medical Sciences and Technology, was initiated to promote research on health equity in India. Set up with financial support from the International Development Research Centre (IDRC) Canada, the project aims to

> "*contribute to the advancement of a sound, actionable and measurable evidence- base on inequities in health in India with a view to influencing government and civil society initiatives to prioritize the reduction of health inequities".*

'Health equity research' is defined for this project as research that enquires into inequities in health across social groups; recognizes that factors influencing health inequities operate at multiple levels from the global to the individual; and acknowledges the simultaneous operation of multiple axes of deprivation or oppression to create inequities.

***Specific objectives of the project***:

i. Evolving, through a consultative process, a country-relevant- multi-disciplinary research agenda on health inequities.
ii. Supporting and promoting research on identified priorities for health inequities in India to expand the breadth and depth of the evidence-base on health inequities in India.
iii. Nurturing research capacity in health equity research among young researchers across sectors and disciplines.
iv. Engaging in knowledge translation activities throughout the project cycle to increase visibility to health equity concerns among key constituencies such as health equity researchers, policy makers, civil society actors engaged in advocacy for health and for social justice.
v. In order to achieve (i) to (iv), working in partnership with and forging a community of health equity researchers as well as practitioners across academic disciplines and across academia, policy makers and civil society actors.
vi. Enhancing the capacity of Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology as a centre with expertise on cutting-edge, multidisciplinary research on health inequities in India.

The project has been of four years' duration, extending from 1 October 2014 to 30 September 2018. The total grant for the project was Canadian Dollars 544,800/- (Approx INR 2.95 Crores). The project is now formally completed.

This document is an end of project evaluation. The purpose is not course correction, but rather a review of the project as a whole from its own end point, and therefore as the starting

point from which a way forward may be mapped. The questions that the terms of reference ask of us are also stated clearly in this perspective (See Annexure 1).

We therefore review the successes to understand and acknowledge what has been achieved and achieved well by any standards. We examine the shortfalls from this perspective not to apportion blame, but to see what did not work well and the conditions and approaches that did not facilitate the achievement of the target. Thus, we have undertaken a realistic evaluation of what worked and what did not, and, why.

# SECTION 1

## 1.1 Evaluation Team (henceforth the Team)

The **Evaluation Team** consisted of three persons who were also involved in the two earlier reviews of the Project. R. Srivatsan and Renu Khanna had conducted the Mid Term Review in 2016 while Padmini Swaminathan had reviewed the project at the end of year three. In different ways and in different capacities, all three have had some association with the Project: for instance, Padmini Swaminathan was a resource person at the Tribal Health Research Methodologies workshop conducted in March 2017; she chaired a session at the annual conference on Health Equity held in January 2018; she also peer reviewed some of the papers submitted for publication. R Srivatsan has participated in the intersectionality workshop in August 2015; Renu Khanna was involved in different capacity building components of the project, specifically the Methodology Workshops on "Cutting Edge Research in Health Inequities: Concepts & Methods", the NHSRC workshops with State Planning Units and State Health Resource Centres on 'Health Equity Report Cards and Analysing Programmes from a Health Equity Perspective'. The three evaluators also come from different backgrounds and disciplines. This earlier engagement as reviewers and the familiarity with some of the components of the project also informed the **Methodology** adopted for this evaluation.

The Team visited AMCHSS from September 26 to 29, 2018 (both days inclusive).

## 1.2 Methodology

The reviewers decided to focus **more** on the progress of the Project post the Mid Term and the third-year reviews. The extensive documentation of the Project in the form of periodic reports to the funders, Minutes of Meetings of the various committees that had been constituted as part of governance structure of the project, academic papers and reports of field-based studies, etc., formed the base from which the reviewers commenced their evaluation exercise (see Annexure 2 for the documents consulted for evaluation).

Four primary interviews were conducted by the Team during their visit to AMCHSS: (i) the Principal Investigator; (ii) Head of AMCHSS; (iii) one of the two doctoral students supported by the Project (the other doctoral student was away for field work and although attempts were made to speak to him over the phone, we could not establish contact with him); and (iv)

another doctoral student not supported by the Project grant but who participated in project activities.

Transcripts of 'Closing Interviews' conducted with ten persons associated with the Project in different capacities were made available to the Team. These interviews were aimed at eliciting views (of the persons interviewed) on various aspects of the project and how the interviewees felt the Project had influenced their work and their way of thinking about the theme of Equity. These interviews were facilitated by Surekha Garimella, a consultant appointed under the Project to assist in documenting the Final Report of the Project.

The Team also heard audio recordings of the Meeting of the Steering Committee held on 12th September 2018.

The Evaluators wished to interview the faculty member who was the recipient of the faculty grant under the Project, as well as another faculty member who had been a resource person for all the 'Cutting Edge' workshops. Unfortunately, both these faculty members were not available during the period when the Team visited AMCHSS.

1.3 **Terms of Reference (TOR)**: Box 1 provides details of the questions framed by the PI as part of the TOR which guided the evaluation.

**BOX 1**

***Expectations from the end-of-project evaluation***

The overall expectation is to have a candid assessment of what we have managed to achieve, and insights into what were our shortcomings and why they may have come about. This would help us in our future endeavours. A minor objective would be to critically assess our plans to continue the work started in this project through another platform – a network of those working on health equity as researchers, implementers and/or advocates/activists.

The specific questions that may be addressed in the end-of-project evaluation include:

- *Did the project achieve (or likely to have achieved) its objectives?*
- *If not, why not?*
- *What has worked well/not so well?*
- *How efficient and effective, inclusive and democratic have*

# SECTION 2

## 2.1 Did the project achieve its objectives?

A comprehensive document incorporating the Objectives, Activities, Governance Structures, Processes followed to fulfil Objectives, Achievements and Outcomes, has been put together by the Principal Investigator. The Document is very exhaustive, and provides detailed understanding of how:

(i) the project was conceptualised;

(ii) each of the different components were arrived at, to address the specific objectives of the project;

(iii) processes were put in place to govern the project;

(iv) the different components of the project were implemented; and

(v) the extent and form in which outcomes of the project have been actualised.

Based largely on the above document and supplemented with several other materials (listed in Annexure 2), our overall assessment of the Project is that it has not only fulfilled its mandate in terms of what it has set out to do but has in fact gone beyond its mandate and undertaken additional activities (such as capacity-building workshops) because of the wide interest generated by the theme and the usefulness of the whole exercise experienced by participants.

Equally impressive achievements of the Project are: (i) the collaborative nature of the initiative; (ii) bringing together a diverse range of personnel cutting across public/private institutions, civil society activists, academics from universities and research institutions, policy makers, etc; and (iii) the motivation of students and young researchers

The output from the project is phenomenal – it traverses a wide range and includes academic publications like books, special issue on Equity in journals, policy briefs, web-portal, etc. Besides, Workshops, Conferences, and such other activities have ensured the wide dissemination of the project findings, besides enriching at every stage the project itself through active participation of the invitees.

