Society for Community Health, Awareness, Research and Action (SOCHARA)

A RESEARCH ENCOUNTER

The Research Experience, Agenda and Paradigm of SOCHARA

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Karthikeyan

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REPORT OF ANNUAL TEAM RETREAT

Contents

INTRODUCTION

Research is recognized as an important tool to combat the inequality that exists in health. Incorporating research into social movement and community health work and transforming this finding to bring social change is very critical in this process. To further this process SOCHARA builds a multi-disciplinary team of researchers to achieve the universal goal of "Health for All". In order to facilitate collective action for this goal the researchers and activist from various clusters are brought together to discuss and learn from each other.

Retreating from the day today work the whole team members of SOCHARA came together to reflect upon what SOCHARA has been doing in the past many years and think of a future direction for individuals in their journey in Community Health and the SOCHARA team as well. This year the theme selected for the annual retreat was on "RESEARCH". Hence, two days was specifically devoted to the reflection of SOCHARA'S encounter with research as research in one of core components of SOCHARA. The two days programme specifically aims at identifying the research interest of each individual, learn from SOCHARA's research encounter, and understand the research projects that is currently going on.

PARTICIPANTS

Twenty SOCHARA team members from Bangalore, Chennai, and Bhopal participated in the workshop. The participants includes:

Mr. Mohamed	Mr. Prasanna
Dr. Ravi	Mr. Naresh

Mr. Santosh	Mr. Juned
Mr. Razi	Mr. Dhirendra
Mr. Bhagwan	Dr. Rakhal
Dr. Adithya Pradyumna	Mr. Prahlad
Mr. Chander	Mr. Karthik
Mr. Kumar	Dr. Yuvraj
Mrs. Shani	Mr. Sabu
Mr. Suresh	Mr. Ameer

Session 1

The session started with the reflective introduction of team members in their Community Health Journey. Dr. Ravi started the session with poem by Rudyard Kipling:

"Six noble gentle men taught me all what I know

WHO and WHAT and WHEN

WHERE and WHY and HOW"

Then team members were asked to reflect upon them self and share about themselves on the basis of these six questions such as: Who are you? What is your background? When did you join SOCHARA? Where did you join? Why did you join? How are you interested in research? Followed by, twenty team members started their sharing. The sharing highlighted the team member's diverse social and the political and educational background, and each member differencing approach and experience of research. However, the experience shared by the team members demonstrated how the research can be spearheaded for the policy formulation, implementation, and most importantly for the advancement of community health.

Session 2

In the afternoon session Dr. Ravi gave an broad over view of SOCHARA's history of study, reflection and action. Dr. Ravi stated the session with the sharing of his experience of "Bharatdarshan" undertaken by him and Dr. Thelma Narayan, by which they integrated the experience of community health work undertaken from many parts of India. These decade long journey gave them the deeper insight and gave strong conceptual foundation to SOCHARA in its inception. In the subsequent session, Dr. Ravi discussed how SOCHARA's research encounters helped in understanding the underlying determinants of health and how SOCHARA's research contributed to the civil society. Followed by Mr. Sabu and Mr. Karthik presented four of the major studies conducted by SOCHARA. Each study was presented on background, significance and methodology, and Dr. Ravi and Mr. Mohamed explained the study result and how the result was translated into social action.

The researches presented were:

1. THE BHOPAL DISASTER AFTERMATH: An epidemiological and socio-medical survey.
2. STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY ORIENTATION: *Building on Indian Medical College Experience.*
3. CHANGE IN MEDICAL CURRICULA THROUGH FEEDBACK FROM GRADUATES WITH EXPERIENCE IN PERIPHERAL HEALTH INSTITUTION
4. Evaluative feedback from members concerning the Catholic Hospital Association of India (CHAI).
5. CONTEXTUAL AND POLICY LEVEL ISSUES IMPORTANT FOR THE FURUTE HEALTH RELATED WORK OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA
6. A Study on the Policy Process and Implementation of the National Tuberculosis Control Program in India.
7. A STUDY ON DISPARITIES IN HEALTH AND HEALTH CARE SERVICES.
8. Understanding Global Public Private initiative: Case study of Global Alliance to eliminate Lymphatic Filariasis.
9. External Evaluative Study of the Mithalin Programme in Chhattisgarh

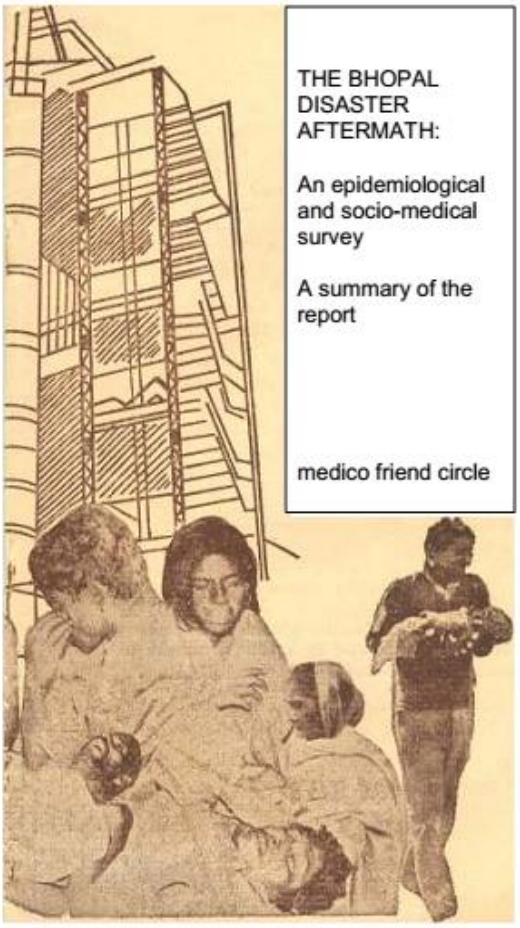
The detailed summary of these studies are given in the subsequent pages.

THE BHOPAL DISASTER AFTERMATH: An epidemiological and socio-medical survey.

Ravi Narayan, Thelma Narayan

INTRODUCTION

The disaster that took place in Bhopal on 23 December, 1984 was the worst man made environmental accident recorded in the history. 1754 people were reported to be dead, over two lacks of people were mentally or physically disabled by a mixture of toxic gases including Methyl Isocyanate. Though the relief efforts were started immediately, the effort was handicapped by the lack of authentic information on the nature of the gas released. Neither the Union Carbide nor the Center which sent an expert technical team to Bhopal to study the disaster released the nature of the toxic gas released into the atmosphere. This lack of proper information prevented the better rehabilitation work and increased the suffering of the victims. The expert committee was bound by official secrecy act and hence, they were prevented from revealing any information. Under these circumstance, the local NGOs and the citizen's forum invited Medico Friends Circle to conduct and epidemiological investigation to provide accurate information to facilitate a better relief work. Hence, mfc members visited Bhopal in the mid February. The first field visit of mfc group revealed the conspiracy of official secrecy regarding all information on the disaster, and the resultant lacuna in the rehabilitation. Furthermore, the NGO were not encouraged to take up any relief program. Hence, mfc had decided to conduct an epidemiological assessment of the current health status and health problems of the people, examine the findings in the light of two



controversial theories, evolve a critique of the medical research and relief programme and to make recommendations for a more meaningful relief and rehabilitation policy.

METHODOLOGY

The Study Population: The study was a community based, case/control study. Two slums were selected for the study: (i) J P Nagar situated in the close vicinity of the Union Carbide factory and the worst affected by the gas leak. (ii) Anna Nagar 1 0 km away with the least exposure, which served as the control. Rapport was established with the people by explaining to them our objectives and making it very explicit that we were not there to offer any financial compensation, medical treatment etc. The slum dwellers were given a hand out in Hindi explaining the role of mfc and a commitment was made that the salient findings of our study and our recommendations would be made available to them.

Sample Selection: The families for study were selected by random sampling. Only subjects above 10 years of age were selected. Those less than ten years were excluded in view of their probable inability to report symptoms correctly. All details were entered in a pre-designed proforma. In addition, lung function tests were done by standard procedures using a portable spirometer by a doctor fully familiar with measuring these under field conditions.

FINDINGS

The victims described a broad range of symptoms arising from most of the different systems in the body. JP Nagar residents had a much higher (statistically highly significant) incidence of these symptoms compared to Anna Nagar. The commonest symptom was breathlessness on accustomed exertion. The mean values of lung function tests were statistically significantly lower in JP Nagar as compared to Anna Nagar particularly in the age group 15-44 and 45-60 in both sexes. The pattern was primarily restrictive. An' important finding of grave significance is that 65% of the working persons in JP Nagar experienced a drop in income ranging from 20% to 100% as opposed to only 9% in Anna Nagar. This reflects the way in which the physical/ mental disability of the people caused by the disaster has affected their working and earning capacities. A point of utmost significance is that the victims of the Bhopal gas disaster mostly belong to the lowest strata of society and are not in a position to fight for their rights, be it medical aid or monetary compensation. It is, therefore, not very surprising that the government and its organisations have shown marginal interest in the after effects. It also

reveals a lack of interest among our scientific community in investigating an environmental disaster of an unprecedented nature. On the other hand, one can observe the striking contrast with which all attempts were made to retrieve the Black Box of Kanishka, whose mid-air explosion resulted in the death of only 326 persons but needless to remind of the upper socio-economic class.

RECOMMENDATIONS

Research recommendation: The research and follow up studies should shift focus form hospital/dispensary based studies of seriously ill patients to family/ community based ambulatory patients. In addition, well designed clinical trials should be further initiated using sodium thiosulphate as a therapeutic and epidemiological tool to further establish the significant role it could play in the mass therapy.

Care, Surveillance and Rehabilitation: Firstly, Psychosocial assessment and consequent counseling and rehabilitation are urgently required. Secondly, mass treatment with sodium thiosulphate based on ICMR guidelines should be initiated maintaining good medical records. Thirdly, a surveillance programme should be undertaken to assess risks to pregnant mothers, unborn babies and new born babies. In addition to this, a long tern surveillance of lung function in view of the postulated damage to lungs and resultant lung fibrosis should be provided. Finaly, a comprehensive listing of all gas disaster victims should be prepared for mass treatment, compensation and rehabilitation.

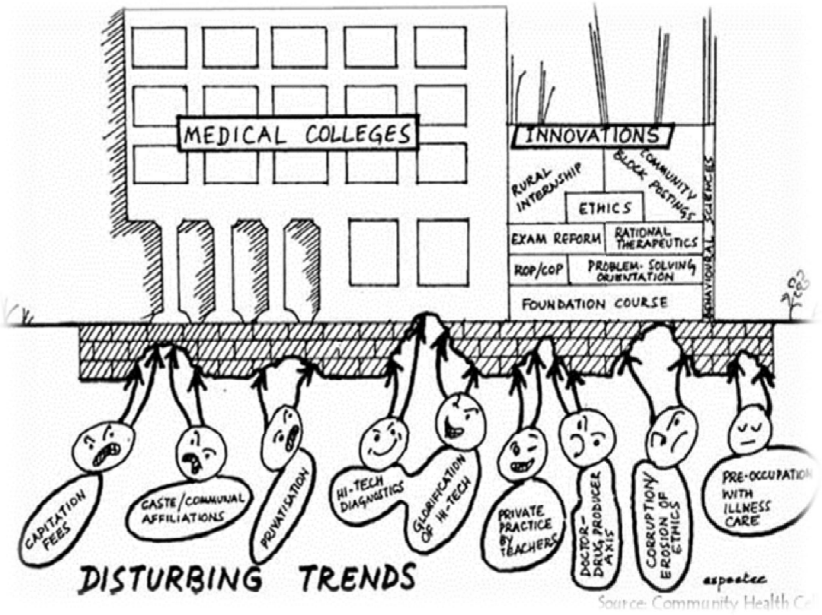
Communication: Firstly, there is an urgent need to evolve a continuing education strategy for all health personnel including doctors working in both government and non-government centers. These could be through newsletters, handouts and informal group meetings. Secondly, there is an urgent need for dynamic creative non-formal health education of the affected community through group meeting posters and pamphlets with information and messages built around their life style, culture and existing socio-economic situation. Thirdly, the government machinery alone cannot handle such a a massive task. The government must adopt a policy of enlisting the help of all non-governmental agencies and groups wishing to work in Bhopal.

