Fifth workshop on

Cutting Edge Research on Health Inequities:

Concepts & Methods

25 – 29 Nov 2019 at Visthar CRC, Bengaluru, India

Workshop Report

Version 1.3

Organized jointly by

Azim Premji University, Bengaluru

The George Institute for Global Health, India

Health Equity Network India (secretariat: Institute of Public Health Bengaluru)

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Table of Contents

1. About the workshop

Background: There are major differences in health status and utilization of health care services in India, whether it is across class, caste, gender or some other axes. Yet the evidence for these differences is still patchy, and the pathways through which inequities in health are created and sustained are still unclear.

The Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, under the 'Closing the Gap: Health Equity Research Initiative in India' to strengthen health equity research in India, supported by the International Development Research Centre (IDRC), Canada, initiated the Cutting Edge workshop series on health equity research methods and successfully conducted four workshops in collaboration with Azim Premji University. In its four editions, the partnering teams along with researchers and activists across the country developed and implemented this training programme aimed at young-to-mid-level researchers and practitioners on concepts of health equity and methodological issues in addressing research questions on inequity in health in India.

In its fifth iteration in 2019, the Cutting Edge Workshop on Health Equity Research Methods was jointly organised by Azim Premji University, the Health Equity Action Lab (HEAL) at the George Institute for Global Health, India and the Health Equity Network India (HENI), an individual membership based network formed in 2018 with a mission to enable transformative research and mobilize knowledge for action on health equity in India through a diverse and inclusive network of individuals and organizations.

About this workshop: The five-day workshop was held from 25th to 29th August 2019. The aim of this workshop was to inspire public health researchers and activists to engage with research on health inequities in India. At the end of the workshop, participants were expected to:

- Gain clarity on concepts related to equity and inequities in health including the intersectionality framework,
- Develop an understanding on how to approach health research with an equity lens,
- Acquire skills for planning research that help understand pathways that create or contribute to inequities in health using qualitative, quantitative and mixed-method approaches, and
- Be introduced to approaches to studying the consequences of intersecting social inequalities on health inequities.

Participants: Twenty participants attended the workshop. The participants came from across the country with a range of work experience from civil society, journalism to academic universities. Further details of the participants of this workshop can be found in **Annex 1**

Figure 1. Workshop participants, resource persons and organisers

Workshop programme: The workshop programme was framed in four clusters as below:

- Cluster-1: Introduce participants to conceptual frameworks for examining health inequities
- Cluster-2: Aims to expose participants to methods in researching and measuring health inequities using quantitative, qualitative and mixed methods
- Cluster-3: Was designed to participants an opportunity to learn about perspectives that shape research questions, methods chosen, and use of health inequities research through interaction with diverse resource persons who combine research with advocacy or activism and
- Cluster-4: It was intended to help participants apply the skills that they have been exposed to, during the workshop through presentation and group exercises proposing research on health equity themes.

Detailed programme details can be found in Annex 2.

Financial and administrative arrangements: This workshop was the fifth in a series of health equity research methodology workshops. This workshop was jointly organised and funded by Azim Premji University, and the George Institute for Global Health, India (using HEAL program grant funding) and the Health Equity Network India through its secretariat at the Institute of Public Health Bengaluru. It was a residential programme held at Visthar CRC (a conference and retreat centre) in the outskirts of Bengaluru.

2. Workshop sessions

S1: Introduction to the workshop, participants & initial expectations

This session started the workshop and began with a round of introduction from the participants and faculty, and their expectations from the workshop. Organisers set the ground rules for the workshop and shared general instructions on participation in the coming days. Few of the expectations enlisted by participants were:

- To know more about the inequity concept
- To understand reproductive health problems, non-communicable diseases and child health from equity lens
- To find an opportunity to work with equity network
- To understand practical application of equity concept
- To know more about inequities existing among disadvantaged and also gender inequities
- To know more about influence of social determinants on health

The main aim of the workshop was to inspire public health researchers and activists to engage with research on health inequities in India. The speaker shared the specific objectives of the workshop. (mentioned earlier). Organisers then provided a brief background on the status of health equity research in India. The current literature on health inequities in India mainly establishes that the problem exists and identifies correlates, usually demographic, social and economic. It however does not provide sufficient information that is required for any action on the ground. The lack of understanding of mechanisms then results in strategies that are driven preconceived expert-driven notions, thus, resulting in interventions that often are a poor fit and do not succeed in addressing the existing inequity in question. Hence, the urgent and important need for an explicit research agenda on health inequities is warranted.

The research agenda on health inequities includes research that:

a) asks the 'what', 'where' and 'when' questions for groups on whom little research exists
b) asks the 'how' and 'why' questions for groups whose disadvantages are well established
c) explores the role of the health system in mitigating or accentuating inequities
d) examines interventions that have addressed health inequities, to understand what works where and why

S2: Power walk by Renu Khanna

The power walk was a field activity to sensitize participants to the underlying inequities in society. Participants were assigned specific characters and requested to arrange themselves in a straight line. Then the speaker read out different situations and the participants were asked to take a step ahead if it was applicable to them in that particular role/character. Different situations were considered to

determine and capture various socio-economic factors. The discussion revolved around the characters, and what the power (or lack of it) felt like through reflection on certain questions.

Figure 2. Pictures from the power walk exercise

- Reflection on specific characters taken on: Examples of characters were deputy director of education, visually impaired young man, female sex worker, policewoman, etc. Participants shared

on how they assumed the character they played, assumptions made about the character often reinforcing stereotypes and their decision-making process.

- Who or what is responsible for holding some people back? This question brought out a variety of possible actors and factors like community at large, vulnerabilities as a result of the state's apathy in providing essential services and social support, existing socio-cultural norms, being blind to the privilege that one has, other structural inequities and the apathy to recognize them, and market that strives for capital gains.
- What were the channels to make themselves be heard? The common channels mentioned were peer groups, civil society organizations, frontline workers, and researchers. Political advocacy and empowerment of the marginalized were also mentioned.
- What were other influencing factors that could be thought about? The positionality of researcher matters that this was recognized by all, with some discussion around the privileged perspective. While playing the role of different characters, the participants felt that they at times reinforce existing structural norms, and thereby rob characters of their agency due to their preconceived biases.
- Implications for research: There is a need to explore how norms evolved, were adopted, how and when did it change or how can we change them. Research for health equity is about helping to explore the how and why question behind what we see in society, and the existing patterns of inequities need to be studied.

S3: Intersectionality by Devaki Nambiar

At the end of this session the participants were expected to link personal experiences and reflections from power walk to the concept and provenance of intersectionality.

