







STUDY PROTOCOL

Designing a socio-normative intervention to reduce anemia in Odisha India: A formative research protocol [version 1; peer review: 2 approved]

Erica Sedlander ¹, Rajiv N Rimal¹, Sameera A. Talegawkar ², Hagere Yilma ¹, Wolfgang Munar ³

¹Department of Prevention and Community Health, The George Washington University, Milken Institute School of Public Health, 950 New Hampshire Ave, Washington D.C., USA

²Department of Exercise and Nutrition Sciences, The George Washington University, Milken Institute School of Public Health, 950 New Hampshire Ave, Washington D.C., USA

³Department of Global Health, The George Washington University, Milken Institute School of Public Health, 950 New Hampshire Ave, Washington D.C., USA

V1 First published: 20 Mar 2018, 2:15 (<https://doi.org/10.12688/gatesopenres.12808.1>)

Latest published: 10 May 2018, 2:15 (<https://doi.org/10.12688/gatesopenres.12808.2>)

Abstract

Background: More than half of women of reproductive age in India are anemic. Anemia is associated with increased risk of preterm delivery, higher maternal mortality and contributes to fatigue, which affects women's work productivity. The World Health Organization (WHO) recommends daily oral iron and folic acid (IFA) supplements during pregnancy and weekly supplements for women of reproductive age. Government programs and global donors have distributed and promoted IFA supplements in India for over four decades. However, initial intake and compliance remain inadequate.

Objectives: This protocol describes the formative research phase of a larger study, which will test, through a randomized controlled trial, the hypothesis that a social norms-based behavioral intervention in Odisha, India will improve uptake of IFA supplements and reduce anemia among reproductive age women as compared to usual care. The focus of this paper is on the formative research required to develop a sound intervention. We will examine socio-normative barriers to and facilitators of IFA supplement uptake.

Methods and analysis: Based on the Theory of Normative Social Behavior, we will adopt a mixed-method, multilevel approach. We will collect data using focus groups, in-depth interviews, observations, Rapid Participatory Ethnographic Evaluation and Research (PEER) techniques, and perceptual mapping methods. Our sample includes reproductive age women (pregnant and not pregnant), their husbands, their mothers/in law and key stakeholders. After analyzing the results, we will hold a convening in India to collaboratively design the intervention. Following the intervention design, we will test components of the intervention, gather user feedback and tweak as necessary. Additionally, to improve adoption and sustainability of the intervention, we will conduct policy dialogue with

Open Peer Review

Reviewer Status  

Invited Reviewers

1 2

REVISED

version 2

published
10 May 2018

version 1


published
20 Mar 2018



report



report

- 1 **Nilesh Chatterjee**, World Bank, New Delhi, India
Genevieve Fernandes, University of Edinburgh, Edinburgh, UK
- 2 **Ashraf Al Alam** , University of Sydney, Sydney, Australia

Any reports and responses or comments on the article can be found at the end of the article.

stakeholders throughout the formative research.

Impact: This study will contribute to the social norms and behavioral intervention research and inform policymakers about the value of adopting a socio-normative approach.

Keywords

behavioral intervention, maternal anemia, folic acid, IFA supplements, study protocol, social norms, formative research, qualitative study

Corresponding author: Erica Sedlander (esedlander@gwu.edu)

Author roles: **Sedlander E:** Conceptualization, Investigation, Methodology, Project Administration, Writing – Original Draft Preparation, Writing – Review & Editing; **Rimal RN:** Conceptualization, Funding Acquisition, Investigation, Methodology, Project Administration, Writing – Original Draft Preparation, Writing – Review & Editing; **Talegawkar SA:** Conceptualization, Investigation, Methodology, Writing – Original Draft Preparation, Writing – Review & Editing; **Yilma H:** Conceptualization, Investigation, Methodology, Writing – Review & Editing; **Munar W:** Conceptualization, Investigation, Methodology, Writing – Original Draft Preparation, Writing – Review & Editing

Competing interests: No competing interests were disclosed.