Finally, it is imperative that the victims as well as the entire country must be provided with all the details of how the accident occurred, of the nature of the chemicals released and of the reason why the detoxification by sodium thiosulphate has been so badly mismanaged.

STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY ORIENTATION:

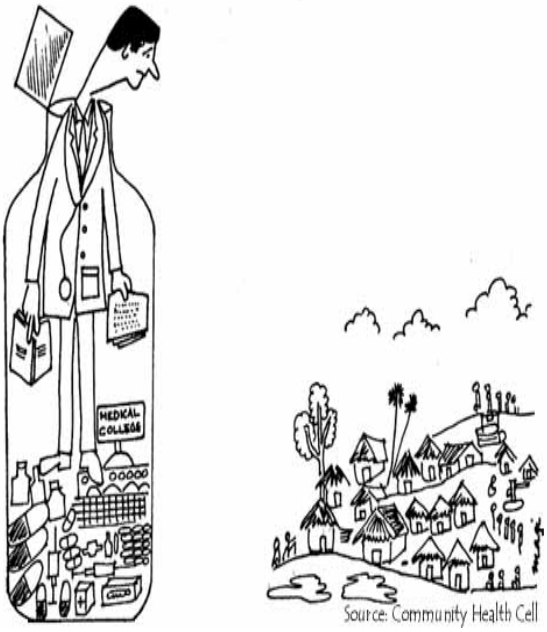
Building on Indian Medical College Experience.

R. Narayan, T. Narayan and S. Tekur



INTRODUCTIONThe social and community orientation of medical education in India has been subject to rigorous academic discussion and all the government expert committee such as The Bhore Committee (1946), Mudaliar Report (1961), and Srivastava Report (1975) which were constituted to suggest reforms and new direction in medical education reiterated the need for social and community orientation of medical education in India. Evolving a medical curriculum tailored to meet the health challenges of the community was very critical to improve the health status of the community. However, the growth of privatization, and the resultant mushrooming of medical education institution, growth of capitation fee, the nexus between the doctors and drug producers, and the rampant corruption have eroded the medical ethos and community orientation. Though there were isolated effort made by few medical colleges to make medical education more community oriented they were of limited impact due to the lack of interaction between these colleges, due to inadequate publication on the strength and weakness of these innovative efforts, due to lack of objective evaluation and peer group assessment of these innovative ideas. Hence, it was very critical to analyze the effort made by

few Medial Educational Institutions to communitize the medical education. Thus the objective of the study was to: To document descriptively/ analytically- key recommendations/ experiments/ innovation/ experience in medical education.



- To review key alternative training experiments to identify issues, perspectives, ideas, pedagogy relevant to medical education.
- To build an anthology of Ideas from a sample of recent medical graduates with primary / peripheral health care experience.

METHODS

The Study adopted a multipronged data collection method which included both classical and interactive approach. These were as follows:

CLASSICAL/ ESTABLISHED	INTERACTIVE
Literature Review	Peer Group correspondence and meeting
Letters to Colleges (with remainders)	Field visits to colleges and group discussions with faculty interns
Letters to Trainers (with remainders)	Correspondence with medical college respondents and Community Health Trainers
Questionnaire Survey (Graduate)	

25 colleges responded to the survey and seven others were identified through the literature survey, a sample of 32 out of 125 colleges in India (23.6%).

KEY FINDINGS

Stratrategies for reorientation: Fifty strategies were identified and they were broadly classified under following themes:

- Educational Technology
- Widening horizons
- Improving skills developments
- Moving outside the teaching hospital
- Transcending compartmentalization
- Promoting self-directed learning

The factors that promoted change are:

- Institutional Mandate
- Institutional objectives
- Instructional Objectives
- Medical educational group
- Staff development Process
- Field Practice area
- Institutional Policy supporting community Health
- Cultural Transformation and Value Orientation
- Networking and Dialogue

- Reflective Evaluation

Obstacle/ Barriers to Change are:

- Confusion between excellence and relevance
- Continuous shift between tertiary and primary care
- Lack of vision and orientation
- Isolated response to reform
- Effect of Market economy on value orientation
- Too much planning and too little follow up
- Allergy of students and teachers to community exposure
- Unsuccessful transplantation of foreign ideas
- Staff withdrawal due to cynicism or fatigue
- Lack of openness to change in top leadership

CONCLUSION

The study has brought together through various methods an overview of the Indian medical college experience to help medical educators to evolve a process of change with locally evolved initiatives in mind.

CHANGE IN MEDICAL CURRICULA THROUGH FEEDBACK FROM GRADUATES WITH EXPERIENCE IN PERIPHERAL HEALTH INSTITUTION

T. Narayan and R. Narayan

INTRODUCTION

Evolving a community oriented medical education curriculum has been a stated intention of many expert committee, professional bodies and some medical colleges. Though the study undertaken by CHC, Bangalore explored the isolated experience of Indian medical college to make the medical education socially relevant, it was also critical to evolve a medical curriculum through feedback from medical graduates with experience in peripheral health institution.

OBJECTIVES

- To elicit feedback on all the major aspects of the undergraduate medical course.
- To identify in the undergraduate medical curriculum

I. Areas those were useful, relevant and adequate

II. Areas that needed further strengthening, areas of lacunae

III. Areas that could be reduced or deleted

METHOD

- As an instrument of the study a questionnaire was developed. The different aspect of the medical education on which it elicited feedback were:

I. All the preclinical, Para clinical and clinical subjects, including medical ethics

II. Additional skills in patient care and hospital work like nursing, management's communication and training.

III. Internship.

- A total of thirty seven different aspects were covered through open ended questions. Questionnaire was pilot tested on 10 respondents. Modification was made based on this as well as on comments by the advisory Committee.

SAMPLE

- Out of 120 selected participant 53 (44.16%) participant responded.
- The criteria for the respondents were:
- The medical professionals who had graduated from any India medical college during the decade of the 1980s.
- They had completed a minimum of two years working experience as a doctor in any peripheral health institution in India.
- The sample was not statistically chosen to represent any particular region or college.
- The eligible respondents were identified from applicants to postgraduate medical entrance exams where rural service was given special recognition.
- Anonymity of the individual respondent as well as the medical col was maintained.
- The questionnaire was given/sent to 120 eligible respondents. Of these 78 were given out by the researchers and the remaining through contact people but the later was not successful.

FINDINGS

The first part of the finding deals with the profile of the work experience of the respondent. The part b of the finding details the feedback according to each subjects of the curriculum.

PROFILE OF THE RESPONDENTS WORK EXPERIENCE IN PHIs IN INDIA

- The majority of the respondents graduated in the year 1980s hence the feed-back was related to the current practice in education

- The average duration of the work experience was 2 years and 10 months.
- The respondents have worked in a total of 80 PHIs located in 10 states of India and 1 Union Territory.
- Several graduates had worked in more than one PHIs. The majority of the PHIs were located in rural area. Most of the experience of the respondents had been at the level of providing secondary level medical care. However, they had often been involved sometimes in the same institution in primary care. However, they had often been involved sometimes in the same institution in primary care as well.

SUMMARY OF THE FEEDBACK ON DIFFERENT ASPECT OF THE UNDERGRADUATE MEDICAL COURSE

Skills development

There was a strongly expressed need for greater development of skills and competences, particularly in basic nursing procedures, emergency medicine, minor surgical procedures, obstetrical care, local anesthesia, running simple laboratory and pharmacy, assessing community health needs and evolving simple strategies to meet them; training health workers; management, communication

Curriculum Change

Introduce integrated teaching with special focus on clinical application, and on common problems

- Reduce unnecessary theoretical details
- Reduce pre-clinical phase from 1.5 year to 1 year
- Introduce/strengthen the teaching of psychology and sociology and experience in basic nursing procedure during the six months thus gained in the first eighteen months.

Source: Community Health Cell

- Emphasize the four primary clinical disciplines, especially obstetrics
- Change the concept that "short posting" is relatively unimportant.
- During the final year or internship there should be postings to the pathology laboratory, blood bank pharmacy, medical records department and accounts sections.

Community Health Suggestion

- Integrate preventive and curative aspects in all phases
- Emphasize community health teaching with practical training in health education, nutrition, school health, epidemiology, statistics, and occupational health.
- Ensure involvement in ongoing community heath programs during studentship/internship
- Increase teaching programed that are community based, including exposure to PHIs
- Internship should include postings to PHIs.

Examination System

- The examination system need to focus on assessing basic necessary knowledge and skill, the logical approach to diagnosis and rational treatment.
- There was also a need to change methods of assessment to process of continuous assessment, increased use of MCQs.
- Several short cases with discussion.

The other key suggestions

- Career guidance to enhance students' option for work in PHIs.
- Sharing of experience by PHI doctors with students during the undergraduate medical course
- Internship as the most useful learning phase, needed to be strengthened.
- Introductory lectures on alternative systems of medicine, holistic health and traditional health practices.

- Development of healthy attitude, lifestyles, values and ethics during the undergraduate course.

Evaluative feedback from members concerning the Catholic Hospital Association of India (CHAI).

Thelma Narayan, Johney Jacob, Tomy Philip, Xavier Antony

INTRODUCTION

Catholic Hospital Associaltion of Indian (CHAI) was estabilished as a Society in 1944 by a group of sisters involved with medial work in different parts of India. Upholding an ethical values in medial care CHAI strived to fostering the professional education of nurses, doctors, pharmacists, laboratory technicians and auxiliary nurse midwives. In addition to it, CHAI also tried to address the issues relating to the betterment of medical care and to the professional management of hospital. Over the years many important events and changes have taken place in the roles and the objectives of CHAI as there have been changes in thinking regarding the concepts of causation of disease and types and levels of intervention that would improve the health of people, both as individual and as community. The health and medical scenario of India also changed during these years due to the tremendous growth in the government and private sectors and changes in disease patterns among the population. Under this context, the role of CHAI in the subsequent years had to be located in the broader context reflecting analytically on the past and the present functioning to equip better with the subsequent years. Hence, the present study aims:

- To reflect on the function of Catholic Hospital Association of India during the last fifty years, with special focus on last twenty five years.
- To understand the possible role CHAI could play to meet the needs of its members, the national voluntary health sectors, and the health apostolate of the Church.

With the specific objectives of eliciting information and feedback from CHAI members on:

1. Their involvement and nature of interaction with CHAI.
2. Their expectation from CHAI in relation to their own activities

3. Their views regarding the appropriateness and adequacy of CHAI's activities

4. Their views regarding factors contributing to the gap between expected and observed actions.

5. Their suggestion regarding alternate measures to be adopted to fill in the gap.

METHODOLOGY

Preparation project proposals and modification.

Sampling

i. **20% random sample was selected using stratified random sampling.**

ii. **The member institutions were divided into two categories based on the size.**

iii. **Region was stratified into two based on the major health indicators as IMR and CDR.**

Distribution of membership by region and size of institution:

	0 – 6 Beds		More Beds
Better Health indicators	1,018		537
Poor Health Indicators	572		143
Total	1590		680

Distribution of the sample by region and size of institution

	0 – 6 Beds		More Beds
Better Health indicators	204		108
Poor Health Indicators	114		29
Total	318		137

Data Collection

- Interview schedule.

The interview schedule was pilot tested and made necessary change. It contained two part:

Part A - Sent to every individual institution

Part B – Collected feedback about the various aspect of CHAI from selected samples only.

Investigators

- 40 people from Catholic religious community were selected Mysore and Delhi.
- They were given 5 days orientation on the CHAI, the purpose and the objectives of the study and conducting in-depth interview.
- Feed back data was collected during the 1991 December and May-June 1992.
- Supervisory field visit was conducted by the team members during the interviews
- Mailed Questionnaire.
- Part A of the questionnaire was sent to the remaining 80% of the institutions (1815) to collect information regarding the medical health related work of all CHAI constitutional members.
- Data Analysis
- The data was coded and entered into computer for further analysis.
- D- base 111+ was used for the analysis of the data

RESULT

Feedback on various aspects of CHAI has been gathered from members those on the Executive Board, representatives of regional units, as well as from the staff of CHAI. All members had the opportunity to share their views regarding the strengths and weakness of CHAI, their expectation from CHAI and their suggestion regarding future thrust. 20% member institution members which were selected for a detailed study gave feedback on objectives, organizational structure and each of the various programmes and actives of CHAI. The level of involvement of members with CHAI during the past five years was also studied.