The session started with asking participants to recall their roles in the power walk and assess how some of the factors influenced them to step ahead or stay back in the walk. Various insights came through, like reflexivity, positionality as a researcher, geographic locations, available privileges, oppressions they undergo in the society etc., do matter in taking decision. Examples of case study on indigenous people and risk of non-communicable diseases was enriching as it highlighted how tangible variables are largely focused rather than other determinants which also influence on tribal health. Throughout the session, the speaker insisted that the young researchers look from the broader lens to the health of an individual, instead of superficial and immediately visible variables. She explained it using an example on sex workers how they are always being targeted towards HIV instead of looking their life as a whole because their various problems and pathways in which they are into it, if we don't understand the details, we will not be in a position to provide solution for such communities.

This session highlighted the following points:

- Intersectionality promotes an understanding of human being and shaping of their interactions based on different social locations - race, ethnicity, gender, class, migration status, religion.
- The concept intersectionality has emerged from the belief that all oppressions are interlinked and cannot be solved alone
- Intersectionality matters in global health because multiple factors interact, people experience privilege and oppression simultaneously and more than that our own position matters since we as researchers are working towards social justice. So, we need to be integrative, harmonized and aligned to each other.

Readings:

- Kapilashrami A, Hankivsky O. Intersectionality and why it matters to global health. Lancet. 2018 Jun 30;391(10140):2589-2591. doi: 10.1016/S0140-6736(18)31431-4.
- Hankivsky, Olena. (2014). Intersectionality 101.

S4: Introduction to concepts & theoretical frameworks by Arima Mishra & Devaki Nambiar

The main objective of the session was to unpack and examine 'equity' conceptually and methodologically**.** The participants were divided into two groups and each group was given a case study to read and reflect upon a couple of questions — who were the vulnerable, and what were the processes that created such vulnerabilities?

The first case story was the chapter "What killed Annette Jean?" from Paul Farmer's book. The participants listed the causes from the chapter that included the illness tuberculosis and malnutrition, but also lack of awareness about the illness, the health system and access and preparedness of the health series. Gender and traditional beliefs were other factors identified. The discussion went from the immediate causes to larger societal issues, and the need for establishing causal linkages between them was highlighted. Certain questions were also deliberated upon like how to delineate the pathways through which these determinants operate, and how a person's case study could also represent more than an individual's story but as a representation of a group.

The second case story was about the death of women after sterilization in Chhattisgarh published in The Hindu paper was taken for discussion. Participants discussed and critiqued around the title as who are these women? What were the causes of the death? The purpose of these exercises was to encourage participants to think around how and why questions and make them familiar about why it is important to discuss these questions in equity research.

The session introduced the participants to a number of social science concepts like health equity, structural violence, vulnerability, embodiment, etc.

- **Health equity and inequity:** It is the absence of systematic disparities in health between more and less advantaged social groups. Health inequity is the systematic disparities in health which are avoidable, unfair and unjust.
- **Structural violence**: Concept by Paul Farmer used in health but originally from peace research (Johan Galtung). "Structural violence is a form of violence wherein some social structure (economic, political, medical, legal) or social institution may harm people by preventing them from meeting their basic needs. It is an avoidable impairment of fundamental human needs." Structural violence inflicts unjust outcomes on people. There are two other kinds of violence- symbolic and experiential violence. E.g.: Potential life expectancy in the general population might be significantly longer than actual life expectancy of disadvantaged groups, due to factors like economic inequality or sexism. The discrepancy between potential and actual life expectancy is caused by structural violence.
- **Vulnerability**: The discussion went around who are vulnerable and how to identify them. The speaker mainly highlighted that, the aim should not be stuck in identifying these vulnerable groups rather the focus should be on the conditions and processes which leads to vulnerability.
- **Embodiment**: This concept is given by Nancy Krieger who says, Bodies as sites of how history, society and politics play out, studying the pathway of embodiment is important: Our living bodies tell stories about our lives, whether or not these are ever consciously expressed. Embodiment is a construct and process which is central to eco-social theory. It mainly highlights that;
  - Bodies tell stories and cannot be studied separately from the conditions of our existence
  - Bodies tell stories that often, but not always match people's stated accounts
  - Bodies tell stories that people are unable to tell because they are unable, forbidden or choose not to tell.

Key points that emerged were the need to look at social organizations embedded within the economic and political system, that create and perpetuate inequities, how vulnerability is dynamic in society and is continuously shared by various forces from local to global, and how focusing enquiry on social practice and the historical forces that shape them can help us unpack vulnerability. Key messages of the session were:

- Go beyond what is immediately visible
- Shift attention from individual to social structure
- Unsettle the status quo
- Focus on relation/interaction/interfaces that contribute to inequity
- Inequity is not static/given hence needs concepts to capture dynamic process of inequity

Readings:

- Braveman P, Gruskin S. 2003. Defining equity in health. J. Epidemiol. Community Health 57:254–58

- Diderichsen F, Evans T, Whitehead M. Chapter: The social basis of disparities in health. Challenging inequities in health. 2001. Oxford University Press.

S5: Who am I in research? by Prashanth N S

The session aimed to help participants explore why epistemology and methodology matter before we talk of methods for deeper engagement and nuanced understanding of addressing equity questions. The session was broadly divided into four broad verticals. This predominantly studied aspects of self in relation with the knowledge and an overview of the history of social sciences research. This was particularly critical, as the session implored the participants to evaluate their epistemological stance prior to undertaking research.

1. The first part of the session was dedicated to a discussion on who is a researcher? What makes me a researcher?

The resource person invited the opinion of the group on this subject. The participants pointed to several factors that make them a researcher. This ranged from 'my ability to question' 'my training' 'my systematic, yet objective perspective' 'my gut feeling'. These statements became the basis for the rest of the discussion

2. The second part of the session looked into the history of social science research and finding *science* in public health

After a broad discussion of the evolution of sciences which predominantly rely on patterns and process and a consequent ability to predict, the facilitator touched upon the medical roots of public health. Whilst sciences rely on a ritualistic systematic approach to prove predictions, public health research too relies on systematic questioning approach. However, public health research is geared towards action and change to aid the facilitation of discourse. The discussion then brought out a broad question "why are urban policies aggravating the exclusion of migrant communities". The question as a research question was our ability to observe a pattern, attributed to a certain process and the answer to the question can potentially induce action or change. Whilst the process is ritualized and systematic, the central tenet it relies on is a social construct- namely, exclusion and an apparent inequity. This construct and the subsequent ability to measure it constitute the research

3. The third section investigated the researchers' world view and how that shapes her/his research

- However, the migrant question reflects the researcher's point of view which centrally hinges on her priors and her engagement with the body of knowledge. This was discussed further with a discussion on an inductive and a deductive approach. This centrally relies on the researchers' understanding of the nature of reality and how one can know it. On the basis of this, the researcher can believe that there is an actual truth or many truths, and this constitutes the research paradigms one identifies with: positivist, post positivist, critical realist, or constructionist.