Grant information: This work was supported by The Bill and Melinda Gates Foundation grant number ECNS91245N. *The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.*

Copyright: © 2018 Sedlander E *et al.* This is an open access article distributed under the terms of the [Creative Commons Attribution Licence](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

How to cite this article: Sedlander E, Rimal RN, Talegawkar SA *et al.* **Designing a socio-normative intervention to reduce anemia in Odisha India: A formative research protocol [version 1; peer review: 2 approved]** Gates Open Research 2018, 2:15 (<https://doi.org/10.12688/gatesopenres.12808.1>)

First published: 20 Mar 2018, 2:15 (<https://doi.org/10.12688/gatesopenres.12808.1>)

Introduction

Anemia is a condition where the number of red blood cells and their oxygen carrying capacity is insufficient to meet the body's physiological needs¹. Iron deficiency is the most significant contributor to the onset of anemia². Globally, anemia affects 1.62 billion people, which corresponds to almost 25% of the population. While young children and pregnant women have the highest rates of anemia, non-pregnant women make up the greatest number of individuals with anemia³.

Anemia can lead to poor physical capacity and performance, influencing work productivity as well as increasing risk of preterm delivery and higher maternal mortality^{2,4}. Maternal anemia could also lead to infantile iron deficiency, negatively affecting children's physical and cognitive development^{5,6}. Iron-deficiency anemia among women of reproductive age (WRA) leads to a substantial double burden on the potential economic development and well-being of the population. Near-term consequences of anemia among WRA include reduced labor productivity and non-workplace activity (e.g. child care, household maintenance, leisure-time physical activities) due to fatigue⁷. In the longer term, iron deficiency during pregnancy and early childhood causes permanent reductions in children's cognitive capacity and socio-emotional functioning that will impact their productive capacity across the life course^{8,9}.

Anemia is a significant public health problem in India¹⁰, with more than half of its women between 15 and 49 years diagnosed with the condition¹¹. Reasons for these are multifactorial and include consumption of a predominantly plant based diet; micronutrient deficiencies, such as vitamin B12; and hookworm and malarial infections. Physical and cognitive productivity losses associated with anemia in India are estimated to be 6% of Gross Domestic Product (GDP).

In 2012, the World Health Assembly Resolution 65.6 endorsed a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (CIP), with six Global Nutrition Targets for 2025, with its second target aiming for a 50% reduction of anemia in WRA (15–49 years)¹². Taking iron supplements prevents anemia, and in low-income, predominantly vegetarian countries where anemia rates can be severe, it is more efficacious than increasing consumption of iron rich foods¹³. The WHO recommends daily oral iron and folic acid (IFA) supplements during pregnancy and weekly supplements for women of reproductive age¹⁴.

Current government led programs to reduce anemia in India

India has implemented several programs to tackle anemia including the National Nutritional Anemia Control Program, implemented in 1970, to promote regular consumption of iron rich foods and to provide iron and folic acid (IFA) supplements to pregnant and breastfeeding women¹⁵. The Ministry of Health and Family Welfare also developed the National Iron+

Initiative Program (NIPI) to address supplementation interventions for pregnant and lactating women and supplementary nutrition for pregnant, lactating women and adolescent girls to increase protein intake¹⁶.

Additionally, the Adolescent Girls Anemia Control Program provides weekly IFA supplements to adolescent girls¹⁷. In addition to the existing programs, several researchers have designed and conducted randomized controlled trials in India to reduce anemia in WRA^{18–21}.

Despite universal distribution and receipt, the intake of the IFA supplement remains low. Data from the 2015–2016 cycle of the India Demographic Health Data show that 91 percent of pregnant mothers reported that they received IFA supplements during their last pregnancy but only 37 percent consumed them for more than 100 days during pregnancy. Clearly, there are significant demand side barriers that contribute to low uptake and compliance.

Barriers and facilitators to IFA uptake and compliance

Several studies, including recent investigations in Kenya and Nepal have indicated that *knowledge barriers* exist, with women reporting that they did not receive adequate information from their providers when they distributed their IFA tablets^{22,23}. A summary of four qualitative studies in India showed that in each study, many women did not know the importance of consuming iron supplements or the link between anemia and iron supplements²⁴. Another recent study in India, reported that pregnant women were unaware of the association between anemia and maternal outcomes²⁵.

Perceived and real *side effects* have also been implicated by numerous studies as being critical barriers. Specifically, adolescents and WRA reported that side effects include gastric problems, stomach pain, weight gain and nausea^{26,27}. Additionally, pregnant women in India report beliefs that taking too much iron may cause too much blood or a large baby, making labor more challenging^{25,28}.

The WHO has expressed concern that the current *dose of 100mg IFA supplement* for women in India is higher than their recommendations and may therefore itself be a barrier to use¹⁰. And despite the demonstrated acceptability of weekly or twice weekly supplementation in smaller trials and state-level pilot programs in India, the 2012 national scale-up of weekly IFA supplementation with 100mg iron targeting school-age youth has met resistance due to concerns regarding the gastrointestinal side effects²⁹.