Fifteen major Strength and Weaknesses, Expectation, and Future Thrusts were identified: The important ones among them were: Support, concern and service for its members, Health action and other publications, Training programmes, seminar, and courses, Meetings and

correspondence with members etc as strengths. Poor interactions between CHAI and its members, poor personal contact and communications, and sense of alienation felt by members, Inadequate focus on rural based members and their activities, CHAI does not fulfill the needs of its members and does not look into their problems etc as weakness. Better interaction between CHAI and members through visits more personalized correspondence, financial assistance, guidance and support to member institutions, especially smaller ones, training programs at states level, preferably using regional languages etc were as major expectations. Focus on rural and tribal areas and their development, community health and development, Health for all by 2000 AD, health awareness and education were major future thrust area.

CONTEXTUAL AND POLICY LEVEL ISSUES IMPORTANT FOR THE FURUTE HEALTH RELATED WORK OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

INTRODUCTION

The policy Delphi research was done to identify broad contextual and policy issues that CHAI needed to consider in its plan for the future action. And to explore the possible role that CHAI could play in the future in the context of the national situation and the national health policy. The Socioeconomic, political and health scenario of India was discussed as it these issues had major bearing on the formulation of the future direction of CHAI.

METHODS

- A list of 108 possible panelists who has expertise in diverse background was prepared by the CHAI study team.
- A letter of invitation was sent to the selected panelists with a tentative time frame of the study. 49 panelists from diverse back ground agreed to participate as panelists in the method.
- Firstly, a document with history, aims and objectives, organizational structure, thrust area was sent to the members. Alone with it first round of questionnaire was sent it elicit the response on economic, political and social trends which may occur in the next fifteen years that would have impact on the health status of people in India. In addition to it,

panelists opinion on what issues that CHAI should focus on priority base for the next fifteen years also has taken.

- From the ideas that emerged from the first part of the discussion and the immediate issues that CHAI was suggested to focus upon a second round of questionnaire was sent to the panelist that covered seven broad areas.
- The basic premise of health work that CHAI need to consider in its future work
- The important health problems that CHAI should respond
- The type of health action that CHAI should promote
- Identify the group/constituencies that CHAI should focus its activities.
- Organizational aspects or mechanisms that could be introduced or strengthened to enable effective functioning.
- Strategies of work or interventions needed to implement its objectives and priorities.
- Need for role identification.

The common theme that emerged from the first discussion and the difference also sent to the panelist to generate further discussion. The final analysis of first and second round of discussion was made available to all the member of CHAI for the future direction and decision making

FINDING

Economic Trends

Majority of the panelist felt that the growing privatization, liberalization and the repayment of foreign loan would reduce the government spending on development and welfare sector like health, education and housing. Though minority of the group will be benefitted by this economic policy, majority of the people comprising farmers, unorganized labors and landless labors will not be benefitted. The children, women and the illiterate will be at he receiving ends. Due to increased commercialization and privatization of medical and health care services the cost of diagnostic and curative medical services will raise at a galloping rate, consequently the poor people will have less access to such service

Social Trends

With the breakdown of the traditional family structure the overall status of women will increase, however the condition of the aged and the marginalized people will deteriorate with increasing urbanization and inadequate basic facilities. There will be an erosion of values in social life, the sense of community feeling will be replaced by narrow sense of individualism. Mass medias would cause a major shift in the value system and mental health will become a major concern due to increased lack of identity, materialism, false values and lack of spiritual strength. However, there will be increased education, increased litigation in health field and strengthening of consumer protection council. Science and technology will improve the life of the average persons.

Political Trends

The study projected that the new unipolar world would decrease the autonomy of states. The political parties would make use of divers' forces for their own wasted interest and self seeking politicians dominate the political scene. The gap between the haves and the have not would increase and the inequitable distribution of resources will continue. There would be greater awakening among the marginalized especially dalits, tribals and backward classes. There wold be increased political consciousness and student's movement with an increased demand for people centered participatory process.

Health Scenario in India

The study projected that the health problems in India would show a complex epidemiology in the subsequent years. While the country continued with the problems of poverty, poor hygiene, poor nutrition and poor environment, the country would increasingly experience the problems of development, affluence and modernization. The new disease would come up along with the resurfacing of older disease problems with newer trends and patterns. The countries ability to deal with these challenges would be severely hampered by the broader socio-economic, political, cultural factors emerging on the national and international scene that will determine the countries development, welfare and health policies.

A Study on the Policy Process and Implementation of the National Tuberculosis Control Program in India.

Thelma Narayan

INTRODUCTION

Tuberculosis was one of the major public health problem in post Independent India. Hence, interventions were introduced in 1948. BCG vaccination within a vertical programme was the main strategy with a focus on urban areas and children, among whom TB was then considered to be the major problem. In addition to it, indigenous research was initiated and supported by the government through the establishment of new institutional bodies, in order to understand the problem better. With limited finances, it was felt that prevention was the best approach. Over the years, research findings challenged then current assumptions and gave shape to the National TB Programme (NTP) in 1962. By this time, effective chemotherapy was available at low cost. Better drug regimens were developed by the 1970s. The functional unit of the NTP was the District TB Programme (DTP). BCG, early case detection, domiciliary chemotherapy , integrated with general health services, supported by District and State TB Centres were conceptualised as the key strategic components. However, the world's largest controlled BCG trial in Chinglepet, India, found that the vaccine did not prevent adult pulmonary TB and that it played no role in controlling disease transmission. Infrastructure for the NTP at state and district levels began to be established and team training of DTP teams was undertaken. Major problems in implementation became recognised and were reported by the government and other research institutions and bodies from the early 1970s. However, these findings and evaluation reports resulted in little change in action and performance. Poor implementation has resulted in more than half a million deaths annually. Thus, from 1947, about 25 million people have died of a disease that has been curable at low cost from the 1960s. Many more millions suffer needlessly. The poor, at greatest risk, are most affected, having less access to effective care. A proportion get functionally disabled due to advanced disease and a substantial proportion also become indebted due to the disease. Although a number of analyses and authoritative evaluations identified weaknesses in the TB programme from the 1960s, and made recommendations, implementation problems continued to exist. This study hypothesised that these problems and gaps cannot be explained only by technical or managerial deficits, but that societal and political issues, played an important role. Hence the study aimed at exploring and analyzing:

- What explanatory factors underlie the perceived implementation gap of the National Tuberculosis Programme in India?
- Can these be analysed in terms of policy content, contextual factors, policy process and actors?
- What are the implications for policy from this analysis that can strengthen the NTP?

METHOD

An empirical, historical/longitudinal, in-depth case study of NTP was undertaken, using a mix between a bottom up and top down framework to study policy process and implementation. In the first phase, the policy was reviewed focusing on its implementation in the National, state, district, and local level. In the second phase Interviews were conducted with TB patients, elected representatives front line health workers, doctors, district and state staff, national programme managers, researchers and representatives, from international agencies.

Multiple Source of Data.

a) Semi-structured/in-depth interview

b) Review of internal documents, records, published reports, media reports.

c) Observation of implementing agencies at local, district and state level.

Multi level sample

- Samples were drawn from following administrative and political units:
- Local/village,Taluk or sub-district, District, State, National, International.

The validation of the study was done through triangulations of data from multi source of information and multi methods of data collection. A research assistant with experience of survey research from local area was trained to conduct semi-structured in-depth interview. The check list of questionnaire was double translated into Kannada. The patients were interview at their home and half of the interviews were tape recorded. Regular debriefing session with the research assistant were held.

FINDING

This study set out to explain the factors underlying the acknowledged gap between the goals of the National Tuberculosis Programme (NTP) in India and its actual implementation. A specific contribution of the study is that it incorporated a participatory, bottom-up approach, with views from TB patients, particularly the poort, from elected people's representatives and front-line staff. It has thus adopted an integrative approach looking at the interaction between all levels of the policy process, including international influence on policy, national and state level policy, as well as what actually happens at district and taluk level and how patients are affected. It thus differs from much policy analyses that tend to remain at national or macro level and are implicitly top-down. Because this study explicitly adopted a value base of social justice and equity, and the poor are disproportionately at risk of TB, a sample of impoverished patients was consciously selected and the focus was on the public sector which is mandated to deliver free services. It was necessary to use this analytic approach with the biological and epidemiological aspects of the disease as backdrop. The study therefore started with a review of these aspects, and then explored how these were translated into TB policy and practice. An implementation gap identified in quantitative terms is reported in this thesis at National, state and district levels. Epidemiological, public health and operational parameters all point to a gap, although unrealistic expectations due to the use of prevalence rates of the 1950s, may accentuate its dimensions. Additionally, considerable suffering due to TB, observed among impoverished patients, adds a tragic qualitative dimension to the gap. Deficits were observed, to a smaller extent, even in the best scenario situation, where an GO used community based TB interventions with assured drug supplies and finances, in a compact talk for over three years, suggesting that the problem is complex. The gains made by the government's TB programme in India since 1947, and particularly the NT., are recognised and reported in the study. These include research studies evolving the concept and content of the NT, infrastructural growth, institutional development, and aspects of the pharmaceutical policy.

CONCLUSION

In conclusion, by taking a policy analysis approach this study demonstrates that several factors, other than technical issues, affect the success of implementation. It highlights conflicts and dilemmas at different levels. The interests of patients, of medical professionals (public and private), of allied health professionals and workers, of the pharmaceutical and diagnostic

industries and of the state in TB control are interdependent. Though apparently working towards a common goal, they represent inherently strong conflicting interests, needing mediation and resolution, so that the wellbeing of the majority of patients is safeguarded.

A STUDY ON DISPARITIES IN HEALTH AND HEALTH CARE SERVICES

A S Mohammed

Introduction

Karnataka State with 27 Administrative districts has an estimated population of 540.27 lacks as per the estimates of 2001. During the past century and particularly after independence in 1947, several gains have been made in health and health care in Karnataka. Life expectancy at birth has increased from 37.15 to 61.7years and from 36.15 to 65.4 years for males and females respectively, between 1951 and 2001.The Infant Mortality Rate (IMR) declined from as high as 148/1000 live births in 1951 to 69 in 1981,and further to 57 in 2000(SRS 2000). In this sensitive key indicator, the goal of 60 fixed in the 1983 National Health Policy has been reached. The crude Birth Rate has fallen from 40.8/1000 populations in 1951 to 22.0 in 2000 and the total fertility rate from 6.0 children in 1951 to 2.13 in 1998-99.SmallPox has been eradicated. The State has become free of plague and more recently of guinea worm infection. The incidence of polio cases has been reduced to zero by December 2000 and until now, for more than two years, the nil status has been maintained. The progress in brining down Crude Death Rate by more than two thirds from 25.1 in 1951 to 7.8 in 2000 is noteworthy. Public Health care programmes richly deserve much of the credit for this. However, the state of Karnataka ranks 131 on Human development index scale at Global level and has 33.16% of the population below poverty level. It has been observed that there exist disparities in health and health care facilities in between:

Region: North and South Karnataka.