4. What makes the study of public health a body of research?

- The crux of the argument appeared to be the transformative nature of knowledge and how public health research can induce this change via the creation of organized knowledge.
- Therefore, what makes public health research a body of science is its ability to explain a phenomenon and a mechanism that can test a 'knowable' question.

Readings:

- Gilson L, ed. Section 7: Understanding the nature of social and political reality. Health Policy and Systems Research: A methodology reader – the Abridged Version.

S6: Quantitative approaches to studying & measuring health equity: Indicators & methods by Shreelatha Rao Seshadri

This session aimed to help participants to understand the logic, strengths and weaknesses of quantitative methodological approaches. Quantitative approach involves two essential actions, namely measurement and comparison, and denotes expression of an idea using numbers. Moving from equality to equity involved two aspects - assessing the degree of deviation from equality, and the moral or ethical concern with inequality.

The major points that came out of discussion during the session were;

- Equity involves assessing the degree of deviation from equality and the moral and ethical concern with equality and as with the quantitative approaches, large numbers always have the big value.
- Work on inequity started in mid-1800. Early theoretical development happened during 1900 to 1965, during 1965 to 1990 large epidemiological studies tried to quantify the health gap. After 1990, social epidemiology came up as a new discipline.
- Speaker mentioned that, now there is demand and supply side reason to do this research. Technical expertise in this field, availability of computer/laptop and availability of different types of analytical packages make life easy to do quantitative research on inequity.
- Speaker also stressed upon having a theoretical perspective on why a certain unequal distribution might represent inequality and how our theory helps us to define what we mean by inequity.
- She mentioned that, researchers need to think about specific variables which will help to measure inequity and then strategize for collecting data and analysis.
- Speaker mainly insisted that the researchers select the research design based on research questions rather than hierarchy of the design.

A limitation of this type of approach is that while it provides useful information on what factors lead to inequity, it remains silent on the 'how' question. However, this approach allows for comparison of similar situations to help make comments on what represents a higher degree of inequity, and this is its strength.

A key point made was that there is no one way towards measurement of inequity; measurement depends on context. Not quite often but yet, it is dictated by data availability. Another key point that emerged was that quantitative techniques helped to arrive at gaps or represent differences. However, to conclude that this was inequity depended on moral judgements, and this perspective needs to grow in society today.

Readings:

- Banerjee AV, Duflo E, Glennerster R. Putting a Band-Aid on a Corpse: Incentives for Nurses in the Indian Public Health Care System, *Journal of the European Economic Association*, Volume 6, Issue 2-3, 1 May 2008, Pages 487–500, https://doi.org/10.1162/JEEA.2008.6.2-3.487
- Marmot M, Allen JJ. Social determinants of health equity**.** Am J Public Health, 104 (suppl 4) (2014), pp. S517-S519

S7: Qualitative approaches to health equity research (framing questions & using methods) by Arima Mishra

This session aimed to help participants to understand the logic, strengths and weaknesses of qualitative methodological approaches**.** The session began with a quick round of perspectives of participants on their thoughts on qualitative research. The participants shared that they found qualitative research to shift focus from researcher to participant, allows voices of all stakeholders to be heard, and provides space for face-to-face interaction. Some felt that qualitative research could be formative research involving open-ended questions that allows for in-depth exploration for an issue. This helps answer the how and why question, understand pathways, and generate relevant hypotheses. Few of them also felt it as non-numeric, non-statistical, it gathers experiences of individuals. However, few admitted that they felt that qualitative research is not replicable and thereby findings cannot be generalized.

The speaker then initiated her talk by explaining that the focus of the session would be qualitative modes of inquiry and not methods i.e. epistemology not methodology. She highlighted the importance of focusing on when and why a qualitative mode of enquiry is used, what it entails and implications on the research process. She emphasized the importance of framing research questions and discussed two instances with participants.

The speaker then shared her experience in conducting research on local health traditions. She explained in detail how they framed the questions, the iterative process of research that followed, and the different methodologies then undertaken to answer the questions identified. Following the summary, she also shared the challenges in the field and the dilemmas that the research team faced as they struggled between research and action.

The key takeaways discussed were the importance of framing a research question, being sensitive to the study of everyday practices and mechanism of inequities, understand that a research can explore deeper methodological engagements by studying multiple sites and the importance for research to be reflective and critical. The speaker emphasized that qualitative modes of inequity involved co-creation of knowledge with participants and researcher and restrained from commenting or comparing with quantitative methods.

The session ended with discussion with participants on methods, biases involved, ethics and importance of researcher. It was discussed that researcher is very much visible in the knowledge production and its synthesis, and it was hence important to consider one's position when undertaking any research. Speaker concluded her session saying that one needs to be sensitive and reflexive while framing research questions while using equity lens and qualitative research is an iterative and evolving process.

Readings:

- Samuelson et al. Do health systems delay the treatment of poor children? A qualitative study of child deaths in rural Tanzania. *BMC Health Services Research*. 2013, 13:67

Figure 3. Pictures from the sessions

S8: Mixed methods research- questions that bring it together by Venkatesan Chakrapani

This session aimed to help participants to understand the logic, strengths and weaknesses of mixed methods approaches. The session took the participants around the understanding of features of Mixed Methods Research (MMR) and its application. Session also gave some examples of potential MMR questions and the kind of design that it follows. Speaker initially explained the importance of quantitative and qualitative research to set the stage for discussing the importance of MMR. He mentioned that MMR is a combination of quantitative and qualitative research which mainly helps to understand deeply the phenomena of interest and to arrive at better corroboration of the findings that our research is intended to.

MMR is used for addressing a range of exploratory and confirmatory questions to draw better and stronger inferences. He explained about how inductive and deductive approaches are used in the mixed methods of research. He highlighted the ways to form mixed method research question, he mainly

explained three ways either this can be quantitative or qualitative separately or an overarching MMR question which includes both, therefore such questions are better answered using MMR. Talking about the design of MMR, he mentioned that triangulation is the strength of the MMR which helps to draw robust conclusions from different designs such as explanatory, exploratory or sequential designs. The session was enriching as the speaker made it lively in understanding MMR through his actual work that he had carried out in his experience. He mainly gave an example of HIV related sexual risk among men who have sex with men in India and explained the way to use mixed method approach in that study.