**Table 1** captures in as concrete form as possible the Expected/Mandated outcomes of the project as well as the Additional outcomes, bringing out in the process which outputs were mandated and which are additional. One activity - facilitating a faculty grant – could not be fulfilled, reasons for which have been documented in the comprehensive report of the PI.

## Table 1

### Objectives, Activities (Expected and Additional), Outcomes

| Serial number | Description of Objective and Activities | Achievement of Activities Planned/Expected/ Additional | Nature of Outcomes/Comments |
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| A | **Evolving a multidisciplinary research agenda** | | |
| 1. | Knowledge synthesis exercise | Expected | Resulted in a book published by Springer which was not originally expected or planned |
| 2. | Identification of research gaps | Expected | |
| 3. | Consultations/discussions to generate and agree on a health equity research | Expected | This exercise spread over three years and with intense |

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| | agenda | | participation from a wide range of scholars from diverse organizations and backgrounds, resulted in a Health Equity Research Agenda. More important, its output is 'owned' by all the participants and could provide guidance for further research and activism in this area.<br><br>A paper based on the above, authored by T K Sundari Ravindran and Tanya Seshadri, has been published as a pamphlet and as an article in an international journal |
| B | **Supporting and Promoting Research to expand the evidence base** | | |
| 1. | Three tribal health studies in four states<br>• Public Health Resource Network – PHRN in Jharkhand and Chhattisgarh<br>• The Action Northeast Trust - *the ant* in Assam<br>• Health Action for People - HAP in Kerala | Expected | Together these three studies provide valuable insights into conceptualising Tribal Health from an Equity perspective. Also provides Methodological innovations for researching themes of Equity/Inequity in Tribal Health |
| 2. | **Faculty Project Grant (AMCHSS)**<br>• Geospatial mapping of health inequity among tribal population - Kerala<br><br>• Possible drivers of mental health and wellbeing among tribal women in Palakkad district | Expected<br><br><br><br>Kept getting delayed and finally was not done | The output from the geospatial mapping exercise has not been able to move much beyond mapping to demonstrate how this exercise has enabled the scholar to capture processes of equity/inequity. |
| 3. | **PhD Research Grants**<br>• Under nutrition among tribal children - Kerala<br>• Inequities in the resolution of infertility: exploring pathways that infertile couples resort to - Kerala | Expected | This PhD research grant promises to contribute to the body of knowledge about nutritional status of the tribals in Wayanad. As mentioned above, we were not able to interview the scholar and get further details.<br><br>The discussion with the Ph.D. scholar engaged with |

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| | | | the theme of infertility revealed to us that the scholar was not able to articulate coherently what she considered 'unfair and avoidable' and therefore 'inequitous' in the torturous pathways resorted to, by infertile couples. |
| 4. | **MPH Field Study Grants**<br>• Physical and social environment and their effect on the health and well-being of lower limb amputees: An Exploratory study.<br>• Depression and its related factors among small and marginal farmers in Yavatmal district of Maharashtra.<br>• Menopause related symptoms and their correlates in Kollam district, Kerala.<br>• Tuberculosis Mortality and Risk factors for death in newly diagnosed TB patients with tuberculosis registered under RNTCP in Bilaspur district, Chhattisgarh.<br>• Health care seeking behavior for stroke in rural Gadchiroli, Maharashtra<br>• Individual and social-environmental level protective factors for institutionalized adolescents' mental health in Kerala.<br>• Access to health care among under five children in the Banjara community, Karnataka.<br>• Prevalence of potentially malignant oral disorders: a comparative study among interstate migrant labourers – Kerala. | Expected | These grants motivated students to undertake Health equity research and helped students to do their field studies in remote districts of 6 states |
| C | **Nurturing research capacity of young researchers** | | |
| 1. | Providing ongoing mentoring support to the grantees listed under B above by a multidisciplinary panel of experts in India | Expected | Three partners' workshops were held and provided opportunities for peer feedback, mutual and cross learning and to theorise together from an interdisciplinary |

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| | | | perspective. Also attended by students of AMCHSS |
| 2. | Abstract submission by early-career researchers for the National Conference 2018, detailed feedback and mentoring and funding support to attend the conference | Expected | |
| 3. | eSSH special supplement providing a forum for early-career researchers to showcase their research on health equity; | Additional | Some abstracts presented in the National Conference and others were developed into full fledged papers with mentoring support provided to complete the papers. All papers have since been published and available online. |
| 4. | Conducting training workshops on methodologies on health equity research.<br>*Cutting Edge Research in Health Inequities Research: Concepts and Methodologies* | Additional | Four such workshops were conducted reaching out to around 100 young and mid-career health researchers. The manner in which these workshops were planned and executed generated much interest and demand which in turn resulted in conduct of additional workshops being held. These workshops also established collaborations with three research and educational institutions. (IPH, APU, GWI) |
| 5. | Workshop on participatory action research in response to PhD students' demand | | Attended by 31 participants including 9 from other institutions |
| D | **Enhancing Institutional Capacity of AMCHSS** | | |
| 1. | Library enhanced through addition of books | Expected | This resource which has been created by the project, is, in our opinion an important achievement and contribution that can form the base for future and further work on the theme of Health Equity. |
| 2. | Data sets, qualitative data analysis software acquired | Expected | |
| 3. | Exposure to faculty and students through<br>- research partners' workshops,<br>- participation in the 4 Cutting Edge Research Methodology workshops, and the PAR workshop<br>- attending webinars,<br>- writing blogs for the health | Well beyond expectation in terms of number of such events, their advancing educational content and the response to them. | Although enhancing capacity of AMCHSS was expected, it seems to us that what was done went beyond much what was expected. The students – PhD and MPH – were majorly impacted because of the |

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| | inequities web portal,<br>- participation in two AMCCON national conferences | | exposure provided. |
| 4. | Visits by three international scholars<br>Simone Diniz from Brazil: *Feminist movement's contribution to respectful and rational maternity care*;<br>Helene Schneider from South Africa: *Methodologies in Health Policy and Systems Research*;<br>Viroj Tangcharoensathien from Thailand: Pathways to Universal Health Coverage | Planned but Outcomes of these visits went beyond what was expected. (See our comments in the next column) | A series of lectures which were recorded and uploaded on a YouTube channel. These scholars also did public lectures, and this contributed to enhancing the reputation of AMCHSS. Dr Viroj Tangcharoensathien from Thailand was a resource person in a dialogue between health officials from Kerala and Tamil Nadu on UHC, facilitated by AMCHSS as a part of this project. |
| 5. | Faculty ownership to create a Centre of Excellence in Health Inequities Research | Could not happen to the desired extent | This is an opportunity lost. But since a base has been created, could be taken up in future. |
| E | **Forging a Community of Health Equity Researchers** | | |
| 1. | Creating a dedicated web portal on health equity research | Planned | Reaches out to over 2000 subscribers. Repository of a lot of material / resources on Health Inequities |
| 2. | Conducting seminars | Planned | Seminars oriented participants to concepts in health equity and made health equity research an agenda |
| 3. | Disseminating through a range of forums the outputs of knowledge synthesis and knowledge creation including publishing in multiple formats | | Tribal health studies were disseminated in the four states where they were conducted and succeeded in making the achievement of health equity an important issue to be addressed amongst state governments, donors, academic and research institutions. Newspapers and media carried regular pieces on status of health equity.<br><br>Health Policy and Systems Research Supplement with three articles – one on structural drivers of health inequities; another on |