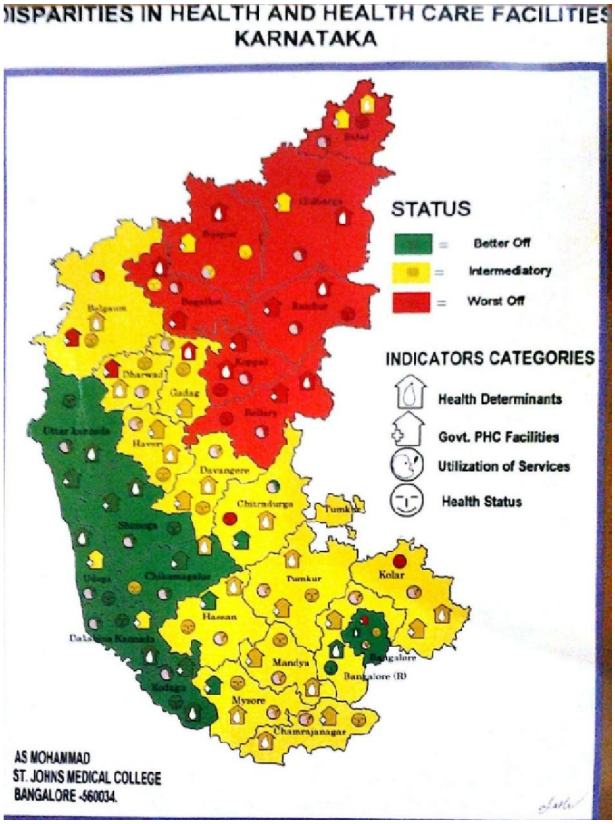
Districts: 27 Districts

Disadvantaged: Lower class and Caste

Vulnerable groups: Age and sex

In order to address the disparities in Health and Health care services it is very critical to understand the disparities that exist between the regions, districts, class, age and sex. Hence, the study aimed to understand:

- To Determine the disparities in Health determinants
- To determine the disparities in Health status
- To determine the disparities in Health Care resources allocation.
- To determine the disparities in Health Care utilization
- To determine the most disadvantaged districts in Karnataka to evolve and initiate more focused projects in these districts



Methodology

The study was conducted based on the secondary data. And the data was checked for its quality and quantity and regional disparities were assedssed on the basis of available data on indicators in the following essential categories:

- Health Determinants
- Heath Status
- Health Resource Allocation
- Health Care Utilization Indicators

- Over all Indicators.

Each indicator in the above mentioned categories was standardized and algebraically added for each district. The total was re-standardized and a composite index as Standardized Z score was obtained for each district, which gives the relative position of the district on the scale in Karnataka State.

UNDERSTANDING GLOBAL PUBLIC PRIVATE INITIATIVES - CASE STDUY OF GLOBAL ALLIANCE TO ELIMINATE LYMPHATIC FILARIASIS

A CHC/ WEMOS COLLABORATIVE STUDY

Dr. Thelma Narayan and Mr. Naveen

With increasing health inequalities, and poverty and a decreasing health budget globally – Rapid rise in Global Public Private Initiatives (GPPI) (idea of CSR/ ↑ financial & material resources +political support) Wemos promoted case studies in LI / MI countries for understanding GPPI at field level and its effects on local health systems .

Global Alliance to Eliminate Lymphatic Filariasis (GAELF) formed in 1997 to eliminate LF by 2020

GAELF approach is to improve the access to health products (MDA programme).

WHO + Glaxo smith Kline + Merck &co + local governments etc.

In India increased burden of LF and GAELF implemented through NFEP.

Objectives

To study the influence of GAELF on NFEP- India and its implementation in Karnataka with reference to fulfillment of, 'Right to Health and Health Care, particularly the poor

Specific objectives

- Study content/organizational structure/ financing/ operating mechanism.
- GAELF's linkage with general health services and PHC
- Implementation- focus on access, equity and sustainability.
- Study all above with a framework of Right to Health and Health Care.
- Identify conflicts of interest/ how those mediated (if any)

Methodology

- Qualitative research study.
- Participated – 2 workshops (Synchronize concepts/methods/discussion on preliminary finding)

- Literature review - Health & Health care situation and to do a policy analysis of GAELF & NFEP(+ interview).
- Purposive sampling.
- Data collections tools: Observation, Individual In-depth Interviews and Focus group discussions.
- Observation of SC's, PHC's and CHC's.
- FGD's with providers, patients & Community.
- FGD's and Interviews – Taluk/ district/ state/ national programme units + officials at DOHS.
- Individual interviews – VCRC (Pondicherry), HSP of academic institutions/ NGO resource centers.
- Principles of research ethics were maintained
- Linkage maintained with RPHCC of JSA.

Key recommendations

- Need for discussion/debate/ dissemination of research findings with all stakeholders.
- Core values including CP, respect for local health traditions and systems of medicine and respect for Right to Health & Health care need to be identified and accepted as framework for GPPA.
- Local capacity building for strengthening PHS
- Need more research and advocacy on GPPI's and an openness to diverse local solutions (Alternative approaches)

Review of Jan Swasthya Rakshak Scheme Govt. of Madhya Pradesh July – September 1997

The 'Jan Swasthya Rakshak' scheme launched by the Government of Madhya Pradesh in 1995, is a significant effort aimed at bridging the wide gaps and disparities in health and human development in the state. It is especially significant because since the development of the concept of the disadvantaged BIMARU region in planning circles in India (comprising Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) there has been a growing concern, that these states need some radical and innovative strategies to make health care a reality for the large numbers of marginalised and socially disadvantaged sections of society, who are presently not reached by the existing services.

However, the idea of village based health workers and the involvement of the community in their selection, support and supervision is not new. There have been governmental and non-governmental initiatives in this area and to contextualise the JSR Review was undertaken.

Objective:

- To do review of JSRS of Madhya Pradesh

Terms of Reference / Specific objectives

- Document profile of JSR's (5 districts)
- Examine the process of selection by community
- Document content and methodology of training
- Document examination system for certification
- (Administrative and management aspects + attitude/ perception by community, panchayat & health dept. officials)
- No JSR received certification. (performance of JSR in the field was not feasible)

Methodology

- Mixed method (Quantitative and Qualitative).
- Functional areas: Attitude/commitment of JSR + extent of deviation of scheme in its implementation
- Levels of Admin set-up: Organized health services setup, JSR and Consumers/their representatives.
- Purposive sampling / multi-stage random sampling (mostly driven by purpose/scope/ time)
- Data collection techniques/ tools: Surveys, secondary sources(records), Indepth Individual interviews and focus group discussions
- Material: Questionnaire (structured/unstructured/ multiple choice items) and open ended unstructured interviews.
- Number of questions common to respondents for validation of data.

- Data was analysed manually and with help of computer (statistical software)

Key recommendations

- Selection: Widely publicize the scheme/reduce minimum eligibility (women & tribal cand)
- Training: Emphasize preventive and promotive aspects.
- Exams: Give stimulated case studies for assessment
- Functions of JSR: Need to explain to villagers and JSR devote time for prevention / promotion.
- Administration: Need widescale publicity, distribute certificates on time and organize workshops with PRI representatives.

Review of Jan Swasthya Rakshak Scheme Govt. of Madhya Pradesh July – November 2001

Dr. Ravi Narayan, Dr. Dhruv Mankad, Dr. Shyam Ashtekar, Prof. Mohammad ,Dr. Abhay Shukla, Dr. Shashikant Ahankari, and Shri.Amulya Nidhi.

Background

Reaching primary health care to village and Adivasi communities all over India has been a major challenge for the central and state governments in India. In the early 1970s, inspired by experiments in the voluntary / ngo sector and on the recommendation of the Srivastava Report the Government of India launched the Community Health Workers Scheme. Due to political exigencies, professional neglect and lack of sustained policy support and initiative, a large half number of the CHWs continue to 'exist' in the country on paper drawing a small monthly stipend due to legal requirements, but not functional in any other way. The unfulfilled agenda continues into the next century. The state of Madhya Pradesh, responding to its own health situation and challenge, which includes a high unmet need of primary health care in the vast rural / adivasi areas of the state, launched the Jana Swasthya Rakshak Scheme in November 1995, under the Integrated Rural Development Programme for unemployed youth to provide

round the clock curative and preventive and promotive health services in every village of Madhya Pradesh.

In 1997, a Review of the Jana Swasthya Rakshak Scheme was organised by the Madhya Pradesh government supported by UNICEF, after part of the training phase was over. The participatory, interactive review facilitated by Community Health Cell (CHC), Bangalore and entitled "Reaching Health to the Grassroots" was conducted between July-December 1997 and made important recommendations on the objectives, administration, selection, linkages, logistic support, communication, training, criteria for certification, supervision-monitoring-evaluation, examination; core project team and peer support.

In 2001, this, second Review was undertaken at the request of DFID and with full cooperation of the government of Madhya Pradesh especially, the new (SJSGY). The initial term of reference was expanded by the review team so that various policy options and perspectives could be provided for mid-course correction and creative modification of the ongoing scheme. Six researchers toured six (6) districts that were selected on the basis of HDR as well as to get a representative sample of the diversity of Madhya Pradesh). The teams studied 2 blocks per districts, 1 CHC and PHC per block, 2 villages per CHC/PHC were selected. The Review started in end of July 2001 (initial exploration) and the field investigations were done in three weeks in September.

Objective

To review the JSR scheme of Madhya Pradesh

Methodology: Qualitative

- 2 preparatory field visits: One with RGM officials/ JSR villages/a Bengali doctor and other to observe training sessions –trainers, JSR's (Build rapport /nature of JSRS/feel of programme/ Frame TOR, actual methods & questionnaires/ logistic planning).
- Issues covered: scheme/selection, Training, work content and community.
- Purposive sampling- Selected districts based on HDI, Region representation and tribal population. (6 districts, 2 blocks, 1 CHC/PHC, 2villages+3 RFWTC)
- Samples at levels: District (collectors, CEO, ZP, CMHO etc), Block (CEO, BMO,trainers)and Village(JPSS members, JSR, ANM,TBA) including key informants. (Trainee JSR -204 & Working JSR – 22)
- Questionnaires were used.
- Data collection tools: Literature review, In-depth individual interviews, FGD's, observations and photographs.
- Data analysis: Content analysis carried out by consultants. Quotes used to describe situation lively (in Hindi). Case studies on JSR presented.

Final prescription

- Think- JSR as a system, rather than individuals
- Control quack practice
- Comprehensive task-list & problem-oriented training.
- Work out drugs list for primary care, make rate lists
- Include other healing systems
- Educate community about scheme
- Provide public space for 'JSR center'
- Involve NGO in the process.

REVIEW OF EXTERNALLY AIDED PROJECTSIN CONTEXT OF THEIR INTEGRATION INTO THE HEALTH SERVICE DELIVERY IN KARNATAKA. TASK FORCE ON HEALTH AND FAMILY WELFARE, GOK

Background

Since the early 1970's the Karnataka Government has negotiated and received variousgrants and loans from international funding agencies, including the World Bank, for health related projects that supported the growth and strengthening of primary and secondary health care services in the state. These externally aided projects have had their own particular focus; objectives; framework; operational strategies; and management information systems geared to support and or enhance both quantitatively and qualitatively, different aspects of Health Sector Development in the state. Each of them has their own cycles of mid-term reviews and concurrent reviews.

Objectives

- To review projects collectively in relation to PHC and Public Health System development in Karnataka using a SWOT approach
- Strengths of each project + positive learning experiences.
- Weakness/ difficulties encountered
- Opportunities created/ exist to enhance PHC & PHSD
- Threats/ distortions inadverently caused by project assistance.

Methodology

- Mixed method: Qualitative + quantitative (3months)
- Purposive sampling
- Data collection tools/ techniques: Individual In-depth interviews, informal FGD's, Interactive participation workshop, literature review and survey.
- Interactive participation workshop (sustainability, accountability etc.)
- Questionnaire survey (evidence contribution to review)
- (Directors / project leaders & other staff/ MO)

Key recommendations

- Develop strategic planning capacities in health sector to handle complexity
- Develop mechanisms of integrated planning, a start for program managers/ implementers networked into coordinated planning mechanism (integration & sustainability)
- Both mechanism need multi-disciplinary expertise
- Need focus on equity,gender, regional disparity; and policy imperatives like community partnership/ ownership, partnership building and decentralization.

Limitations of review

- Time constraint – a huge challenge. (10 EAP in health in state and only 4-5 months)
- Literature reviews, interactive interviews with large numbers within short term framework.
- Need to address all questions originally listed out, some have been answered where others only just considered. (More time would have helped)

REVIEW ACHIEVEMENTS OF STATE HEALTH RESOURCE CENTRE CHATTISGARGH

DR. THELMA NARAYAN , DR. RAJANI VED

Background

At the time of formation of new state chhattisgarh in November 2000, health situation – 20.7 million suffering from diseases of poverty, under-nutrition, anaemia and water borne, and communicable diseases.(+ gaps in HS & its functioning). With steps to strengthen HS, a need for additional body to

provide technical and organizational support. State Health Resource Centre (SHRC) was established on 1st March 2002.

Objectives

- Evaluate the SHRC role in strengthening key aspects of Public health system in Chhattisgarh.