He ended his session saying that MMR is a powerful way of doing research. However, having said that, one needs to be cautious about the availability of enough resources, how the qualitative and quantitative component will be used, how is the priority for quantitative and qualitative, what sequence data will be collected and how does it affect in drawing inferences.

Foundation level books for MMR:

- Curry, L & Nunez-Smith, M. (2014). Mixed methods in health sciences research. A practical primer. Sage Pub.
- Teddlie, C., & Tashakkori, A. (2009). *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioural Sciences*. Thousand Oaks: Sage.

Advanced level Reference for MMR:

- Tashakkori, A., & Teddlie, C. (Eds.). (2010). *SAGE handbook of mixed methods in social & behavioural research* (2nd ed.). Los Angeles, CA: SAGE.

Basic level books in Qualitative Research:

- Uwe flick. (2010). An introduction to qualitative research. Sage Publications.
- David Silverman (2012). Qualitative Research. Sage Publ.

S9: Readings on health inequities (led by Tanya Seshadri)

This session aimed to provide participants with an opportunity to apply the concepts and frameworks that they had been introduced to, through a critical review of articles implicitly or explicitly addressing health inequities or inequalities. The participants were divided into four groups, and each group was assigned the following 5 papers to read and discuss and come out with three main points that they reflect from the readings.

1. Rai T, Lambert HS, Ward H. Migration as a risk and a livelihood strategy: HIV across the life course of migrant families in India. Global Public Health, 2016.

2. Karn SK, Shikura S, Harada H. Living environment and health of urban poor: a study in Mumbai. Economic and Political Weekly August 23, 2003.3575-86

3. Sebastian B. The last resort: why patients with severe mental disorders go to therapeutic shrines in India Chapter 7. Restoring mental health in India: pluralistic therapies and concepts. Oxford University Press. p 184-209

4. Chattopadhyay S, Mishra A, Jacob S. 'Safe,' yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India. Culture, Health & Sexuality 2017.

5. Das V, Das RK. Urban health and pharmaceutical consumption in Delhi, India. Journal of Biosocial Science. Vol 38 Issue 01 Jan 2006 p69-82

Each group spent 45 min reviewing the paper. All groups finished their readings on that day and the next morning, time was provided for discussion. A list of questions was provided to guide their review of the papers, and are shared here:

1. What is the problem being addressed in the paper? Are all individuals affected by the problem in the same way? Why or why not?

2. What are the sources of inequity in the specific case being discussed in the paper?

3. What are the mechanisms/processes through health inequity created/reinforced? Explicate the role of actors as well

4. Any process/factor/mechanism missing in the discussion in the article?

5. What methodologies are applied to the study of health inequity?

6. How would you view the significance of the findings?

Figure 4. Pictures from the group discussion and presentation after

Then the participants discussed within their respective groups. Each group was assigned one facilitator who moderated a discussion within the group of key insights from all five papers, focusing on unpacking the different complex mechanisms. At the end of the group discussion, one person was nominated who shared three main points that came across discussion for the above question is concerned. The involvement of each group was encouraging and productive in terms of the way they were able to analyse and critique the papers that workshop had assigned to them.

3. Case studies of health inequity research

CS1: Nutrition in tribal areas by Vandana Prasad

The speaker took us through her journey as a researcher and activist and shared various insights in the session. She mentioned that, it is Important to acknowledge where you come from – the privileges and the non-privileges that you enjoy or oppressed with as each of these shape experience and outlook as a practitioner/researcher.

Her outlook on the field has been influenced by her clinical work, public health, working directly with the community, and advocacy and political approaches of working with campaigns. She has had experience working with tribal groups, in labour rights, women and child rights, nutrition. In her session she explained the importance of various traditional methods of preparing food for better nutrition and she insists on maintaining a kitchen garden in the courtyard.

In her opinion, we have all been working in the pursuit of intersectionality without consciously seeking it out/defining it. She mentioned that, it is essential to make sure that larger vision translates to all work/all components - however big or small. Every output should be a microcosm of the vision. Similarly, help all individuals involved in work to go beyond being 'a cog in the wheel' and encourage them to think well and make good decisions, in keeping with the larger vision. She went on sharing her experience of working with PHRN and she feels that organizations can position themselves in keeping with their strengths. PHRN was able to set some non-negotiables, and act as a resource group.

She stressed the importance of institutionalizing the learning as it needs to be sustained even if there is transition of human resources which helps to build policies and competing groups in the society. She also spoke about the importance of encouraging work cultures/places that encourage openness, inclusiveness, transparency. She concluded saying that, although research in itself does have value, we should envision action that can result from each piece of research. From an equity perspective, actionability of evidence is very important. This ties in with embedding research into program design.

CS 2: Health of sexual & gender minority populations by Venkatesan Chakrapani

The speaker narrated his exciting journey of playing different roles as researcher, activist and as change maker in the policies. He observed the discrimination that was happening with HIV people. His life turning incident was during his MBBS when he posted in a sexually transmitted disease (STD) unit and health care providers refused to give injections and he was not having clue why is that so. That is where he started his journey to work towards the HIV population. He acknowledges that he was not aware of the term trans women till his MBBS. Having seen the widespread discrimination with HIV people, he decided to dedicate his life for the people with HIV and sexual workers.

He went on sharing his work with a project called SAATHI which initiated the policy and program for free treatment for HIV people. The speaker mentioned that he followed up and ensured the better implementation and access of the treatment. He also wrote policy briefs and did national consultations and his recommendations were passed and that is how small work translated to policy change. So, he believes that research has a lot of power and advised young researchers to publish their findings even if it is small work. He believes that being diplomatic is the best way to translate your work as policy and also it helps to work with government, and policy makers in a harmonious way.

He mentioned that, discrimination even is at the top organizations like USAID which denied using 'I support sex work' by an NGO, instead they wanted to quote it as 'prostitution'. So, he feels that policies are made by a few people who are in power and convincing them is very difficult. On a whole, speaker shared his extensive experience which highlights and delves deep into the major impact of stigma and discrimination into an individual's personal health and vicious cycle of issues apart from low access, marginalization, and being left out.

He tried to bridge the gap between research and policy changes. Did not leave it as just research, marketed the findings and communicated it for changes in the system, took the extra leap and shared the things he found because he wanted it to be HEARD and paid ATTENTION to.

CS 3: Gender & insurance by Rajalakshmi RamPrakash

The speaker helped unravel gender inequities in Publicly funded health insurance Scheme(PFHIS) in her talk. Her experience as a researcher comes from a social work background and an as activist when she exposed the illegal practice of ultra- sound sex determination by posing in as a decoy witness.