Additional barriers in reducing anemia include food insecurity, which may result in a *poor-quality diet*. A 2002 qualitative study reported that dietary restrictions could vary across gender as a woman reported, “eating last” or eating “whatever is leftover” as reasons for inadequate diet³⁰.

WRA do not make decisions about their health in isolation; *social networks* can influence behaviors and family members play a crucial role in supporting the use of IFA tablets in women³¹. Pregnant women whose spouses actively participated in antenatal visits were more likely to demonstrate a significantly higher adherence to IFA supplements than women whose husbands were not active throughout antenatal visits³². Mothers and mothers-in-law can also influence the intake and adherence of IFA in pregnant women, even more than their partners as demonstrated by a formative research study among pregnant women in Bangladesh. However, when it came to money matters, husbands were involved and considered the most important decision-makers³³. Financial decision-making and control within a family may also have implications on a woman's ability to obtain IFA tablets.

A growing body of literature points to social norms as a critical barrier to IFA uptake^{34,35}. Social norms are mores or rules of behavior that are considered acceptable in a group or society³⁶. Evidence from a meta-synthesis of qualitative research on the social determinants of iron supplementation among WRA conducted in 17 countries identified social norms as one of the primary factors limiting uptake of iron supplements, particularly during pregnancy¹⁰. However, to our knowledge, no studies have used a social norms approach to reduce anemia²⁹.

Social norms are different from laws in that they are negotiated through social interactions, whereas laws are codified. Traditions, like social norms are also socially negotiated, but they are more stable. The primary difference is that norms are more dynamic, and shaped and understood through communication processes³⁷ and can thereby be shaped to promote positive healthy behaviors³⁸.

Lastly, the policy context can also act as an enabler or as an obstacle for the spread of evidence-informed IFA policy innovations. The adoption of new evidence and its consideration by domestic policy actors and stakeholders remains a complex challenge for the translation of empirical evidence into policy implementation. The evidence-to-action gap is "stickier" in cases of multi- and trans-disciplinary research programs and in research programs, such as this, that deal with complex, inter-sectorial issues^{39,40}. These challenges have been studied from various disciplinary perspectives including diffusion of innovation theory^{41,42} comparative policy and political science studies^{43,44}, knowledge utilization theory and evaluation influence studies⁴⁵⁻⁴⁷, and the science of team science⁴⁵, among others. What has received less attention, and what comprises a significant focus of this project, are the socio-normative factors that guide policymaking. Two major knowledge gaps are of particular relevance to this study. The first is the need to better characterize the channels and mechanisms through which potential changes in population-level social norms around anemia and IFA use percolate upwards to redesign existing national and state-level policies. The second is the challenge

of facilitating the adoption and utilization of the research evidence by policy actors and stakeholders in Odisha leading to system learning and improved performance in IFA policy implementation.

Conceptual framework

Given the presence of multilevel demand side barriers to IFA use, including social norms themselves, the Theory of Normative Social Behavior (TNSB)⁴⁸ will underpin the formative research and subsequent intervention. The TNSB can help elucidate *when, how and which* norms affect health behaviors³⁹. Two key features of TNSB are particularly important. One is the distinction *between descriptive norms and injunctive norms*. Descriptive norms refer to individuals' beliefs about what other people do and how often they do them. Injunctive norms are what individuals believe that others expect them to do. Descriptive norms are thought to influence behavior because of people's desire to do the right thing or the thing that they believe most people are doing⁴⁹. Injunctive norms are thought to influence behavior because of individual's motivations for connection with others⁵⁰. A second key feature of the TNSB is the distinction between *collective norms* (defined as a property, characteristic or behavior within a group of people) and *perceived norms* (defined as individual beliefs about other people's actions and expectations). A key difference between the two is that collective norms operate at the societal or social network level whereas perceived norms operate at the individual level. While collective norms, which can be thought of as aggregated individual behaviors in a group, may influence perceived norms, there may be a discrepancy between what people in the group actually do and what an individual perceives that they do. For example, women of reproductive age in Odisha may believe that most women do not take IFA tablets when, in practice, many women do. Changing perceived norms around women taking IFA tablets to align with collective norms is one potential approach.