  Specific:

- Study SHRC impact as additional technical capacity
- Review partnerships made and managed
- Review contribution as academic group/ significance of institutional arrangement in PH &PHS
- Review HRM and governance, accountability and financial systems.
- To make overall recommendations for SHRC

Methodology

- Qualitative research
- Method: Purposive sampling (7 districts – Key informants [different stakeholders], field coordinators, health personnel, NGO team members, prashikshaks & Mithanin)
- Data collection tool: Indepth Individual interviews , FGD's and observation (SC, PHC, CHC & district hospital)
- Close interaction with subgroup evaluating Mithanin for sharing perspectives & findings.

Key recommendations

- Need for brainstorming about SHRC's long term role
- Policy implementation needs civil society partnership (which ensures transparency and accountability)
- Need to focus on PHC and new public health for all levels of training.
- Role and relationship of SHRC and SIHFW need clarifications to avoid duplication and confusion.
- Health promotion could be given a separate budget
- Report cards on health institutions by local public (public feedback to institutions)

AN EXTERNAL EVALUATIVE STUDY OF THE MITHANIN PROGRAMME CHHATTISGARH

Background

With Indian Health Systems developed on a top-down model of hospital-doctor centric services, Bhore committee recommended CHW's to address basic health care needs at village. Paradigm shift took after NGO experiments, Chinese barefoot doctors and PHC approach. In this broader stream, Mitanin Programme was a response to improve health and access to health care in Chhattisgarh after formation of this new state. (SHRC took mentor and management when it was established)

Objectives

- To evaluate Mithanin Programme of Chhattissgarh

  Specific:

- Evaluate processes (selection, community, TOT, training & panchayat involvement)
- Evaluate referral systems, fund flows, continuing education and logistic supplies (training materials/drugs)
- Study outcomes (Health education, responsiveness, utilization, CP, Women's health empowerment, linkage with gram panchayats / enhanced capacity of local panchayats for health planning & implementation)
- Study models used for implementation using SWOT principles.
- Gender analysis components of programme
- Identify programmatic challenges faced by Mitanin
- Make recommendations
- Draw out lessons from Mitanin programme for designing ASHA programme.

Methodology

- Mixed method (qualitative and quantitative)
- Stratified random sampling. (based on nature of state/ phase of implementation of project)
- Totally 14/146 blocks were chosen (change in plans)
- At block level- 2 PHC's were selected (accessibility)
- 2 villages/ PHC (Panchayat leaders/ Mitanin/ANM, villagers, health committees member/ Trainer)

- Questionnaire(semi-structured/partly open ended) based on objectives of program/operational objectives of internal evaluation / FGD's/individual interviews
- Final sample (96 mitanins, 495 villagers, 19 trainers, 31 AWW's/ANM's) and 8 doctors.
- Narrative report /case-study with other 300 mitanins.
- Secondary sources: Literature review, newspaper clippings, photographs and film(SHRC).
- Data analysis: quantitative data (EPI INFO 2002) and qualitative data (Narratted experience/meeting &FGD reports). Qualitative data of questionnaires were presented as block wise reports.

Strength of the study

- Using quatitative mind-set, sample size was small. However, in-depth qualitative approach was adopted.
- Relied on geographical spread, depth of inquiry and eight researchers with almost similar findings.
- In addition, discussions with wide variety of people, field visits, observations of events and processes, and reading a large number of documents and reports.

Limitations of the study

- Time given for the study was short. (small sample)
- Budget constraints (second visit – further research)
- Discussions on instruments between researchers limited due to short notice and took over e-mail/ mobile.
- Output measurement not attempted because of no data on mitanin's tasks/ activity
- Confounding factors: Pilot areas/ development & women's empowerment initiatives have an effect on levels of awareness and empowerment of communities and women.

Key recommendations

- Increase and sustain community participation
- Undertake feedback – community/ panchayat members/ mitanins/health staff
- Task based payment can be considered
- Inclusion of preventive- promotive health tasks

- Introducing need based evolving programme content
- Develop need-based evolving programme content.
- Work on reactivation and improving the performances of the public health system whish was important component of overall strategy.

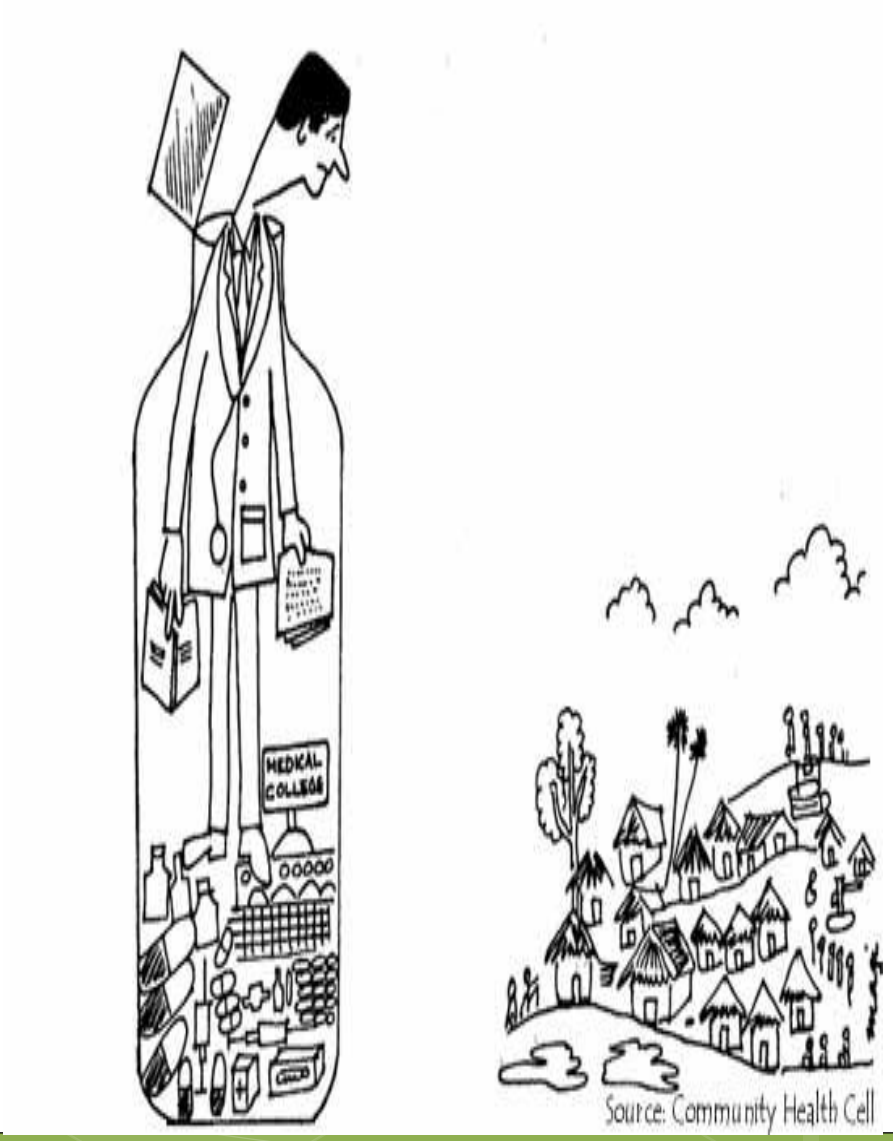
Appendix 1

Strategies for Social Relevance and Community Orientation in Medical Education.

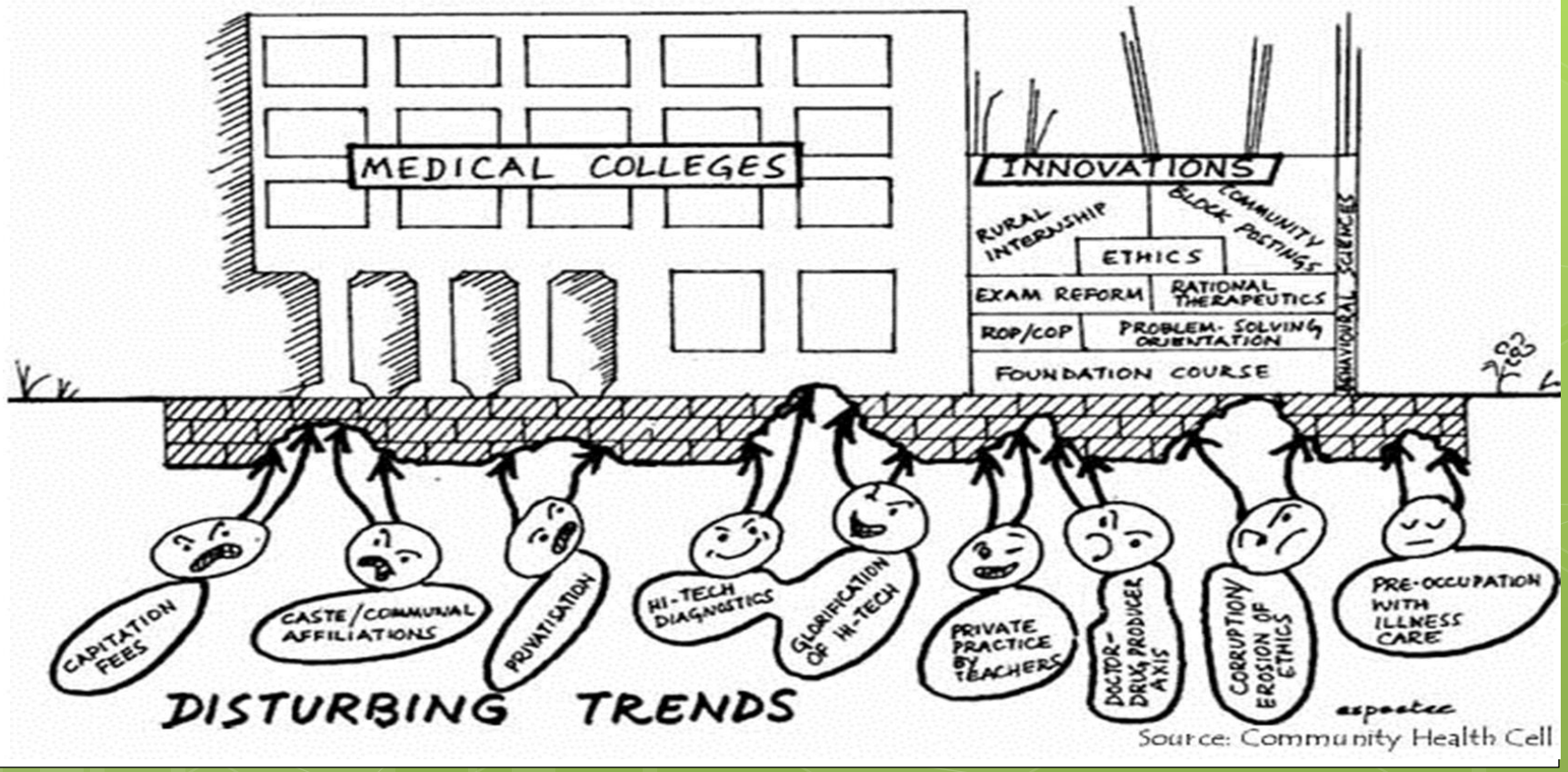
Sochara

Introduction

- Community orientation efforts in India
- The importance of Community orientation of Medical Education in India



- The disturbing trends in Medical Education
- The need for analyzing the effort made by few Medial Educational Institutions to communitize the medical education



Objectives of the Study.

- To document descriptively/ analytically- key recommendations/ experiments/ innovation/ experience in medical education.
- To review key alternative training experiments to identify issues, perspectives, ideas, pedagogy relevant to medical education.
- To build an anthology of Ideas from a sample of recent medical graduates with primary / peripheral health care experience.

Methodology

- The Study adopted a multipronged data collection method which included both classical and interactive approach. These were as follows:

CLASSICAL/ ESTABLISHED	INTERACTIVE
Literature Review	Peer Group correspondence and meeting
Letters to Colleges (with remainders)	Field visits to colleges and group discussions with faculty interns
Letters to Trainers (with remainders)	Correspondence with medical college respondents and Community Health Trainers
Questionnaire Survey (Graduate)	

25 colleges responded to the survey and seven others were identified through the literature survey, a sample of 32 out of 125 colleges in India (23.6%).