Findings from her study:

- Gender barriers exist in the PFHIS implemented in Tamil Nadu (Chennai and Salem). It is skewed against women at the levels of **a) individual** (lack awareness), **b) household** (need permission, financial dependence), **c) community** (poor living conditions, power hierarchy), **d) health system** (inequitable distribution of empanelled hospitals, misleading information from private hospitals, delay and high out-of-pocket-expenditure in spite of insurance), **e) market** (contracting out to profit oriented insurers and poor gender sensitization, changes to financing of public health system from budget line to insurance generated revenue, discriminated of uninsured), **f) policy** (focused on vertical needs-tertiary care and excludes marginalized women, lack of regulation in the private sector).
- Anecdotal evidences of exclusions from enrolment or from treatment suggests that market -based insurance schemes lead to further exclusion and discrimination.
- She highlighted various challenges she faced in her study right from digging secondary data, changing the study design in the middle of the study etc. She urged researchers to anticipate and be prepared to provide as much justice as possible to the work that we do.
- Recommendation that for universal health coverage, one needs to look beyond economic indicators, look beyond maternal and child health care for the health of the women, ensure universal coverage leads to good quality care.

One of the takeaway messages was when you look through the lens of gender and health equity, right from the household to the healthcare institution the life of a woman is quite difficult with no decision-making power vested with her. Somehow, we normalized this everywhere and the equity lens do make a change in making it visible. She also mentioned how the moral hazard of insurance corrupted public hospitals. There was clear injustice happening at the healthcare centre like irrational denial of insurance claim by a woman and giving biased information in order to avoid the woman claiming insurance in future.

It's clearly the unequal, patriarchal, neo-liberal societies leading to gender blindness. But from her narrative, how the speaker dealt with these problems during and after her research gives high hopes that there can be changes made from a research and how and where the researcher could initiate it.

CS 4: Dead women talking by Renu Khanna

The speaker started the session with an introduction and invitation to Medico Friends Circle (MFC) and the MFC Annual Meeting in Feb 2020 this time on dilemmas of young health professionals. She started her session narrating her journey of life. In 2010 following a high number of maternal deaths in the Barwani district hospital, a civil society fact finding team was constituted. The speaker along with two friends, an Obs-Gyn specialist and a long time women's health activist and advocate, found that many deaths in the district hospital were preventable. their fact finding report highlighted the social determinants that lead up to maternal deaths as well as the weak accountability in the entire health system. Following this very disturbing experience, CommonHealth - the coalition of which they were a part - decided to investigate maternal deaths across the country.

The objective of this case study was to illustrate Dead Women Talk as an example of a community-based health inequity. The background context was set as 15% of global maternal deaths happen in India and every maternal death is a tip of the iceberg in terms of the approximately 20 women who suffer from reproductive morbidities. Maternal Death Review (MDR) is mandated by the national government since 2010 to be conducted at district level. This is now revised to Maternal Death Surveillance Response (MDSR) guidelines in 2017. Gaps and challenges: Less than a quarter of the deaths reported to MDSR system of these only 2/3rd are reviewed. These are exclusively nested within the health system with no scope for independent civil society or family participation. No information is available in the public domain and the focus remains on the bio-medical causes. A collaborative civil society initiative -23 CSOs across India approached MDR as community based, rights perspective lens. There was some understanding from earlier work on Barwani fact finding. The study found 124 maternal deaths across 31 districts and 10 states. During the course of the study, it was clear that maternal deaths affected women from marginalized communities disproportionately. Social determinants and health system issues were key contributors and accountability of health systems emerged as important issues. Social autopsy was used as a tool. It is an interview process aimed at identifying social, behavioural and health system contributors. Initially, it was to be a complimentary exercise. However, the total lack of MDR by the district administration made it a supplementary undertaking. There were challenges of language, state administration's resistance and lack of human resources.

There was a parallel system by which Sangathan women reported maternal deaths directly through WhatsApp and SMS to the authorities directly that did not go well with the ASHAs and ANMs. The study highlighted social determinants such as issues of marginalization and exclusion, caste, gender, poverty, religion, nutrition and geography and their interaction with maternal health.

for this study the team developed a SSSR framework (Science, System, Social and Rights). The participants were then asked to analyse Urmila's story using the SSSR framework. The lessons learnt from the study and the story were democratization, focus on social determinants, human rights perspective, increased accountability. There needs to be a shift to identify "High risk" in terms of social, system and rights perspective.

CS 5: Menstrual hygiene: linking the individual & social to ecological by J K Lakshmi

The speaker reflected on health equity through the PEnMen-pilot (Perspective, Practices and Environmental footprints related to menstrual hygiene). In her case study, she narrated the pilot study that was conducted in Hyderabad. Perspective, Practices and Environmental footprints related to menstrual hygiene among girls and women in India – a pilot study in & around Hyderabad. Study adopted in-depth interviews, focus group discussions, photo documentation, life cycle assessment to collect the data. Study identified the most to least used products in the order sanitary pads, reusable cloth pads, menstrual cup.

There is little to no discussion on what happens to sanitary products after they've been used. There is little awareness on what is the interaction between menstrual hygiene management & environment. For example, throwing used pads can be harmful for the environment but little/no choice. A handful of people have started thinking about alternate ways of disposing of sanitary napkins and products, but the majority of people do not, and from a social perspective, what people know, can afford, buy and manner of disposal are all tied to the social environment. In this study, researchers used the social ecological model of health then to show their key findings. The study identified some of the key gaps as follows:

- There are awareness gaps: Missing from education, families don't want to share this information with their children especially with boys/sons.
- There is a lack of options: cloth (easily available), commercial sanitary pads (easily available but can be expensive for some), tampons (not easily available and issues relating with virginity etc) and menstrual cups (not easily available).
- Availability and affordability: Women may not out rightly say that sanitary products are expensive, but some don't change as often – alluding to possible affordability issues. Women are mostly denial or feel embarrassed to talk about and seek advice on it.

She mentioned that, menstrual cups have the least negative impact on the environment followed by tampons, and sanitary pads. She proposed that there is need for policy advocacy work through top down approach advocating for environmentally viable sanitary products, awareness raising and public engagement. Conducting sessions in rural areas for girls and women, conduct sessions for men and women together, tie up with media agencies to reach the most rural areas regarding the use of sanitary products is the need of an hour.

The speaker brought some of the key challenges that she faced while doing this study such as selecting the right participants, forming homogenous groups for focus group discussion, challenges with spectators and audience (e.g.: school principal walking into the classroom while discussing sanitary issues which was hindering girl students to express their opinions), confidentiality issues (e.g.: teachers being part of the focus group discussion was major hurdle despite giving enough explanation to them). Discussion around how this can be looked at through an equity lens took place during the session. She spoke about asking questions about awareness, accessibility, affordability, autonomy/social ease throws lot of discussion on these kind of topics when it comes to equity and apart from that, social and environmental implications that sanitary practices does is also an important area to look into as earth is a participant too in this kind of scenario in that sense, it is important to ask the question, what happens to the health of the planet?.