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| | | | socially constructed vulnerabilities and health inequities; the third piece is the research agenda |
| 4. | Conducting training methodology workshops on health equity research (This has been detailed in Section C above under: Nurturing Research Capacity for Young Researchers) | Additional | |
| 5. | Involving end-users of knowledge such as policy makers and program managers and health advocates in all stages of the initiative | Planned | This was planned but went much beyond what was expected. The Steering Group played a very important role in taking the ideas of this project to different constituencies. The NHSRC collaboration resulted in 26 states in India taking on health equity report cards, programme analysis from an equity perspective in the context of SDGs agenda of 'Leave No One Behind'.<br><br>Each of the tribal health studies led to state level acceptance of the findings - preparation of a Baiga development plan in Chhattisgarh – now integrated in the state's PIP and funded |
| 6. | Creation on YouTube channel and original videos with lectures | Additional | This is a very valuable resource that has been created out of this project. |

## 2.2 Academic Assessment of Achievement

We have already alluded to the fact that the outputs from the Project have been diverse and quantitatively very impressive. It needs to be stated here that the Project was one of its kind, wherein it attempted to flesh out what underlay the social and economic inequalities in India experienced by sections of the population but specifically focused on capturing health inequalities.

Reading through some of the outputs of the Project (academic writings and observations from Closing Interviews, for example), it is clear that the comprehension of the concept of 'inequity' which is something more than ***unequal*** and includes aspects that are 'unfair and avoidable', has taken root among the researchers and activists, even if not all outputs

explicitly bring out the nuances stemming from the application of this concept in their respective activities.

**2.2.1: Becoming aware, conceptually**:

To quote from a couple of Closing Interviews:

> *…equity and inequities were foreign concepts to me… I really didn't know how to go about it, how I should approach certain things, which are related to inequities or equities as such… after the workshop I really went back to my research questions and now some of my objectives were really derived out of my learnings from the equity workshop. In that way, I am really happy that now its more fuller kind of research I may be doing* (Closing Interview with Sreenidhi)

> *I really liked the case study part of it (the workshop). I really liked the whole activity part as well. I think that's where we applied also. In that sense, I think it covers a lot of things which possibly we wanted: like it covered concepts, then it covered the application part, then we eventually ended using it ourselves, so there was a whole (sic); we were all doing our own work and then we were also critically appraising it. In some sense all levels of learning were being covered* (Closing Interview with Dr. Saurabh Rai)

Two quotes (below) illustrate the application of learnings from the capacity building workshops carried out under the project, which is documented in the Third Annual Report submitted to IDRC in 2017. The third quote of a Steering Group member is a reflection from his interaction with participants of the project.

Excerpts from the Third Annual Report submitted by the PI to the IDRC in 2017:

1. One of the resource persons who visited one of the states a month after this [the NHSRC Consultation with state planning managers and SHRC representatives in 2017] wrote to me (the PI) with much excitement:

   *"xxxxx said that after the Health Inequity Report Cards workshop he started seeing everything differently. His colleagues were doing a study on JSSK (Janani Sishu Swasthya Karyakram) for the department and he tweaked a lot of angles in it based on his insights after the workshop. They have done a mixed methods study. And have decided to give the department the report that they want. But have a lot of other interesting data. Findings match the NSSO data Rs. 3000 OOPE - actually more when you add all the opportunity costs, although the programme (JSSK) is said to provide all services free of cost for the user".*

2. One participant developed a teaching module on health equity for the MPH Programme in which she teaches:

   *"Thank you so much to you, all other resource persons ….for giving such a wonderful learning experience. I am hereby sending the Health Inequities syllabus prepared for our MPH programme. Please upload it to the Health Equity website and I would like*

*to have comments from all members."* (University teacher, participant in the July 2017 workshop).

3. Reflection by a Steering Group member who has had fairly continuous and extensive engagement with the Project:
*"I don't know if we've achieved bringing out a completely new perspective. What I think we have done and that's specifically looking at the four workshops and the feedback of the students that went through the workshops, I think all of them almost (about 80-90% of those who went through the workshop) have talked about... coming out with 'eyes wide open', you know, gaining a completely new perspective that they never imagined they could have before they entered the workshops. A lot of interest in qualitative methods, which they didn't think were… strong, suddenly… the whole intersectionality perspective for the first time… So I think from among the four workshops, students have come out if not with clear skills, but at least with the awareness that they have different perspectives… Now whether that is going to be translated into actual research is, I think too early for us to say"* (Closing Interview with Dr. Rakhal Gaitonde)

**2.2.2: Long way to go towards application and analysis of data from Equity/Inequity angle:**

The fact that this project required an approach that was multi-disciplinary, inter-sectoral, and used the lens of intersectionality, etc is mentioned at several places. It would be useful to back up these observations with concrete examples from research output/findings, how the use of these approaches enabled the project to bring out the aspects of equity/inequity, hitherto not possible in the absence of these approaches.

The project has critiqued literature on health inequities that focus on 'health disadvantage', 'poor health of the poor'... where disadvantage becomes akin to personal attribute... Is it the contention of the Project that focusing on the theme of Equity ipso facto implies addressing ***causes*** and therefore could help in ***prevention*** **or** ***reduction*** **in inequities**? If so, this needs to be stated, explicated and highlighted.

One of the outcomes of the Project is the publication of a set of articles in a special issue on Health Equity of the journal, eSocial Sciences[1]. The articles cover a range of topics, each in their own way attempting to capture how equitous/iniquitous is our society in terms of health outcomes, health care service delivery, etc. A cursory reading of a few of the articles makes it eminently clear that research and researchers in our country have a long way to go in being able to concretely demonstrate, why, for example, despite the existence of several pro-poor, pro-women, pro-children social welfare policies there is rising social and economic inequalities – is it in the conceptualization/design and/or rules governing implementation of these policies that unfairness gets built-in and entrenched? Implicit in most of the articles is the notion of unfairness but its explicit articulation is missing. To that extent, it seems to us that there is still some gap, both, in the application of the concepts of the equity/inequity as

[1] See at: http://www.esocialsciences.org/eSSH_Journal/CurrentIssue.aspx Accessed on 1st October 2018.

well as in the ability to draw out and analyse field data that has been able to capture iniquitous scenarios.