Key findings

Stratrategies for reorientation: Fifty strategies were identified and they were broadly classified under following themes:

- Educational Technology
- Widening horizons
- Improving skills developments
- Moving outside the teaching hospital
- Transcending compartmentalization
- Promoting self-directed learning

Forerunners of Community Orientation

- six colleges identified in literature review was considered as the forerunner of community oriented strategies because they have numerous innovations and sustained process of reorientation in their programmers. The reason for their sustained commitment to both quality and reform arose from a combination of factors which included:

Specific focused mandate, smaller number of admissions, autonomous of private management, own entrance examinations and selection procedures, adequate teaching hospital bed, well organized rural and urban field practice areas, and commitment to community oriented/ community based programs. All these colleges tried out or introduced anywhere between 10-20 of the 50 strategies.

The field visit to seven colleges

- The field visit to seven colleges and informal discussion with teachers and intern identified key factors that promoted change, as well as major obstacles and barriers to change.

The factors that promoted change are

- Institutional Mandate
- Institutional objectives
- Instructional Objectives
- Medical educational group
- Staff development Process
- Field Practice area
- Institutional Policy supporting community Health
- Cultural Transformation and Value Orientation
- Networking and Dialogue
- Reflective Evaluation

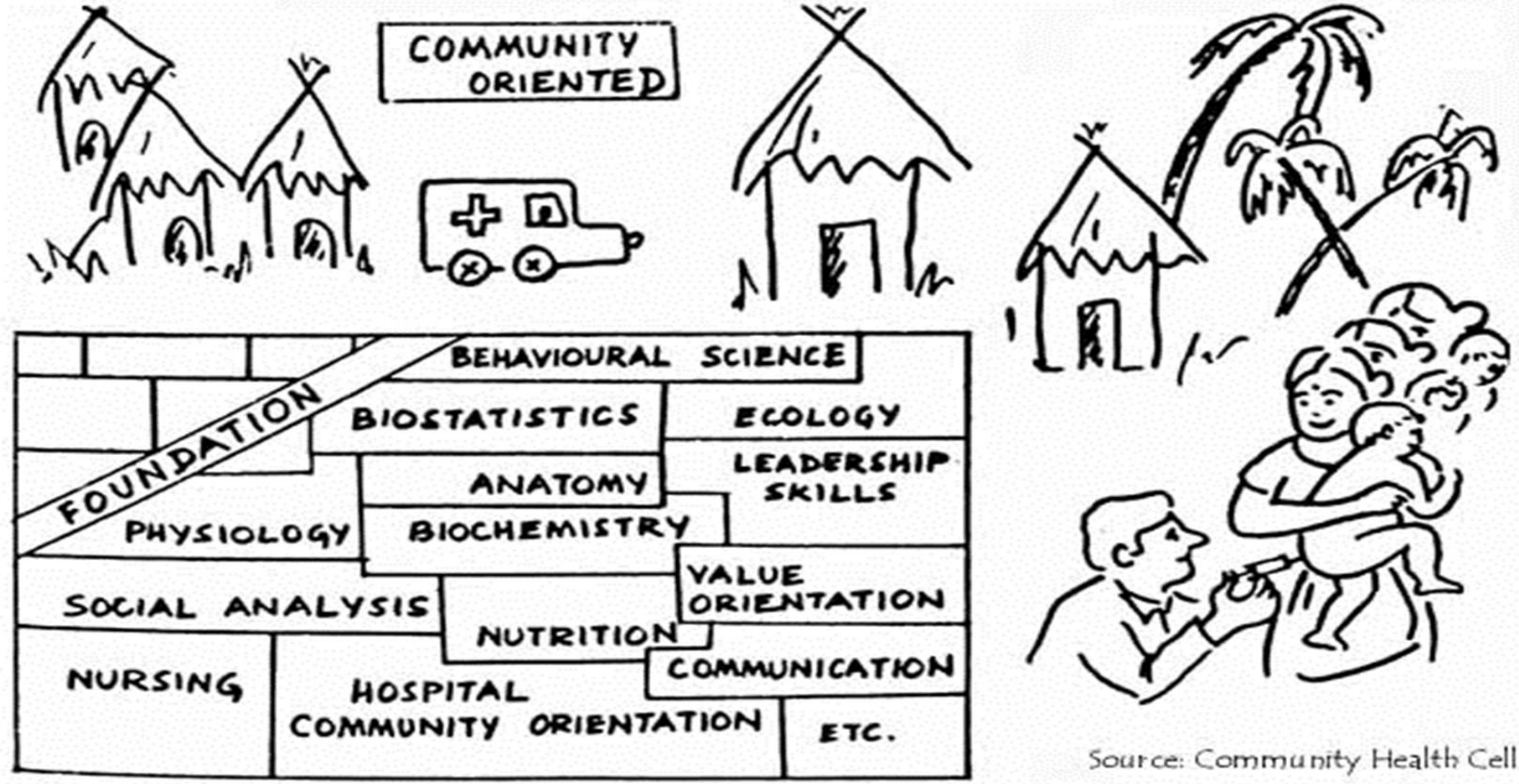
Obstacle/ Barriers to Change:

- Confusion between excellence and relevance
- Continuous shift between tertiary and primary care
- Lack of vision and orientation
- Isolated response to reform
- Effect of Market economy on value orientation
- Too much planning and too little follow up
- Allergy of students and teachers to community exposure
- Unsuccessful transplantation of foreign ideas
- Staff withdrawal due to cynicism or fatigue
- Lack of openness to change in top leadership

Conclusion

- The study has brought together through various methods an overview of the Indian medical college experience to help medical educators to evolve a process of change with locally evolved initiatives in mind.

Evolving Medical Curriculum through Graduate Doctors Feedback



Introduction

- The effort to mould community oriented medical education curriculum.
- Effort of CHC to evolve community oriented medical education curriculum.

- The importance of feed back from medical graduate with work experience in PHIs.

Objectives

- To elicit feedback on all the major aspects of the undergraduate medical course.
- To identify in the undergraduate medical curriculum

I. Areas those were useful, relevant and adequate
II. Areas that needed further strengthening, areas of lacunae
III. Areas that could be reduced or deleted

Methodology

- As an instrument of the study a questionnaire was developed. The different aspect of the medical education on which it elicited feedback were:

I. All the preclinical, Para clinical and clinical subjects, including medical ethics
II. Additional skills in patient care and hospital work like nursing, management's communication and training.
III. Internship.

- A total of thirty seven different aspects were covered through open ended questions. Questionnaire was pilot tested on 10 respondents. Modification was made based on this as well as on comments by the advisory Committee.

Sample

- Out of 120 selected participant 53 (44.16%) participant responded.

The criteria for the respondents were:

- The medical professionals who had graduated from any India medical college during the decade of the 1980s.
- They had completed a minimum of two years working experience as a doctor in any peripheral health institution in India.
-
- The sample was not statistically chosen to represent any particular region or college.
- The eligible respondents were identified from applicants to postgraduate medical entrance exams where rural service was given special recognition.
- Anonymity of the individual respondent as well as the medical col was maintained.
- The questionnaire was given/sent to 120 eligible respondents. Of these 78 were given out by the researchers and the remaining through contact people but the later was not successful.

Finding

- The first part of the finding deals with the profile of the work experience of the respondent. The part b of the finding details the feedback according to each subjects of the curriculum.

PROFILE OF THE RESPONDENTS WORK EXPERIENCE IN PHIs IN INDIA

- The majority of the respondents graduated in the year 1980s hence the feed-back was related to the current practice in education
- The average duration of the work experience was 2 years and 10 months.
- The respondents have worked in a total of 80 PHIs located in 10 states of India and 1 Union Territory.

- Several graduates had worked in more than one PHIs. The majority of the PHIs were located in rural area. Most of the experience of the respondents had been at the level of providing secondary level medical care. However, they had often been involved sometimes in the same institution in primary care. However, they had often been involved sometimes in the same institution in primary care as well.

SUMMARY OF THE FEEDBACK ON DIFFERENT ASPECT OF THE UNDERGRADUATE MEDICAL COURSE.

- **Skills development**

There was a strongly expressed need for greater development of skills and competences, particularly in basic nursing procedures, emergency medicine, minor surgical procedures, obstetrical care, local anesthesia, running simple laboratory and pharmacy, assessing community health needs and evolving simple strategies to meet them; training health workers; management, communication

Curriculum Change

- Introduce integrated teaching with special focus on clinical application, and on common problems
- Reduce unnecessary theoretical details
- Reduce pre-clinical phase from 1.5 year to 1 year
- Introduce/strengthen the teaching of psychology and sociology and experience in basic nursing procedure during the six months thus gained in the first eighteen months.
- Emphasize the four primary clinical disciplines, especially obstetrics
- Change the concept that " short posting" is relatively unimportant.
- During the final year or internship there should be postings to the pathology laboratory, blood bank pharmacy, medical records department and accounts sections.

Community Health Suggestion

- Integrate preventive and curative aspects in all phases
- Emphasize community health teaching with practical training in health education, nutrition, school health, epidemiology, statistics, and occupational health.
- Ensure involvement in ongoing community heath programs during studentship/internship
- Increase teaching programed that are community based, including exposure to PHIs
- Internship should include postings to PHIs.

Examination System

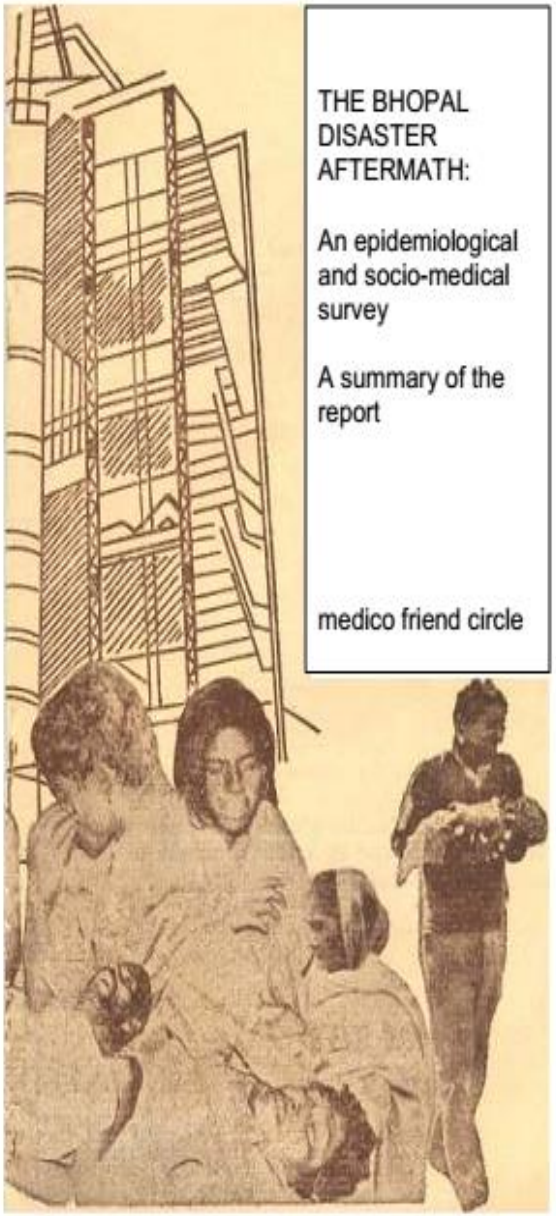
- The examination system need to focus on assessing basic necessary knowledge and skill, the logical approach to diagnosis and rational treatment.
- There was also a need to change methods of assessment to process of continuous assessment, increased use of MCQs
- Several short cases with discussion

The other key suggestions

- Career guidance to enhance students' option for work in PHIs.
- Sharing of experience by PHI doctors with students during the undergraduate medical course
- Internship as the most useful learning phase, needed to be strengthened.
- Introductory lectures on alternative systems of medicine, holistic health and traditional health practices.
- Development of healthy attitude, lifestyles, values and ethics during the undergraduate course.

THE BHOPAL DISASTER AFTERMATH: An epidemiological and socio-medical survey.

SOCHARA



Introduction

- Bopal Gas tragedy in 1984
- The challenges of rehabilitation
- The official secrecy act
- Involvement of Medico Friends Circle

Objective of the study

(i) make an epidemiological assessment of the current health status and health problems of the people;

(ii) to examine the findings in the light of the two controversial theories;

(iii) to evolve a critique of the medical research and relief programme

(iv) to make recommendations for a more meaningful relief and rehabilitation policy.