She mentioned that, there can be different solutions for different people at different points of time which she illustrated with visual representation of equity using colour pencils which denoted not everyone has access to all facilities; they should be able to use what they can. Those who do not face issues relating autonomy, access, and affordability should use environmentally friendly products and owe it to the environment.

Report back from groups on learning

In this session, groups shared their reflections on the different case studies present. Application of the health equity lens to research, motivation of researchers, the importance of framing questions and how research itself can be transformative were some of the key points that were discussed.

Participants also highlighted that they learnt the importance of publishing work how much ever small it is, change begins even from small work and hence bringing it to the platform where it is visible is important and some of them also mentioned that research is a powerful way to bring change and if it does it with equity lens then it has a lot of societal impact. Few of them appreciated the activist nature of speakers and how they took risks for the social cause. Discussions were also followed on challenges in bringing ideas into action and the importance of keeping the right network and discussing in the right forum were highlighted as a measure to overcome challenges.

3. Application exercise: Developing research question, objectives, conceptual framework and approaches to implementing the study

The participants divided themselves into four groups and they were expected to choose any one broad area and each group was expected to conceive and construct a health equity research proposal applying the learnings from sessions across the days of the workshop focused on the research

question, methods adopted, and explain in detail why and how this proposal is developed and what is the inequity problem that they are addressing. Topics chosen from the groups were;

1. Barriers faced by frontline workers in providing reproductive healthcare services to homeless women in Delhi Urban (Reproductive health)
2. With mirth and laughter let wrinkles come; are we ready for geriatric care? (Geriatric health)
3. Is the fruit to be blamed? Understanding child mortality in Muzaffarpur, Bihar (Child health)
4. Are the Bananas SAD? Exploring stress, anxiety and depression among university students using mixed methods (Mental health)

Details of all group work presented is enclosed in **Annex-4**

Figure 5. Pictures from the application exercise discussions

It was an enriching session in terms of participants showing their enthusiasm in group activity and also bringing innovative ideas in their work. The presentations were reflections of their learning from the previous four days. Each Presentation was evaluated and given feedback from resource persons to bring more focus and clarity in the research questions, methods and analysis plan, so that participants will benefit from their exercise.

4. Concluding session including takeaway messages and feedback

The facilitators Arima Mishra and Devaki Nambiar took the participants through the journey of this workshop. They were able to trace the sessions and learnings from day 1 to 5.
Feedback was received from participants in a plenary format and included the value of understanding how people doing health equity research link up their work and lives and how that in turn relates to the methods and approaches they use. Participants also noted the diversity of the group and the richness that this brought to the workshop. It was also noted that the agenda was 'alive,' allowing ample participation and that it felt like a safe space for discussion and that facilitators were approachable. The fact that the workshop was residential was felt to be advantageous because this facilitated teamwork (as well as singing and dancing!). The reaffirmation that health research work is a political project and that such research should not be siloed from advocacy and action for change was also underscored.

Some thoughtful suggestions and important areas of improvement were also given: it was suggested that more emphasis be placed on framing or reframing research questions with a specific session on this. It was also suggested that the workshop cover how to link up with the media to increase the impact of research. Another area was to develop a training of trainers' model to amplify the impact of the capacity-building itself. Some noted the challenges of internet connectivity and mosquitoes at the venue - not a deal breaker - but certainly an annoyance! There was some discussion around sharing rapporteur notes and keeping that on track and finally, that it would be useful to create and connect alumnae in meaningful ways.

Key takeaway messages were:

- There is no one brand on research in health inequities, and that it is multi-disciplinary, and no one disciplines has all the theoretical frameworks for this research.
- At all levels in society, whether health systems, academia or civil society, emerge relevant research questions that need to be answered.
- It is key for this research to be collaborative for the strengths of each of our discipline, experiences and worldviews to come together to make sense of the complex processes underlying inequities.
- The importance of the research question is well-established through most of the sessions and group work. It is important to keep in mind while pitching a research question, the multi-level power distribution of the structural nature of inequities. In addition to this, it is also key to do no harm i.e. to not frame or follow questions that reinforce existing inequities.

- Coming to research methods, it is important to try and reduce the power differential and be mindful of co-creation of knowledge through research.
- Health equity research is a collaborative process, but ultimately it is the motivation underlying the research that makes the difference.

Feedback from participants and resource persons

An online evaluation was made available for both participants (11 items) and resource persons (12 items) for roughly two weeks following the course. Fifteen responses (out of 22) were received for participants and six (out of seven) for resource persons.

Participant responses

Participants noted their expectations and all but three indicated that they were met or exceeded. Among those for whom expectations were not met, comments were:

> *I had a better understanding of the concepts - but there was still some confusion about how to apply the theoretical information to improving research/implementation design.*
>
> *Being mentored to do a full health inequity research - this expectation has not got fulfilled as not formally part of the design. Hence will take this up with friends / Researchers on a personal basis. And wherever HENI can pitch in , would really appreciate.*
>
> *Unfortunately I did not feel that breakthrough but very much inspired by the sessions by activists researchers. Discussions on funding at times were disgusting as I personally feel that if you really want to do something, one or the other door will be open for you. And that sort of motivation was not flowing in the discussions on funding.*

We also found that 93.3% of participants were satisfied or completely satisfied with the overall balance of topics and materials dealt with in the course (see figure 6).

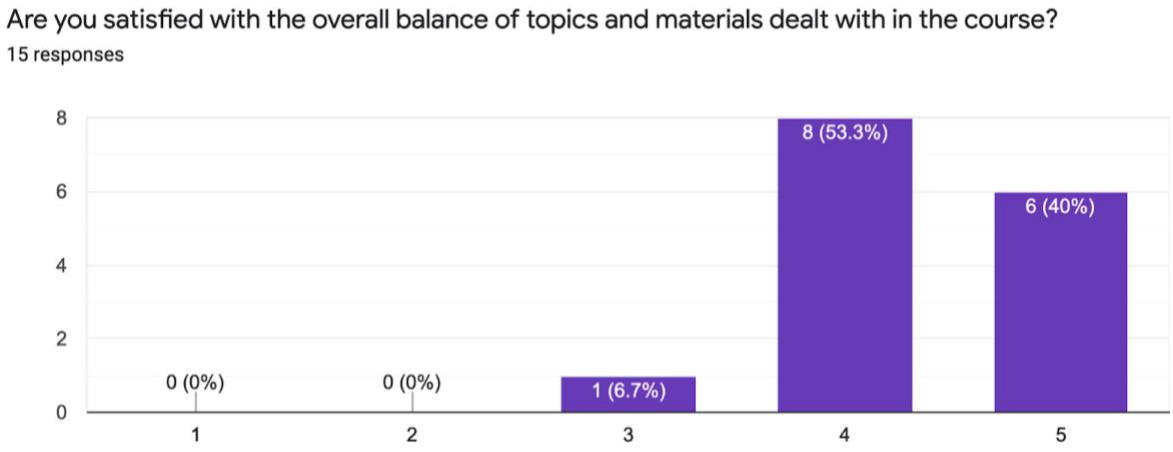

Figure 6. Online feedback query and response

Two thirds of participants read materials during the workshop, while 20% noted that they could not read most of them. Notwithstanding this, the suitability of the materials was felt to be high by most participants.