According to the TNSB, it is important to assess the source of normative influence, whether it is one's peers, family members, or other influential people, because the closer the social distance between oneself and the referent others, the stronger the influence³⁹. This study points to the influence that mothers/mothers-in-law and husbands have on women's likelihood to take IFA supplements. Finally, the TNSB states that the impact of norms has to be evaluated in the context of people's aspirations to emulate others around them, the level of similarity they feel with them, the extent to which they believe they will receive benefits by engaging in the behavior, and whether they believe social sanctions will be imposed if they fail to comply. This has important implications for our formative assessment, as it points to the importance of understanding how WRA and their social network members think about IFA in terms of the costs and benefits, pressures to conform, and possible linkages between IFA or anemia and their future aspirations.

Research methods and analysis

Aims and objectives. By the end of the formative assessment period, we will have designed, adaptively tested, and refined an intervention that can be feasibly and effectively implemented to reduce iron-deficiency anemia among women of reproductive age and pregnant women in Odisha, India. To achieve this goal, the formative assessment has the following aims:

1. At the community level, to identify key contextual, administrative, policy, and service environments that either facilitate or hinder access to and use of IFA supplements among women of reproductive age and pregnant women
2. At the interpersonal and individual levels, to identify norms, referent groups, and the extent to which they act as barriers or facilitators to IFA use and compliance among reproductive age women and pregnant women
3. To design, pilot test, and subsequently modify and finalize an intervention to increase IFA use and compliance and to reduce anemia among reproductive age women (with a focus on transforming harmful norms and promoting beneficial norms)

The formative assessment will be conducted from March to December, 2018. After analyzing results, a convening workshop will be conducted in July, where, a first draft of the intervention plan will be formulated. We will pilot test the various components of the intervention to determine its feasibility and effectiveness. Findings from these pilot evaluations will inform and refine the final intervention, which will be developed by December, 2018.

Figure 1 depicts the formative research workflow.

Research setting

Odisha, India

Odisha is an eastern Indian state on the Bay of Bengal. According to the 2015–2016 India Demographic Health Survey, 83% of households in Odisha reside in rural areas and 67% of women

and 84% of men are literate. The vast majority of household heads are Hindu (95%) and 23% of households belong to a specific tribal culture. The total fertility rate (TFR) in Odisha is 2.1 children per woman. About half (51%) of women in Odisha have anemia with a higher rate for women from a tribal culture, those following the Christian faith, and those with no schooling⁵¹.

Research team

We will conduct the research as a close partnership between the George Washington University (GW), IPE Global, our implementing partners based in Delhi and DCOR Consulting, a research firm based in Odisha, India. The research team consists of university-based researchers with expertise in qualitative research, social norms and global behavior change interventions. This expertise will be supplemented with expertise in nutrition and gender studies, particularly as they relate to the Odisha context, from IPE Global and DCOR Consulting. These partnerships will be instrumental to gain access to the community and to understand the local context.

Research design

Qualitative inquiry can improve the description and explanation of complex, real-world phenomena related to attitude and behavior change. Quantitative research alone is often insufficient to understand these complicated processes^{52,53}. Our research team proposes to examine *why* IFA supplement use is low despite recommendations from the government and existing programs promoting its uptake and *which* existing social norms promote or hamper uptake. Additionally, surveys and quantitative methods have been the primary tool to test theories on social norms and to understand the prevalence of existing norms in communities^{54,55}. Some theorists have suggested that more qualitative research would be useful in illuminating the process of social norm change in different situations⁵⁶. We respond to that call.

Data collection modalities

We will collect qualitative data via in-depth interviews, focus groups, Participatory Ethnographic Evaluation and Research (PEER) interviews, and observations in various venues.