The study population

- The study was a community based, case/control study. Two slums were selected for the study: (i) J P Nagar situated in the close vicinity of the Union Carbide factory and the worst affected by the gas leak. (ii) Anna Nagar 1 0 km away with the least exposure, which served as the control. Rapport was established with the people by explaining to them our objectives and making it very explicit that we were not there to offer any financial compensation, medical treatment etc. The slum dwellers were given a hand out in Hindi explaining the role of mfc and a commitment was made that the salient findings of our study and our recommendations would be made available to them.

Sample Selection

- The families for study were selected by random sampling. Only subjects above 10 years of age were selected. Those less than ten years were excluded in view of their probable inability to report symptoms correctly. All details were entered in a pre-designed proforma. In addition, lung function tests were done by standard procedures using a portable spirometer by a doctor fully familiar with measuring these under field conditions.

Findings

- The victims described a broad range of symptoms arising from most of the different systems in the body. JP Nagar residents had a much higher (statistically highly significant) incidence of these symptoms compared to Anna Nagar. The commonest symptom was breathlessness on accustomed exertion.

- The following symptoms were highly significantly different (higher) in JP Nagar as compared to Anna Nagar: cough with expectoration, chest pain, blurred vision, photophobia, headache, fatigue, loss of memory for recent events, weaknessin extremities, muscle ache, abdominal pain, nausea, and anxiety/depression, dry cough, breathlessness at rest, watering of eyes, skin problems, bleeding tendency, and impotence

- On grouping the symptoms according to the systems, most of them are related to the pulmonary system (respiratory), the gastrointestinal system (digestive), the eye and the central nervous system
- 35% of the patients had gastro-intestinal, central nervous system and eye symptoms in the absence of any lung findings.
- Women in the reproductive age group reported menstrual irregularities such as shortened menstrual cycles, altered pattern of discharge, pain during menstruation and excessive white discharge.

- Nearly half of the nursing mothers in J P Nagar reported a decrease or complete failure of lactation. 8% of the men reported impotence. Many residents had symptoms of anxiety, and some had frank depression. Many had loss of memory for recent events. Mean haemoglobin concentrations in both males and females were significantly higher in JP Nagar than in Anna Nagar, suggesting that compensatory mechanisms in the body had begun to respond to the hypoxia.

- . The mean values of lung function tests were statistically significantly lower in JP Nagar as compared to Anna Nagar particularly in the age group 15-44 and 45-60 in both sexes. The pattern was primarily restrictive. An' important finding of grave significance is that 65% of the working persons in JP Nagar experienced a drop in income ranging from 20% to 100% as opposed to only 9% in Anna Nagar. This reflects the way in which the physical/ mental disability of the people caused by the disaster has affected their working and earning capacities.

- A point of utmost significance is that the victims of the Bhopal gas disaster mostly belong to the lowest strata of society and are not in a position to fight for their rights, be it medical aid or monetary compensation. It is, therefore, not very surprising that the government and its organisations have shown marginal interest in the after effects. It also reveals a lack of interest among our scientific community in investigating an environmental disaster of an unprecedented nature. On the other hand, one can observe the striking contrast with which all attempts were made to retrieve the Black Box of Kanishka, whose mid-air explosion resulted in the death of only 326 persons but needless to remind of the upper socio-economic class.

Evaluative feedback from members concerning the Catholic Hospital Association of India (CHAI)

Introduction

- The fiftieth Anniversary of Catholic Hospital Association of India.
- The need for reflection on past and searching for the future direction.

Aim of the Study

- To reflect on the function of Catholic Hospital Association of India during the last fifty years, with special focus on last twenty five years.

- To understand the possible role CHAI could play to meet the needs of its members, the national voluntary health sectors, and the health apostolate of the Church.

Objectives

- To elicit information and feedback from CHAI members on:

1. Their involvement and nature of interaction with CHAI.
2. Their expectation from CHAI in relation to their own activities
3. Their views regarding the appropriateness and adequacy of CHAI's activities
4. Their views regarding factors contributing to the gap between expected and observed actions.
5. Their suggestion regarding alternate measures to be adopted to fill in the gap.

Methodology

- Preparation project proposals and modification.
- Sampling
  i. 20% random sample was selected using stratified random sampling.
  ii. The member institutions were divided into two categories based on the size.
  iii. Region was stratified into two based on the major health indicators as IMR and CDR.

Distribution of membership by region and size of institution

	0 – 6 Beds	More than 6 Beds	Total
Better Health indicators	1, 018	537	1555
Poor Health Indicators	572	143	715
Total	1590	680	2270

Distribution of the sample by region and size of institution

	0 – 6 Beds	More than 6 Beds	Total
Better Health indicators	204	108	312
Poor Health Indicators	114	29	143
Total	318	137	455

Data Collection

- Interview schedule.

The interview schedule was pilot tested and made necessary change. It contained two part:

Part A – Sent to every individual institution

Part B – Collected feedback about the various aspect of CHAI from selected samples only.

Investigators

- 40 people from Catholic religious community were selected Mysore and Delhi.
- They were given 5 days orientation on the CHAI, the purpose and the objectives of the study and conducting in-depth interview.
- Feed back data was collected during the 1991 December and May-June 1992.
- Supervisory field visit was conducted by the team members during the interviews

- Mailed Questionnaire.

Part A of the questionnaire was sent to the remaining 80% of the institutions (1815) to collect information regarding the medical health related work of all CHAI constitutional members.

Data Analysis

The data was coded and entered into computer for further analysis.

D- base 111+ was used for the analysis of the data

CONTEXTUAL AND POLICY LEVEL ISSUES IMPORTANT FOR THE FURUTE HEALTH RELATED WORK OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

Introduction

- The policy Delphi research was done to identify broad contextual and policy issues that CHAI needed to consider in its plan for the future action. And to explore the possible role that CHAI could play in the future in the context of the national situation and the national health policy.

METHODS

- Introduction to The Policy Delphi Method
- A list of 108 possible panelists who has expertise in diverse background was prepared by the CHAI study team.
- A letter of invitation was sent to the selected panelists with a tentative time frame of the study. 49 panelists from diverse back ground agreed to participate as panelists in the method.

- Firstly, a document with history, aims and objectives, organizational structure, thrust area was sent to the members. Alone with it first round of questionnaire was sent it elicit the response on economic, political and social trends which may occur in the next fifteen years that would have impact on the health status of people in India. In addition to it, panelists opinion on what issues that CHAI should focus on priority base for the next fifteen years also has taken.

- From the ideas that emerged from the first part of the discussion and the immediate issues that CHAI was suggested to focus upon a second round of questionnaire was sent to the panelist that covered seven broad areas.
- The basic premise of health work that CHAI need to consider in its future work
- The important health problems that CHAI should respond
- The type of health action that CHAI should promote
- Identify the group/constituencies that CHAI should focus its activities.

- Organizational aspects or mechanisms that could be introduced or strengthened to enable effective functioning.

- Strategies of work or interventions needed to implement its objectives and priorities.

- Need for role identification.

The common theme that emerged from the first discussion and the difference also sent to the panelist to generate further discussion.

- The final analysis of first and second round of discussion was made available to all the member of CHAI for the future direction and decision making

A Study on Disparities in Health Care Services

Dr. A S Mohammed

Introduction

- Health Status in Karnataka
- Disparities in Health and Health Care facilities
- The importance of addressing the health disparity

Objectives

- To Determine the disparities in Health determinants
- To determine the disparities in Health status
- To determine the disparities in Health Care resources allocation.
- To determine the disparities in Health Care utilization
- To determine the most disadvantaged districts in Karnataka to evolve and initiate more focussed projects in these districts

Methodology

- The study was conducted based on the secondary data. And the data was checked for its quality and quantity and regional disparities were assedssed on the basis of available data on indicators in the following essential categories:
- Health Determinants
- Heath Status
- Health Resource Allocation
- Health Care Utilization Indicators
- Over all Indicators.

- Each indicator in the above mentioned categories was standardized and algebraically added for each district. The total was restandardized and a composite index as Standardized Z score was obtained for each district, which gives the relative position of the district on the scale in Karnataka State.

UNDERSTANDING GLOBAL PUBLIC PRIVATE INITIATIVES - CASE STDUY OF GLOBAL ALLIANCE TO ELIMINATE LYMPHATIC FILARIASIS

A CHC/ WEMOS COLLABORATIVE STUDY

Dr. Thelma Narayan and Mr. Naveen.

Background

- With increasing health inequalities, and poverty and a decreasing health budget globally – Rapid rise in Global Public Private Initiatives (GPPI) (idea of CSR/ ↑ financial & material resources +political support)
- Wemos promoted case studies in LI / MI countries for understanding GPPI at field level and its effects on local health systems

Background Cont…

- Global Alliance to Eliminate Lymphatic Filariasis (GAELF) formed in 1997 to eliminate LF by 2020
- GAELF approach is to improve the access to health products (MDA programme).
- WHO + GlaxosmithKline + Merck &co + local governments etc.
- In India increased burden of LF and GAELF implemented through NFEP.

Objectives

- To study the influence of GAELF on NFEP- India and it's implementation in Karnataka with reference to fulfillment of, 'Right to Health and Health Care, particularly the poor.

Specific objectives

- Study content/organizational structure/ financing/ operating mechanism.
- GAELF's linkage with general health services and PHC
- Implementation- focus on access, equity and sustainability.
- Study all above with a framework of Right to Health and Health Care.
- Identify conflicts of interest/ how those mediated (if any)

Methodology

- Qualitative research study.
- Participated – 2 workshops (Synchronize concepts/methods/discussion on preliminary finding)
- Literature review - Health & Health care situation and to do a policy analysis of GAELF & NFEP(+ interview).
- Purposive sampling.
- Data collections tools: Observation, Individual In-depth Interviews and Focus group discussions.

Methodology Cont….

- Observation of SC's, PHC's and CHC's.
- FGD's with providers, patients & Community.
- FGD's and Interviews – Taluk/ district/ state/ national programme units + officials at DOHS.
- Individual interviews – VCRC (Pondicherry), HSP of academic institutions/ NGO resource centers.
- Principles of research ethics were maintained
- Linkage maintained with RPHCC of JSA.

Key recommendations

- Need for discussion/debate/ dissemination of research findings with all stakeholders.
- Core values including CP, respect for local health traditions and systems of medicine and respect for Right to Health & Health care need to be identified and accepted as framework for GPPA.
- Local capacity building for strengthening PHS
- Need more research and advocacy on GPPI's and an openness to diverse local solutions (Alternative approaches)

Review of
Jan Swasthya Rakshak Scheme
Govt. of Madhya Pradesh
July – September 1997

Dr. Ravi Narayan and team

Background

- Madhya Pradesh – largest land mass + geographical diversity (71,256 villages, population were scattered)
- Poor health indicators (health inequity and in rural MP, IMR – 105/1000 live births)
- Unfilled vacancies in rural health centres (often simple illness turned to severe complications/even death)
- Need for trained person in community to provide preventive, promotive and some curative health service.

Background

- On 19 November 1995, MP government launched Jan Swasthya Rakshak Scheme (JSRS) to improve rural health service.
- JSR expected to provide first aid/treat minor symptoms & diseases, assist in implementation of national health programmes and refer serious cases in time.

Objective:

- To do review of JSRS of Madhya Pradesh

Terms of Reference / Specific objectives

- Document profile of JSR's (5 districts)
- Examine the process of selection by community
- Document content and methodology of training
- Document examination system for certification
- (Administrative and management aspects + attitude/ perception by community, panchayat & health dept. officials)
- No JSR received certification. (performance of JSR in the field was not feasible)

Methodology

- Mixed method (Quantitative and Qualitative).
- Functional areas: Attitude/commitment of JSR + extent of deviation of scheme in its implementation
- Levels of Admin set-up: Organized health services setup, JSR and Consumers/their representatives.
- Purposive sampling / multi-stage random sampling (mostly driven by purpose/scope/ time)

Methodology Cont

- Data collection techniques/ tools: Surveys, secondary sources(records), Indepth Individual interviews and focus group discussions
- Material: Questionnaire (structured/unstructured/ multiple choice items) and open ended unstructured interviews.
- Number of questions common to respondents for validation of data.
- Data was analysed manually and with help of computer (statistical software)

Key recommendations

- Selection: Widely publicize the scheme/reduce minimum eligibility (women & tribal cand)
- Training: Emphasize preventive and promotive aspects.
- Exams: Give stimulated case studies for assessment
- Functions of JSR: Need to explain to villagers and JSR devote time for prevention / promotion.
- Administration: Need widescale publicity, distribute certificates on time and organize workshops with PRI representatives.