We were happy to learn that various sessions were 'favourites' for participants, particularly the live case studies :

> *Dr Prasad's and Dr Renu's presentations because they were incredibly thoughtful in how their personal lives interact with their work as well as how this work relates to a broader political project.*
>
> *Hearing resource person's career journey was also something I'll carry for a long time. e.g. Dr Vandana, Dr Venkatesan, Dr Rajalakshmi. Because this gave me inspiration and also a peek at how each person's pathway is different in the field of health equity*

In addition, the sessions that were valued were the intersectionality session, who am I, group work, power walk, even the quiz:

> *Power walk (Practical demonstration of equity concept...really loved it), group activities (lot of spontaneous ideas and fights and yet arriving at consensus, a great way of learning).*
>
> *Prashant's session on reconsidering the ritualization of research - I have been trying to articulate the same thing for some time and this resonated with me.*
>
> *Intersectionality, as I got to learn a new theory*

We also asked what topics were not covered that should have been. We are including all but two (who said no comment!) the responses as this is helpful for future planning:

> *At least in group work, I understood some of them believe that equity is when there are tribal or Dalit population. There should have been more sessions on various aspects of equity.*
>
> *Challenges in conducting health inequity research would have been useful*
>
> *How is the population health needs assessed, by whom and how in the Indian context? Are our providers culturally empowered?*
>
> *A short field visit may have benefitted to apply some of the concepts and methods learnt during the workshop.*
>
> *Some international context, example of any other LMIC and/or HIC and health inequity there*
>
> *Inequity while delivering maternity services, the disrespect and abuses could have discussed more specifically.*
>
> *The use of Digital tools for health inequity research; the use of digital analytical tools and their limitations ... The use of RCT - and its limitation, politics could have been much discussed.*
>
> *Apart from the two people from Kerala, government organisations were poorly represented. It would be good to get an insight from those working within the system. I think it would be nice to*

offer invitations to nurses, ANMs, others willing to participate and exchange notes. It would also serve, I think, to expand the horizons of those working in trying circumstances within the government system.

I wish we had discussed in depth on forming the research question. We did on the last day but since that is what drives our methods, our understanding etc, we could have spent more time on that.

Although each session was relevant; sessions on methods had to be rushed because of time - it would have been great if we had more time to discuss all the slides presenters had prepared.

Analyse study research design by large scale public health organizations - and see what should happen additionally/instead to ensure intersectionality/equity.

I guess since Qual, Quant and Mixed methods were organised on the same day, there should be a session making a connect between the 3, and how each method is to be used for different types of RQs

The wider debates that are currently being engaged with in the field of health equity. This would have better helped us understand the politics of the people who are working in this field.

Fourteen of fifteen participants noted that there had been a personal impact of the workshop. One person noted that there hadn't been enough time to decide this. Other comments included:

I found myself reflecting on the political project of our work more and more through the course and I feel like it has made me more sensitive to the politics behind study design.

A deep impact is reinforcing the idea of questioning status quo and what is fair vs unfair. Recognising and reflecting on our own biases and things we normalise. It also has given a connect with various people working towards health equity and this itself gives a feeling of support

The experience sharing of some of the Researchers was very reflective. It was inspiring and a learning that transformative work requires follow up action and a touch with the day to day development to have a deeper analysis of happenings and their linkage with macro structures, programmes and policies.

Yes, it has reinforced the importance of asking questions and not looking at something from a single lens.

yes, health inequities are avoidable but without involving the researched (participants) and a researcher merely identifying that inequities exist would be unethical in my view

We also asked what changes participants would introduce if they were to organise this workshop themselves. Suggestions included: greater time for individual sessions, more time with the readings (they should have been sent earlier), some sessions could be adjusted (intersectionality shorter, who am I "sharper," more specific in terms of examples, the approaches sections should be longer), and a field exposure component. There was dissensus in terms of how long the course should be - some said shorter, some said longer. Also, there was a request for longer lunch breaks!

In another question, by way of additional comments, participants noted that support (financial) for projects should be given, there should be a 3 month follow up, presentations etc. should be shared, a Q and A or clinic type session could be added to resolve queries, involving other local stakeholders beyond the health sector was encouraged. There was specific appreciation of the venue, the singing and dancing and a desire to keep this workshop going.

Below are the ratings of the logistics of the workshop, where there was some dissatisfaction among two persons (see figure 7)

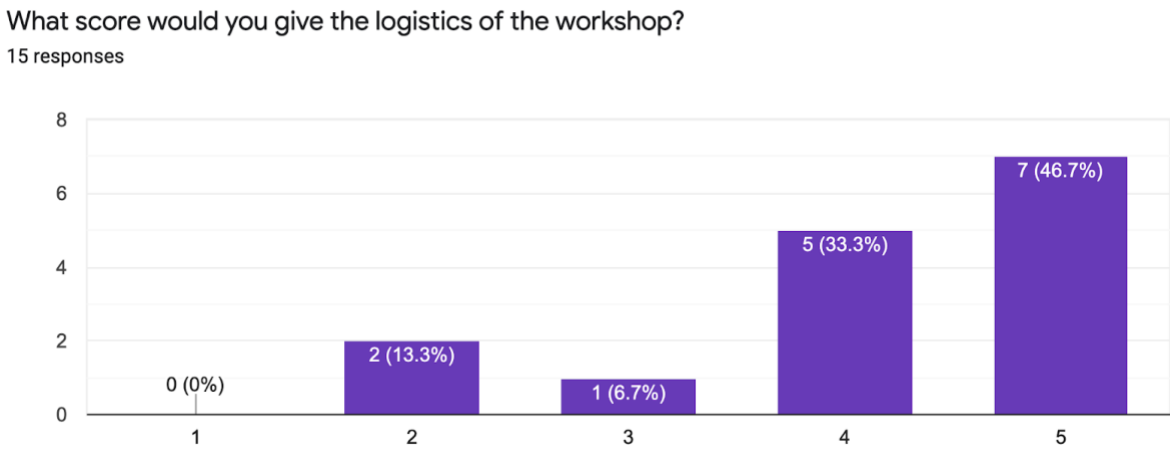

Figure 7. Online feedback query and response

Resource person responses

Among resource persons, five indicated that their expectations were met, at least to some extent. One person noted that given the diversity of participants, their expectations may not be met. Five people felt they had adequate time and information to prepare, while one missed the conference call and did not recall receiving instructions on the case study.