While the set of research on the Tribal population will come out with its own publications, in the overall Report it is extremely important to reflect much more and analytically on what have been the specific learnings on equity from this research. For example, what is it about Conflict that makes health access/healthcare services iniquitous? And which iniquitous situation is different from a non-conflict situation?

Of the three tribal health studies the one that has been the most successful in isolating the concept of inequity from other factors and has focused on the experience of inequity consistently is *the ant* In Depth Study of Health Equity in a Conflict Area (Assam) 2017. This study has been able to demonstrate successfully the intersectional effects of community, tribe and religion in the context of prolonged and intense conflict. It has also been able to trace the manner in which, through the history of the conflict, the health systems have collapsed, leading to a general inequity of the region with respect to national health parameters. The study has also described extremely well the coping strategies and informal systems of health care that have arisen in the context. The success of the project is in the evident adoption of the perspective and the interest shown in the methodology in other conflict zones in other states and countries.

The Public Health Resource Network Report on Health Inequity among PVTGS (Chhattisgarh and Jharkhand) 2017 has grasped the concept of inequity in the introductory sections. However, as the report progressed, it has moved to the health system perspective and has used very few direct experience accounts. The effect of its approach is that the equity perspective that is new to this project has been merged somewhat with the poverty alleviation and tribal health perspectives that already exist in governmental programmes. The PHRN study, though, set out to generate data (thus far non-existent) on the health status and utilisation of health services by PVTGs. It is perhaps one of the first studies to generate this data. It also showed very effectively the inequities even among the already classified vulnerable groups, the Schedule Tribes by comparing the Baigas and the Sabars, two distinct PVTGs. This study points to an important issue – the non-existence of data sets on which to base the 'Leave no one Behind' strategies

Health Action by the People Report on Health Equity Study (Kerala) 2017 has not been able to achieve much of a perspectival shift to the concept of equity. It has remained more or less an account of the programmes that exist already and thus hasn't been successful in developing and benefiting from the equity perspective. However as mentioned elsewhere, once the study team realised that they were not really finding anything new through their quantitative and qualitative studies, they went further to document case studies of particular tribal groups and were able to visibilise the nuances of health inequities from a tribal perspective, in the context of a state like Kerala with its excellent health indicators.

Notwithstanding the variations in the manner in which scholars of the three tribal health studies have comprehended and applied it on the ground, it is our contention that all three studies have collectively and synergistically added to the body of knowledge on Tribal Health Inequities in India.

## 2.3: What has worked well/not so well? Could the objectives have been achieved in another way?

### 2.3.1: What contributed to the success of the project?

#### 2.3.1.1: Leadership

A major factor contributing to the success of the project, in our opinion, is the quality of **leadership** provided by the PI. Many different stakeholders – Tribal Health Research Studies partners, Steering Group members, AMCHSS authorities, to name a few - have highlighted this aspect. Equally, what also comes through very clearly among the many key actors involved in this project through all its stages and its different dimensions, is the commitment to the idea of equity and the passion to work towards its achievement.

Several of those currently associated with the Project in its different components brought out how the Project created space for them to work independently and/or in collaboration with others such that their concerns relating to the theme of Equity/Inequity could be concretely addressed in ways and modes in which they felt comfortable. The evolving design and manner of implementation of the project accommodated the visions and agendas of scholars/activists from diverse backgrounds which, in turn, enabled the coalescence of different approaches to the theme of equity, thereby creating synergy, apart from being inclusive. This helped to increase ownership of the agenda of the project and is one reason why much more was achieved than originally expected.

The leadership was also able to spot opportunities and pursue them through mobilising resources in terms of technical expertise of various kinds, funds, as well as through tapping the tremendous good will and social capital that she commands. While meticulous attention to detail and transmitting this to the teams went a long way in achieving high quality outputs, the constant attempt to broad-base the community of researchers enabled more and different kinds of scholars and activists to be drawn into the Project as partners, individual scholars, etc. The PI's reflections on this are worth reproducing:

> *When we began this project, we did not already have partners. We had wanted such partnerships to grow organically, based on shared interests. We are happy that such organic partnerships have developed and thrived and promise to become more long-term. Thus, rather than be limited by our circle of known institutions to establish partnerships, we have been able to explore, follow a kind of snowball technique where each person or institutions we contacted brought in a few others and we were able to expand the circle. We think that this also prevents the formation of a rigid hierarchy of "the original group" versus others who joined later, allowing people and groups to enter and engage in specific activities of interest to them... We have used multiple entry points and modalities of working to reach out to various constituencies, and this has definitely been a good strategy to adopt. The result is a kind of intense coverage, which seems to have a cumulative positive effect over time* (Third Interim Report to IDRC, 2017).

#### 2.3.1.2: Funder Flexibility

A major factor that contributed to the smooth functioning and ability of the project to fund activities not necessarily planned for in the original proposal, and/or, modify plans mid-way as part of course correction, was the responsiveness, support and flexibility of the donor. The PI notes that IDRC was open to suggested changes and modifications to the original project plan or to any new opportunities that she wanted to pursue. IDRC allowed budgets to be reallocated as needed based on PI's request backed with rationale for the suggested change.

**2.3.1.3: Overall project structure**

The overall governance and implementation structure created for the project enabled the constitution of several Teams to handle and implement various components of the project:

(i) Research teams: for (a) Mapping and Synthesising of existing research on health inequities, (b) Tribal Health Inequities Studies, (c) Faculty grants;
(ii) Administrative support team to negotiate the institutional processes in AMCHSS and SCTIMST;
(iii) dissemination team that worked on the web portal, webinars, media dissemination, and a plan for publications.
(iv) The Steering Group to steer and govern the project.

Each of these teams in different ways made the project a success. While the research teams find adequate coverage in this report, special mention must be made of the administrative and dissemination teams. The efficiency of the administrative team in developing strategies, toolkits and contacts to ensure smooth bureaucratic permissions and disbursements has become a model to follow. The remarkable achievements of the dissemination team especially with respect to the internet resources need to be lauded. The profile and imprint of the project would not have been the same without the dynamic functioning of the dissemination team.

By all accounts the Steering Group has played a critical role in guiding this project. The constitution of the Steering Group was strategic. It had stakeholders from the government – senior and key government officers from Kerala, ICMR and Tamil Nadu, from academia and research as well as from NGOs working on issues of health equity. After the Mid Term Review, the Steering Group was revamped to bring in persons from media, Ministry of Health and Family Welfare and the Tribal Research Institute.

The Steering Group members were actively engaged through the course of the project and going by the deliberations of the Group meetings it is quite clear that they 'owned' the project. They provided valuable ongoing support to the PI in many ways:

a. acting as a sounding board;
b. helping in finding ways to resolve issues such as when the PI realised that in the exercise related to 'prioritising research agenda' she not only needed more time but also advice on how to make the exercise manageable;
c. addressing delays of various kinds;
d. deliberated on the Mid-Term review recommendations and accordingly advised the PI on what was feasible to implement within the project period;
e. helped design the AMCHSS National Conference 2018 and suggested possible plenary speakers.