Review of
Jan Swasthya Rakshak Scheme
Govt. of Madhya Pradesh
July – November 2001

Objective

- To review the JSR scheme of Madhya Pradesh

CHC team:

- Dr. Ravi Narayan, Dr. Dhruv Mankad, Dr. Shyam Ashtekar, Prof. Mohammad ,Dr. Abhay Shukla, Dr. Shashikant Ahankari, and Shri.Amulya Nidhi.

Methodology: Qualitative

- 2 preparatory field visits: One with RGM officials/ JSR villages/a Bengali doctor and other to observe training sessions –trainers, JSR's (Build rapport /nature of JSRS/feel of programme/ Frame TOR, actual methods & questionnaires/ logistic planning).
- Issues covered: scheme/selection, Training, work content and community.
- Purposive sampling- Selected districts based on HDI, Region representation and tribal population. (6 districts, 2 blocks, 1 CHC/PHC, 2villages+3 RFWTC)

Methodology cont….

- Samples at levels: District (collectors, CEO, ZP, CMHO etc), Block (CEO, BMO,trainers)and Village(JPSS members, JSR, ANM,TBA) including key informants. (Trainee JSR -204 & Working JSR – 22)
- Questionnaires were used.
- Data collection tools: Literature review, In-depth individual interviews, FGD's, observations and photographs.
- Data analysis: Content analysis carried out by consultants. Quotes used to describe situation lively (in Hindi). Case studies on JSR presented.

Final prescription

- Think- JSR as a system, rather than individuals
- Control quack practice
- Comprehensive task-list & problem-oriented training.
- Work out drugs list for primary care, make rate lists
- Include other healing systems
- Educate community about scheme
- Provide public space for ‘JSR center’
- Involve NGO in the process.

REVIEW OF EXTERNALLY AIDED PROJECTSIN CONTEXT OF THEIR INTEGRATION INTO THE HEALTH SERVICE DELIVERY IN KARNATAKA.

TASK FORCE ON HEALTH AND FAMILY WELFARE, GOK

Background

- Karnataka govt received grants/loans from IFA – RCH, KHSDP, KFW, IPP-8 &9 etc. (improve health sector)
- Karnataka task force raised questions: learning from projects, how they could be integrated into HS and issues related to sustainability, accountability and transparency.
- Four relevant policy initiatives: Health projects- Misereor; Health partnerships – Memisa/ Netherland and Cebmor Netherlands government ;and policy reflections on World Bank activities in India

Objectives

- To review projects collectively in relation to PHC and Public Health System development in Karnataka using a SWOT approach
- Strengths of each project + positive learning experiences.
- Weakness/ difficulties encountered
- Opportunities created/ exist to enhance PHC & PHSD
- Threats/ distortions inadverently caused by project assistance.

Methodology

- Mixed method: Qualitative + quantitative (3months)
- Purposive sampling
- Data collection tools/ techniques: Individual In-depth interviews, informal FGD's, Interactive participation workshop, literature review and survey.
- Interactive participation workshop (sustainability, accountability etc.)
- Questionnaire survey (evidence contribution to review)
- (Directors / project leaders & other staff/ MO)

Key recommendations

- Develop strategic planning capacities in health sector to handle complexity
- Develop mechanisms of integrated planning, a start for program managers/ implementers networked into coordinated planning mechanism (integration & sustainability)
- Both mechanism need multi-disciplinary expertise
- Need focus on equity,gender, regional disparity; and policy imperatives like community partnership/ ownership, partnership building and decentralization.

Limitations of review

- Time constraint – a huge challenge. (10 EAP in health in state and only 4-5 months)
- Literature reviews, interactive interviews with large numbers within short term framework.
- Need to address all questions originally listed out, some have been answered where others only just considered. (More time would have helped)

REVIEW ACHIEVEMENTS OF STATE HEALTH RESOURCE CENTRE CHATTISGARGH

DR. THELMA NARAYAN
DR. RAJANI VED

Background

- At the time of formation of new state chhattisgarh in November 2000, health situation – 20.7 million suffering from diseases of poverty, under-nutrition, anaemia and water borne, and communicable diseases.(+ gaps in HS & its functioning)
- With steps to strengthen HS, a need for additional body to provide technical and organizational support.
- State Health Resource Centre (SHRC) was established on 1st March 2002.

Objectives

- Evaluate the SHRC role in strengthening key aspects of Public health system in Chhattisgarh.

Specific:

- Study SHRC impact as additional technical capacity
- Review partnerships made and managed
- Review contribution as academic group/ significance of institutional arrangement in PH &PHS
- Review HRM and governance, accountability and financial systems.
- To make overall recommendations for SHRC

Methodology

- Qualitative research
- Method: Purposive sampling (7 districts – Key informants [different stakeholders], field coordinators, health personnel, NGO team members, prashikshaks & Mithanin)
- Data collection tool: Indepth Individual interviews , FGD's and observation (SC, PHC, CHC & district hospital)
- Close interaction with subgroup evaluating Mithanin for sharing perspectives & findings.

Key recommendations

- Need for brainstorming about SHRC's long term role
- Policy implementation needs civil society partnership (which ensures transparency and accountability)
- Need to focus on PHC and new public health for all levels of training.
- Role and relationship of SHRC and SIHFW need clarifications to avoid duplication and confusion.
- Health promotion could be given a separate budget
- Report cards on health institutions by local public (public feedback to institutions)

AN EXTERNAL EVALUATIVE STUDY OF THE MITHANIN PROGRAMME CHHATTISGARH

Background

- With Indian Health Systems developed on a top-down model of hospital-doctor centric services, Bhore committee recommended CHW's to address basic health care needs at village.
- Paradigm shift took after NGO experiments, Chinese barefoot doctors and PHC approach.
- In this broader stream, Mitanin Programme was a response to improve health and access to health care in Chhattisgarh after formation of this new state. (SHRC took mentor and management when it was established)

Objectives

- To evaluate Mithanin Programme of Chhattissgarh

Specific:

- Evaluate processes (selection, community, TOT, training & panchayat involvement)
- Evaluate referral systems, fund flows, continuing education and logistic supplies (training materials/drugs)
- Study outcomes (Health education, responsiveness, utilization, CP, Women's health empowerment, linkage with gram panchayats / enhanced capacity of local panchayats for health planning & implementation)

Objectives cont…

- Study models used for implementation using SWOT principles.
- Gender analysis components of programme
- Identify programmatic challenges faced by Mitanin
- Make recommendations
- Draw out lessons from Mitanin programme for designing ASHA programme.

Methodology

- Mixed method (qualitative and quantitative)
- Stratified random sampling. (based on nature of state/ phase of implementation of project)
- Totally 14/146 blocks were chosen (change in plans)
- At block level- 2 PHC's were selected (accessibility)
- 2 villages/ PHC (Panchayat leaders/ Mitanin/ANM, villagers, health committees member/ Trainer)
- Questionnaire(semi-structured/partly open ended) based on objectives of program/operational objectives of internal evaluation / FGD's/individual interviews

Methodology cont…

- Final sample (96 mitanins, 495 villagers, 19 trainers, 31 AWW's/ANM's) and 8 doctors.
- Narrative report /case-study with other 300 mitanins.
- Secondary sources: Literature review, newspaper clippings, photographs and film(SHRC).
- Data analysis: quantitative data (EPI INFO 2002) and qualitative data (Narratted experience/meeting &FGD reports). Qualitative data of questionnaires were presented as block wise reports.

Strength of the study

- Using quatitative mind set, sample size was small. However, indepth qualitative approach was adopted.
- Relied on geographical spread, depth of inquiry and eight researchers with almost similar findings.
- In addition, discussions with wide variety of people, field visits, observations of events and processes, and reading a large number of documents and reports.

Limitations of the study

- Time given for the study was short. (small sample)
- Budget constraints (second visit – further research)
- Discussions on instruments between researchers limited due to short notice and took over e-mail/ mobile.
- Output measurement not attempted because of no data on mitanin's tasks/ activity
- Confounding factors: Pilot areas/ development & women's empowerment initiatives have an effect on levels of awareness and empowerment of communities and women.

Key recommendations

- Increase and sustain community participation
- Undertake feedback – community/ panchayat members/ mitanins/health staff
- Task based payment can be considered
- Inclusion of preventive- promotive health tasks
- Introducing need based evolving programme content
- Develop need-based evolving programme content.
- Work on reactivation and improving the performances of the public health system whish was important component of overall strategy.

Society for Community Health, Awareness, Research and Action - SOPHEA

Annual Team Retreat

9th and 12th September 2013

THEME: A RESEARCH ENCOUNTER

The Research Experience, Agenda and Paradigm of SOCHARA

Date /Time/Venue	Theme	Resource Person/ Facilitator/Moderator
9th September 2013 Monday		
9.00 – 10.15am SOCHARA Annexe	The SOCHARA family get-together (SOCHARA Team, ARC and Fellows) Songs & a Play	**Cultural Team**
10.15- 3.00pm (SOPHEA Trg Room)	**ACADEMIC & RESEARCH COUNCIL MEETING**	
10.15 - 5.15 pm (SOCHARA Annexe)	**Staff Annual Retreat : Research Workshop**	
10.15- 11.15	**An overview of the Research Agenda of SOCHARA (1984- 2009)** : Broadening the evidence and evolving a new paradigm	**Facilitator** Ravi Narayan, Community Health Advisor
11.15 -11.30	**BREAK**	
11.30 – 1.00	**The Yin and Yang of SOCHARA Research - I** Participatory Research and Health Policy Action (Overview of 5 projects of SOCHARA **)**	**Moderators:** Ravi Narayan & As Mohammad **Presenters:** Karthik & Sabu
1.00 – 2.00	**LUNCH**	
2.00 – 3.30	**The Yin and Yang of SOCHARA Research - II** Participatory Research and Health Policy Action (Overview of 5 more projects of SOCHARA)	**Moderators:** Ravi Narayan & As Mohammad **Presenters:** Karthik & Sabu
3.30 – 3.45	**BREAK**	
3.45 – 5.30	**A Panel Discussion on Sharing of SOCHARA Research Experiences :** Strengths, Opportunities, Aspirations, Results (SOAR)	**Moderator:** As Mohammad **Panelist** Thelma Narayan Prasanna Saligram Rakhal Gaitonde

10th and 11th September 2013 (Tuesday & Wednesday) St. John's Annexe–III Meeting Hall	**National Workshop : " Social Justice in Health and Universal Health Coverage : Challenges, Pathways and Possibilities"**	See Separate Program
12th September 2013 (Thursday) (SOCHARA Annexe)	Annual Team Retreat (continued)	
9.00 -10.00am	**Understanding the CAH Process in Tamilnadu**	**Moderator:** As Mohammad **Presenter** CAH team, Tamilnadu (Ameer, Suresh, Naresh, Santosh)
10.00 – 11.00am	**Reflections on Evidence gathering and its utilization** (Research Opportunities in CAH)	**Moderator:** As Mohammad **Presenter** CAH team , Tamilnadu (Ameer, Suresh, Naresh, Santosh
11.00 – 12.30pm SOPHEA Trg Hall	**Team Sharing and Dialogue with SOCHARA- EC**	
12.30 - 2.00pm	**LUNCH**	
2.00 – 3.15pm	**Environmental Health / other Public Health issues**. - Environmental Health - Environmental Sanitation - Malaria /Nutrition / Maternal Health	**Moderator:** Ravi Narayan **Presenters** -Adithya Pradyumna -Prahlad -MP Team (Juned, Razi, Dhirendra, Bhagwan)
3.15 - 3.30pm	**BREAK**	
3.30 – 5.00pm	**RESEARCH IN SOCHARA : THE NEXT STEPS** i) Academic and Research Council (ARC) ii) Institutional Scientific and Ethics Committee (ISEC) iii) Research areas for individual team members iv) Research training and mentoring of community health fellows v) Funding, documentation and publication vi) Any other matters.	**Moderators:** Thelma Narayan As Mohammad