In terms of preparing better, suggestions included more time, more interactions, review of slides, information regarding the possibility of including an exercise, and more information on background of participants shared in advance of the workshop. As regards the balance of topics and the flow and sequence, there was a moderate to good impression (see figure 8)

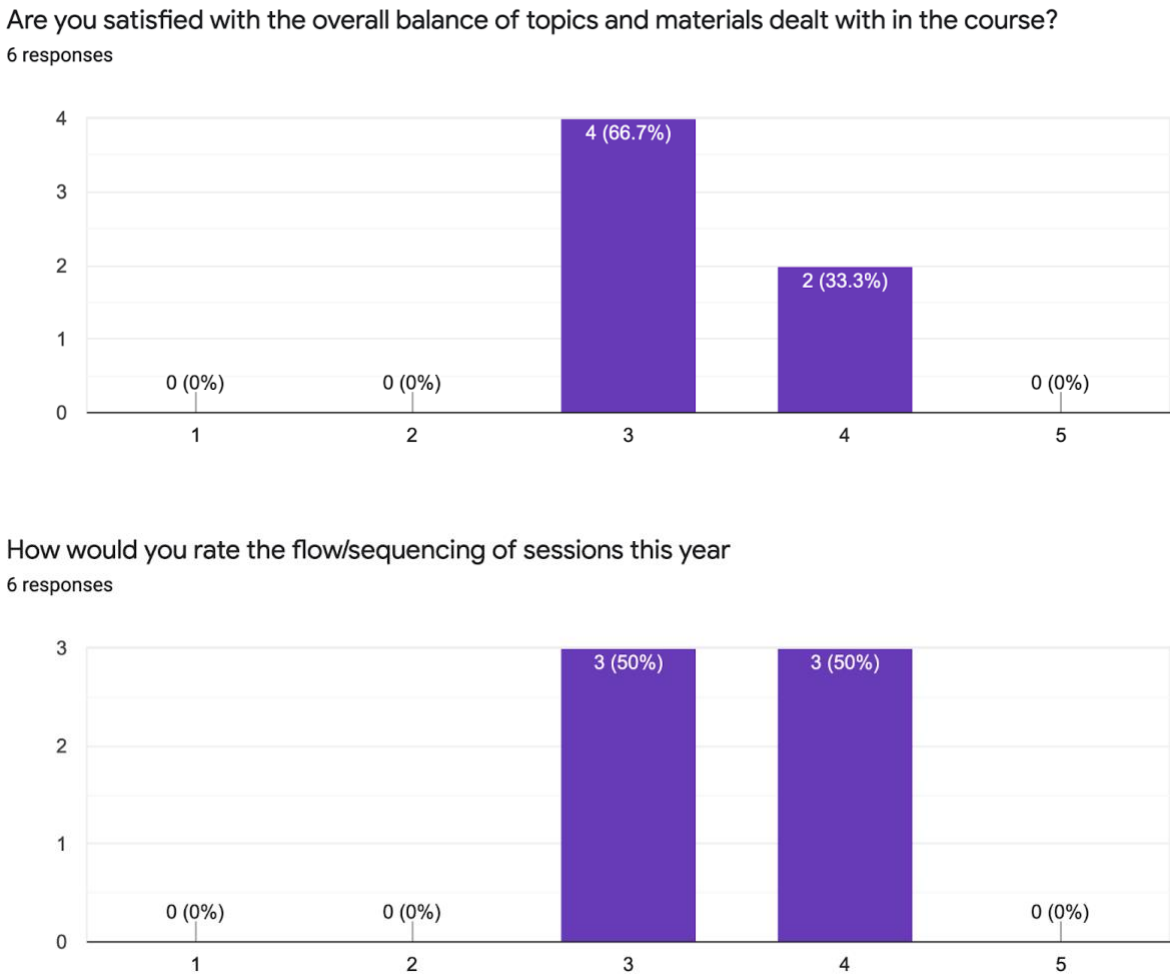

Figure 8. Online feedback responses from resource persons

There were three suggestions on how to improve the sequence:

> *You could try intersperse case studies in between rather than have them all in one sequence.*
>
> *1) More time for research philosophy and positionally perhaps with a at least one slot for group-work, (2) a bit more deep dive into da kind of journal/paper critical reading and analysis*
>
> *Intersectionality can go after the concepts/frameworks; exercises on the different ontology/epistemology/axiology*

Regarding essential and inessential components of the workshop, some resource persons felt they were not in a position to assess. Others indicated that group activities were essential though they had a qualitative methods skew. Frameworks and concepts were felt to be essential, as was lived experience sharing and small group, interactive work. It was also felt that perhaps there didn't need to be so many case studies, that the readings discussion could be shortened and some other sessions lengthened. It was also felt that the methods sections could use more focus. Other suggestions included an applied analysis exercise using qualitative and quantitative methods, also an applied session on framing

research questions (something even participants said), a session on ethical dimensions of health equity research, and the demonstration of a non-equity lens to show the difference.

Other suggestions that were echoed by participants were follow up or more intensive training (one person suggested online certification), mentorship to candidates, and alumnae linkages. Specific suggestions are below:

> *A follow-up a more intensive program (may be from your past cohorts) with rigorous training on quantitative/econometric tools (specific statistical techniques like Propensity score matching, Difference in Differences) and qualitative methods (phenomenology, photovoice). Also a section on Impact Evaluation research, using RCTs for furthering the health equity agenda. You could even ask for a co-payment from candidates and make this a certificate course.*
>
> *At the moment can't think of anything except that we should do an alumni workshop/refresher. Our Online Feminist Evaluation Course recently did an alumni meeting where select past participants presented posters of the application from the Course learnings. So powerful....Maybe something like this? What has the course meant for their work? What have they done with it? etc?*

List of Annexes

Annex 1 - Workshop brochure

Annex 2 - List of participants and resource persons at the workshop

Annex 3 - Workshop programme

Annex 4 - Workshop logistics note

Annex 5 - Presentations made at the workshop (sessions, case studies, application exercise group presentations)