Additionally, several of the SG members offered to take the project agenda into their own institutions or their networks and contacts. The active and intense involvement empowered the government SG members to open a dialogue with their respective governments towards possible policy and programme changes to make health equity an integral part of health agenda.

**2.3.2: What did not work so well? And could the Objectives have been achieved in another way?**

It is the contention of, the Head of AMCHSS, Dr. Raman Kutty, as well as the PI, Dr. Sundari Ravindran, that 'creating institutional capacity' has not happened to the extent expected because of lack of desired ownership of project by faculty members, despite several of them having assented to being part of the Research Team for the Project. The project has thus remained the baby of the PI over the four years with no team or core group being created within AMCHSS to take the agenda of health inequity research forward, or to work towards creation of a Centre of Excellence that was proposed in the Mid Term Review.

It was hoped that at least the faculty grants would result in such a core group being set up. But this has not happened. As mentioned earlier, one faculty research grant did not take off at all. The other one neither kept to the time schedule nor to the standards of rigour in analysis that is expected of academic scholars. To quote the PI's reflections on this issue as stated in the Third Interim Report submitted to IDRC in 2017:

> *Unfortunately, Dr. Ravi Prasad Varma and Dr. Jissa VT did not start their study. They had originally proposed to undertake a quantitative study, but reviewers suggested that the topic chosen was better approached through a qualitative study. The researchers did not feel able to undertake a qualitative study because their areas of specialisation are epidemiology and biostatistics, respectively. We did suggest to them the possibility of submitting an alternative proposal, but by then, more than one year had elapsed since the grant was made, and the time set aside by them for undertaking the study had gone by. They expressed their inability to undertake the study.*
>
> *This has been an opportunity lost to develop expertise of younger faculty members in health equity research. On reflection, one now wonders if a better way to go may have been to offer post-doctoral fellowships of 2 years each and mentor two to four young researchers directly under the project.*

The reasons for the failure to strengthen faculty capacity in the area of health equity appear to lie in the realm of the institutional culture of SCIMST and which largely impacts the way AMCHSS functions. SCIMST is a biomedical research centre in which laboratory research and publications in peer reviewed journals are valued the most. Individuals are rewarded and recognised for individual and not team achievements. Unfortunately, these yardsticks are used to assess faculty in AMCHSS too, instead of devising other methods of evaluation. Thus projects remain individuals' babies instead of full benefits being reaped by the institution as a whole. To be fair, this is not a specific failing of the AMCHSS but is part of the mainstream individualistic and competitive academic culture that has been fully internalized by the faculty.

One wonders whether another opportunity lost is the non-follow-up by AMCHSS and therefore the failure to capitalize on the visits by international scholars. Will these remain limited to one off visits that benefited the students only? With the failure of a core team developing within AMCHSS (for which this project had provided tremendous opportunity), the possibility of collaborative research developing within AMCHSS in future seems highly unlikely going by this experience.

However, one ray of hope (pointed out to us by Dr. Raman Kutty in our interview with him on September 27, 2018) is the appointment as Professor in AMCHSS of a key actor in the project, Dr. Rakhal Gaitonde, who coedited the Springer publication and subsequently was invited to become a Steering Group member. His close involvement with many aspects of 'Closing the Gap' Project, and given his own interest in the theme of the project, could become a positive factor in the continuity of what is left behind once the project ends in November 2018.

### 2.4: How efficient and effective, inclusive and democratic have been the processes adopted by the project?

The manner in which the PI has conducted the project has been exemplary in the key attitudinal aspects that contribute to success: democratic functioning, inclusiveness, effectiveness and efficiency.

The aspect of *democratic functioning* of the project and the PI in particular has been amply demonstrated in the manner in which inputs, criticisms and comments have been openly offered at Steering Group meetings and interview session recordings we listened to.

The project's success, given its objective of building a health equity network in India, depends on its functioning in an *inclusive manner*, welcoming new participants, interest groups and institutions. The participation in this project of resource persons, mentors, advisors and occasional consultants, the manner in which teaching, research and governmental institutions have come forward to participate in the collaborative labour of building a foundation for equity research are proof of the inclusiveness of the project design and execution. This open and inclusive strategy has been referred to as a "snowballing technique" in the PI's comments on page 13 (of which document?). This comment shows how deeply the PI has understood and applied the concept of inclusiveness in a conscious manner.

This participation and willing ownership of the project by these diverse players, collaborators, students, researchers, and stakeholders in general is a clear proof that the programme of generating an evidence base of equity and inequity was stated, shaped and implemented in an *effective manner*. The second step of stating problems of inequity effectively from the perspective of those who struggle in these circumstances has been partially achieved.

The Head of the AMCHSS, Dr Raman Kutty, during our interview with him for this report, directly complimented the project and the PI in particular for setting two benchmarks: a) steering the governance and finance of such a large project successfully through the maze of bureaucratic and accounting regulations, and thus providing a standard of how to work

successfully in such institutions; b) producing an exemplary output of the project in terms of publications, research programmes, governmental advocacy, educational workshops and networks with a fraction of the budget that would be found necessary by other project proposals. These are two clear acknowledgments by a peer regarding the *efficiency* with which the project has been conducted.

### 2.5: Have recommendations from any previous evaluations been implemented? If so, what effect have they had?

The Report of the Fourth Meeting of the Steering Group held on 30-31 January 2017 provides details of the review done by the Steering Group of the key findings and recommendations from the Mid-Term review of the Project (See Annexure 3 for details).

The Third Interim Report covering the period 1 October 2016-30 September 2017 submitted by the PI to IDRC on November 20, 2017, contains details of the manner in which the recommendations of the Mid-term as well as the third-year evaluation of the Project have been taken on board and implemented (See Annexure 4 for details). We have already alluded above to the fact that, post the Mid Term Review, the Steering Group was revamped to bring in persons from media, Ministry of Health and Family Welfare and the Tribal Research Institute.

The Third Interim Report also provides explanation for why implementation of a few of the recommendations was not feasible and/or why some had to be implemented in a modified form. For instance, while the recommendation to make the web portal functional was implemented with enormous investment in technical expertise, human resource, etc, the recommendation regarding bringing out studies in the form of Monographs was modified and a submission has been made to a special issue on Health equity in the journal e-Social Sciences, which has since been published.

The third-year evaluation of the project conducted in August 2017 emphasized the need to consolidate the many outputs from the project and to plan for sustaining the initiative on health equity research even after the formal closure of this time-bound project. While the outputs from the project do provide evidence of the different ways in which knowledge on health equity is being brought together and consolidated, our section on **Ways Forward** illustrates some ways in which this initiative can be sustained, academically and otherwise.

Overall, reading through the Steering Group Meeting Report (January 2017) and the Third Interim Report submitted to IDRC in November 2017, it is clear that all suggestions/ recommendations made by the Mid-Term Review and the Third Year review have been engaged with, details of what have been implemented in what form have been documented, while those recommendations that could not be implemented or were implemented in a modified form, have been stated thus with appropriate explanations.

### 2.6: What has been the impact of the project? What would facilitate the sustainability of its impact? Are we on the right track in the way we have planned for taking forward work initiated during this project?

#### 2.6.1: Impact of the Project

The impact of this project has been at many levels and is also layered.

The fact that key activities of the project have been institutionalised to some extent through collaborations, points to its impact at the most immediate level. In the Institute of Public Health in Bengaluru, NS Prashanth who was associated with the project in many ways, has been able to initiate a Health Equity Cluster through a Wellcome Trust Grant. Prashanth states that the Wellcome Trust Grant application was also an outcome of his association with the project (September 13 2018, Meeting of organisations and individuals coming together to form a Health Equity Network/Consortium and Closing Interview.) The Web Portal and the Webinars have been transferred to IPH and are being now managed from there.

The team at Azim Premji University – Prof Arima Mishra and Prof Shreelata Rao Seshadri– who were the collaborators for the three Cutting Edge Methodology Workshops have committed to making these workshops a part of their teaching calendar.

NHSRC has taken the lead in getting state governments and Union Territories to examine health programmes and schemes from a Health Equity perspective, to facilitate the generation of data that will capture vulnerable groups in the states. There is a strong possibility that this work will continue as long as the current Executive Director is in place, and as long as the PI of this project continues to be on the Governing Board of NHSRC.

At another level, the fact that NS Prashanth has been able to get Wellcome Trust support for a Health Equity Cluster in IPH means that Wellcome Trust has been influenced enough to own the agenda of Health Equity. Similarly, *the ant* through the dissemination of its research on Conflict and Health Systems has been able to interest UNICEF, European Union and Azim Premji Philanthropic Initiative. In fact *the ant* developed a proposal with other partners in the Region for a multicentric study on the lines supported by this project. Another research partner, PHRN through the state level dissemination of its study amongst Baigas and Sabars, was able to get the Chattisgarh Health Department to commit Rs. 50 lakhs in their annual budget for National Health Mission for Baiga Health Development.

In several of the quotes that we have reproduced earlier, many ‘Cutting Edge’ Research Methodology workshop participants have indicated what they would do differently as a result of having attended the workshop – development of a Health Equity syllabus for MPH, doing their PhD research differently, and so on.

The above are some of the more visible ripples created and also articulated because of association with the four year ‘Closing the Gap’ project, and to that extent, in our opinion, the project has made a positive impact. It is quite likely in a project of this complexity that there are some “impacts” that remain unreported and therefore invisible

2.6.2: **Conditions for Sustainability of Impact of the Project**

While the impact of the project has been in terms of its mission and objectives being carried forward through individuals and organizations who had been associated with the project in some capacity, an important condition for its sustainability is its institutionalization in the country’s health systems and services. An important but unexpected fallout of the project has been the entry of the NHSRC and its determination, as of now, to carry forward the initiative

of the project through the different states of the country. As Dr. Rakhal Gaitonde (Steering Group Member) has stated in his Closing Interview:

> *The point is that with NHSRC, it is a central body and at the same time it works purely through the state. So, actually, getting into contact with state officers who are involved with planning, monitoring and evaluation and... pledging them towards more disaggregative statistics is really solid and exciting work. I see this as one of the main ways of taking this forward in the government.*

**2.6.2.1: How Sustainable is the initiative within AMCHSS?**

As mentioned earlier, prospects of consolidation of this cutting-edge health equity work in India within AMCHSS appear to be bleak. Given the larger macro environment – both nationally with the pressures of Department of Science and Technology that supports SCTIMST, as well as within a super specialised and biomedical institution of national importance – garnering support for an issue like health equity research, which demands an interdisciplinary social science approach, may be challenging. The PI and the HOD both hope that the appointment of Dr. Rakhal Gaitonde as Professor and who is expected to join AMCHSS in January 2019, will enable this initiative to be carried forward in some form.

**2.6.2.2: Creation of Network to sustain the initiative (outside of AMCHSS)**

A ‘community of researchers, activists, policy makers have come together to form a loose network for Health Equity work in the country.
Rationale

The observations of Dr. Nakkeeran (associated with the Project as Mentor and who has also participated in some of the activities of the project) provide a rationale for why the aspect of networking is important for sustaining the initiative. To quote him in some detail:

> *One point I’ve been grappling in my mind is again from my own understanding of health.... to make an impact on health equity, there’s a need for the so-called “vulnerable groups” to be addressed. The health system people should work with those groups but unfortunately in India, both in academics and in the NGO sector, the work is done in a very compartmentalized manner. People working on health do not work on the caste system, people who work on the caste system do not work on health... the intersectional and interface work of, say the indigenous population and health, Dalit rights and health, does not really happen... for example if you have a health conference, you don’t see anyone from Dalit rights’ movement. So, with this kind of compartmentalization the idea of equity and inequity cannot be addressed, solely by people working in the health sector. So, if you want to make it sustainable, it has to be in the form of networking across these kinds of intersectional things.*
> (Closing interview with Dr. Nakkeeran)

**The Birth of HENI (Health Equity Network of India)**

In January 2018 after the AMCHSS National Conference, a closed-door meeting was convened with members of the Steering Group, the research partners and a few others to discuss concrete ideas for post project continuity of the ‘community of health equity

researchers.' There was much enthusiasm to continue to work together as a consortium of organisations and individuals. Several younger colleagues took various responsibilities and volunteered to do many essential tasks. A second meeting was convened on September 12, 2018. Around 20 persons were present and around five others who could not be present, committed to being part of whatever formation was decided upon. The day long discussion resulted in the birth of HENI – Health Equity Network of India, with 20 members and a Steering Committee of seven people.

The HENI Vision was articulated as:

> *An equitable society where the highest standard of health and wellbeing for all is a collective responsibility*.

And the Mission that was decided was:

> *To enable transformative research and mobilise knowledge(s) for action on health equity in India through a diverse and inclusive network of individuals and organisations.*

The members present decided that the agenda for the coming five years would be

- *production of **high quality research** (especially primary) that is new/different (4-6 projects), alongside resources that advance the state of the art/science (going beyond description).*
- *adding **value to campaigns and processes**, - becomes a global/regional/sub regional platform – the "go-to" initiative and is linked to organisations working in women's rights, child rights, social inclusion of Dalits/adivasis, LGBTQI rights*
- ***policy shifts towards equity**, partnerships with (3-4) state government departments and some traction at central level*
- *active **collaboration and dialogue** across states/institutions and ages, especially young membership, wide geographic representation (esp from the N East), as well as issue*
- ***workshop or course module** developed and becomes part of academic curriculum in strong institutions*
- *we **expand** as a community of practice – esp attracting young researchers, activists, practitioners*

The Health Equity Cluster of IPH Bengaluru agreed to host the first secretariat. Prashanth NS will be anchoring the Secretariat. Devaki Nambiar was invited to co-anchor, and her decision is awaited. As an immediate measure, the Secretariat would host the web portal and continue the webinars and the newsletters. The frequency of newsletters would be quarterly. Other activities that were committed to for the next six to eight months, were as follows:

1. Faculty from APU will work towards locating the methodology workshops in APU's School for Continuing Education and run it on an annual basis. Other members associated with the workshop in the past will also be involved.
2. A full-fledged course module on health equity (101), would be made available to be run either as a free-standing course or as a module within MPH or other relevant programs. This would be completed by April 2019.

3. A proposal for an edited volume on methodologies for health equity research, drawing on the case-studies taught in the methodology workshops, already on the table would be taken forward. A concept note will be sent to at least one publisher by March 2019.
4. The work with state governments in equity-sensitive health programming and equity-monitoring in collaboration with NHSRC would be taken forward by actively pursuing the possibility of starting this in Chhattisgarh with NHM support.

## 3: Way Forward (Evaluators' Reflections)

There are two parts to our overall reflections on how the Project could be taken forward. One, the impressive nature of the outputs of the Project themselves provide pointers to how they can be further worked upon to increase their ***reach*** through dissemination, and, ***depth*** through further intensive research in the area. The second part of our reflection calls for more in-depth engagement with the conceptual and theoretical underpinnings of the theme, particularly given the fact that the issues of equity/inequity are dynamic, and therefore need to theorized and researched in ways that do not reduce them, say, to static attributes of the marginalised.

### 3.1: Themes for further analysis of Research and Action organically emerging from the Project:

a) How can the rich material generated by the project translate into teaching modules? This question became all the more stark on reading the transcripts where several of those interviewed recalled how their way of doing research, thinking about the relationship between equity and health, etc, had completely changed after attending some of the workshops. A way forward for the project would be to strive towards making Equity an integral part of several of our Courses not just in Humanities, Social Sciences, Law, but in Medical curriculum as well.
b) The research studies implemented under the Project have brought out the iniquitous conditions of life and living among the marginalised sections of our society, demonstrating in the process how inequalities among sections of population within a region and/or across regions have increased. In future it would be useful also to capture scenarios where health inequity has reduced? If so, what were the processes/policies/pathways that enabled this?
c) Providing a comparative perspective to studies on health equity by including researchers and research from similarly placed economies/societies, for example, would enable broad-basing of the theme, and, the facilitation of collaboration among different institutions and scholars, globally.
d) It is a fact that in India, non-access to resources, power and non-provision of basic services to all, is central to emergence and persistence of inequity; hence the focus of most of our research on the marginalised sections of population. Given this overwhelming focus of much of our research, are we losing out on studying inequity in health that may exist/persist among particular sections of our population who may not be resource poor? In future, it may be useful to explore (rather than assume) how equitous/iniquitous are health outcomes among not-so resource poor populations.
e) An important exercise of the project was listing of priorities for intervention research. But if this list is not anchored in our understanding of health equity, intervention may not only become routine but may not specifically address the

theme of equity. Hence the express need to be alert to the fact that some interventions could lead to contexts where interventions intended to correct iniquitous situations could end up creating new forms of inequity and among certain sections of the population or geographical areas.

### 3.2: Conceptual and Theoretical Challenges: Possible Research Agenda for the Future

f) In conceptualizing health inequity going forward from the project, it is important to see it as an open concept. That is, firstly, until such time that this Health Equity Initiative began, the concept of equity for the Indian context was not developed adequately, i.e., the specific point of view and strategy of the equity perspective was not fully developed. However, the moment it emerges as a researchable problem around which the project crystallized, it becomes something that is possible to examine empirically, somewhat spontaneously and with developing theoretical insight, in many locations. As research progresses, equity or lack of it will need to be thought about more sharply in order to determine what inequity is in health care. As the concept of health equity develops, new conditions will come to characterize it and it's opposite (health inequity). It is crucially important to keep alive and foster this development of the concept of equity so that it doesn't become a dead letter. Key to growth and sustainability will be an evolving and sharpening sense of what inequity means.

g) The post-project equity research programme will have to draw on the education of public health students into the frameworks of equity thinking that has been developed in the modules that are being refined. How successful this will be (beyond the HENI work programme) in terms of acceptance and importance will depend on how other public health educational institutions will accept this focus as an important part of their curriculum. It is indeed heartening that APU has taken in aspects of his initiative as part of their agenda.

h) As important as the education and research agenda is the support, acceptance and continued focus on this concept of equity research with those who have collaborated or partnered with the project. Heartening news is that the NSHRC has found the workshops conducted during the project useful and find the equity questions useful for tweaking the government programme. Also encouraging is the fact that one of the participants of the project has developed new leads in this endeavour and has found support in the Wellcome Trust. A third possible path has taken shape in *the ant's* building on its work on conflict and inequity to develop link with studies in other conflict related zones. The positive aspect of these growths is that they have occurred outside the project funding mode and represent strong autonomous organic interest in the equity perspective. This alone is a tremendous indication that the way forward will be driven by such decentralized initiatives which demonstrate and further establish the project's relevance.

i) Advocacy efforts which draw on the above principles are important. In order to ensure that emerging advocacy efforts will be able to think independently about the equity perspective it would be crucial to develop a tool-kit which will help these groups and efforts focus on the right questions. This tool-kit, which will be a set of probes and methods to ask questions and make proposals, will have to be updated perhaps once in two years considering the evolving concept of equity.

j) The academic/activist/advocacy interest group which anchors this growth will have to foster research programmes that help groups of committed and experienced researchers to work on methods, studies and papers that drive the equity agenda ahead through sharper and sharper formulations of the equity problematic. It is this research which will provide an academic/intellectual anchor to the other aspects of the project – i.e., curricular training and advocacy – by providing fresh inputs. How well this crucial component will develop will depend on how successfully, creatively and dynamically HENI is able to play its role in the future.

k) All of the above will lead to the *Health Equity Research Agenda for India* being treated as a live roadmap that will be updated and used to guide research in the project's after-life.

## Annexure 1: Terms of Reference of Evaluation

The evaluation will be carried out by a team of three members, all of whom have engaged with the evaluation of this project while it unfolded. Team members may decide on division of work between them and are expected to produce one consolidated evaluation report that is to be shared with IDRC.

The specific questions that may be addressed in the end-of-project evaluation include (*inter alia*)

- *Did the project achieve (or likely to have achieved) its objectives?*
- *If not, why not?*
- *What has worked well/not so well?*
- *How efficient and effective, inclusive and democratic have been the processes adopted by the project?*
- *Have recommendations from any previous evaluations been implemented? If so, what effect have they had?*
- *Could the objectives have been achieved in another way?*
- *Has the external context and changes therein during the project period affected the project's outcomes?*
- *What has been the impact of the project thus far, what is it likely to be? What would facilitate the sustainability of its impact?*
- *Are we on the right track in the way we have planned for taking forward work initiated during this project?*

## Annexure 2: List of documents referred

***Reports:***

- Closing the Gap: Health Equity Research Initiative-India (Draft Final Report)
- Second Interim Report: 1st October 2015 to 30th September 2016
- Third Interim Report: 1st October 2016 to 30th September 2017
- Closing the Gap Research Partners Workshop Report March 2017
- Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam Report of a study by the action northeast trust (the ant) 2017
- Exploring Health Inequity by Assessing the Nature of Healthcare Utilization and its Correlates among the Tribal Population of Kerala HAP Report 2017
- Exploring Health Inequities amongst Particularly Vulnerable Tribal Groups: Case Studies of Baiga and Sabar in Chhattisgarh and Jharkhand States of India PHRN Report 2017
- Papers published in the Journal, eSocial Sciences

*Other reports/minutes:*

- Minutes of the Steering Group meetings from 2015-2017 (1st to 4th)
- Mid Term Review Report (October 2016)
- Third Year Review Report Dated (October 2017)

***Miscellaneous Documents:***

- A Health Equity Research Agenda for India: Results of a Priority-Setting Exercise
- TK Sundari Ravindran and Tanya Seshadri, "A health equity research agenda for India: results of a consultative exercise".
- Sundari Ravindran's reflections on the Health Equity Project's successes and gaps (ppt)
- Sundari Ravindran's plan for the Health Equity Network of India (ppt)

***Transcripts of interviews about project by Surekha Garimella with following participants:***

- Sree Nithi
- Rakhal Gaithonde
- Prashanth
- Nakkeeran
- Malu Mohan
- Him Kumar Ghimre
- Saurabh Rai
- Vandana Prasad
- Sundari Ravindran
- Sulakshana Nandi

***Recordings of proceedings listened to:***

- Audio recording of the Steering Group Meeting on the 12th September 2018

## Annexure 3: Recommendations of the Fourth Steering Group Meeting Held on 30-31 January 2017 at JNU

The following is the excerpt of the recommendations for action to be taken in the last phase of the initiative in the Report of the Fourth Steering Group meeting:

• The tentative dates for the Conference *[on Health Equity Research]* would be 8-11 January 2018, starting on the evening of 8th and ending by about 3:30 pm on 11th.

• The Conference could combine the AMC-Students' conference.

• The overarching theme for the Conference would be Research for "Closing the Gap".

• Student may be asked to submit abstracts on a broad range of themes related to inequities in health. Non-theme papers could perhaps be considered for one parallel session, if there is a dearth of papers on the theme.

• One plenary could be about the Politics of Health – this would include issues such as neoliberal globalization and health inequities; religious fundamentalism and discrimination; conflict and health etc.

• There could be one plenary with policy makers to share their experiences with policy interventions to address social and economic inequalities.

• One session/ talk could explore the theme of Technology Assessment from a health equity perspective.

• Gender should run through all sessions rather than be relegated to one specific session.

• The inaugural session would show-case Kerala. One suggestion was to have a video-film with testimonies from health care providers about the challenges in working with marginalised communities, especially front-line workers, so that we hear from a constituency that is usually unheard. The main format would be a panel, and the speakers would talk about relatively less-explored health inequities in Kerala, such as health issues of migrant workers; urban poor; coastal communities; elderly; people living with physical and mental disabilities.

• There were suggestions to allow space for forms others than oral presentation: Forum Theatre; Film; Photo Voices; Short Films etc.

• The following are suggestions for plenary speakers: Nancy Kreiger; Rene Lowenson; Abhay Bang; P. Sainath; Sundararaman; Gita Sen; Ravi Duggal; Amar Jesani; Jashodhara Dasgupta; Harsh Mandar; Jean Dreze; Aruna Roy; Satish Deshpande; Bezawada Wilson; Bhargavi Davar; someone from a mental health advocacy organization in Kolkata; Sheetal Amte-Karajgi from Maharogi Sewa Samiti.

## Annexure 4: Some review recommendation implementation in the Third interim report: 1 October 2016 – 30 September 2017

The report as a whole is about 28 pages long, and deals with the general progress of the initiative as a whole. What follow are excerpts of references to attempts to follow the recommendations of the evaluations that have been conducted.

With respect to taking Scheduled Caste and Scheduled Tribe Candidates, the following was recorded:

> 'We did not have any SC or ST applicants for the field-study grant and were therefore unable to give priority to applicants from these ethnic/ caste groups. In fact, the numbers of SC and ST candidates joining the MPH programme in our Institute is very small, at best one in a year. This is probably a reflection that few students from marginalised backgrounds make it to institutions of higher learning, especially when a large tuition fee is involved.'

With respect to general recommendations regarding the website and online activities, the following was recorded

> 'Based on feedback from the mid-term review, a number of improvements were made to the web portal. These are as follows:
> - A Face Book page has been created for the Health Equity website and interface created between the web portal and the FB page.
> - A Social Media strategy has been developed and implemented (Annex 10 contains the Social Media strategy).
> - One hundred and seventy eight (178) new resources were added to the website during the third year, organized along the following monthly themes, with a focus on health

inequities: Tribal Health; Environmental Health; Conflict and health; Discrimination and stigma in health; Inequities related to sexual orientation and gender identity; Stigma, Discrimination and inequities related to sexual and reproductive health; Urban health inequities; elderly; mental health; migration and health; health of minority (based on religion and nationality) populations.

- Resources included journal articles; salient databases and government and international organization reports; YouTube videos and power points.
- Nineteen new blogs written by early career researchers have been featured on the website during October 2016- September 2017.
- An expanded Mapping Exercise was carried out for expanding the stake-holder base for evolving a health equity research agenda for India, and this fed into expanding the web portal's database on researchers and research institutions in India to include a wider range of actors.
- Four webinars have been held during January - September 2017.'

Regarding the third year evaluation, the report has the following significant comments to offer:

> 'Professor Padmini Swaminathan, well known feminist economist and scholar and former director of Madras Institute for Development Studies, Chennai, was identified, in consultation with Steering Group members, as the evaluator for the third year of this project. Professor Swaminathan reviewed key documents from the project, visited our institute and interviewed the PI and some of the team members and had Skype conversations with a sample of persons associated with the project. Her review report focuses on how we may spend the fourth year to effectively consolidate the many outputs from the project and to plan for sustaining the initiative on health equity research even after this particular project and funding for it comes to an end… She has engaged with the issue of what new knowledge will be generated by the project that will inform future research on health inequities in India, and challenged us to tie together our work on evidence synthesis and the research on tribal health. She has also offered us many ideas, which we hope to take forward.'

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