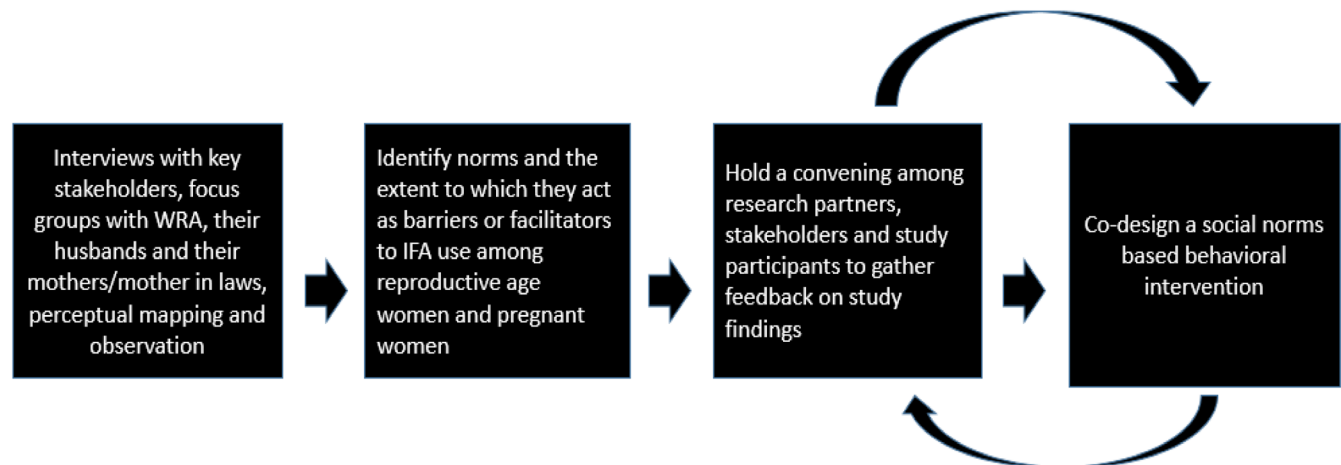


Figure 1. Formative Research Workflow.

In-depth interviews and focus groups. We will conduct in-depth interviews with key informants, Self-help group (SHG) leaders, health providers, and health officials. We will conduct focus groups with women of reproductive age (including pregnant women), spouses, mothers, and mothers-in-law. Prior to focus group interviews, participants will be given a short demographic questionnaire. We plan to conduct approximately fourteen focus groups and fourteen key informant interviews but the final sample size will be determined based on theoretical saturation⁵⁷. [Table 1](#) shows the expected number of interviews and focus groups.

Observational Data. Observation can allow the researcher to draw inferences about a phenomenon that they cannot obtain from direct conversation via interviews or focus groups. Observational data will be collected from four venues: antenatal care (ANC) clinics (both private and government-run), kiosks, self-help groups, and community gathering places. Data collectors will take detailed notes on a standard observation form (See [Supplementary File 3](#)) for each of the following venues:

Kiosk observations will note how well IFA tablets are stocked, where they are stocked within the store, the extent to which they are purchased, their price, and their packaging. Further, kiosk observations will also note how many people are in the kiosks and who these people are (i.e. are they men or women). All kiosks in the catchment area will be observed.

Clinic observations will note whether there are existing communications about anemia and/or IFA supplementation. They will also record notes on the environment including (cleanliness, crowding, wait-time, etc.). If they can observe the pharmacy from the waiting room, they may observe how many IFA

tablets are being dispensed and stocking/stock outs. All ANC clinics – both private and government-run – in the catchment area will be visited.

Data collectors will observe SHGs and take notes about the nature of their interactions with women in the community. They will take note of how well they function, their current knowledge on IFA tablet distribution and consumption; composition of members (age/caste) of SHGs; age of SHGs; kind of activities that they undertake and various challenges they face.

Observations will be made in public venues, which may include markets, water-gathering sites, local bazaars, and other places where people gather. Since diet is an important factor to consider while studying iron-deficiency anemia, we will make note of local diets and dietary patterns, availability of iron-rich foods such as dark green leafy vegetables, the influence of seasonality on availability of foods, and food costs. Observations will also be made on general daily habits including physical activity levels, general household work and leisure time activities.

Perceptual Mapping. We will conduct perceptual mapping exercises to obtain a visual model that depicts how women and their influencers (their spouses/partners, their mothers-in-law, and others in their social network) think about IFA supplements, anemia, and other related factors, including physical and mental fatigue, diet, and work activity (see [Supplementary File 4](#)). Perceptual mapping is a technique used to elicit a mental picture held in common by members of a group. Perceptual mapping helps us understand how people construe various objects, both in terms of what meaning they give to them and how they construe the objects in relation to one another.

Table 1. Expected Number of interviews and focus groups that will be conducted. Preliminary Schedule of Focus Group Discussions (FGDs) and In-depth Interviews (IDIs).

Participants	Session type	# Sessions	# Participants
Self-help group leaders	IDI	4	1
Government/ministry representatives	IDI	2	1
Antenatal service providers	IDI	2	1
Secondary school teachers	IDI	2	1
Kiosk owners	IDI	2	1
Anganwadi/ASHA workers	IDI	2	1
Women of reproductive age (15 – 25) years old	FGD	2	6–8
Women of reproductive age (26 – 49) years old	FGD	2	6–8
Pregnant Women (ages 15 – 49) years old	FGD	4	6–8
Younger men (18 – 25) years old	FGD	2	6–8
Older men (26–49) years old	FGD	2	6–8
Mothers-in-law	FGD	2	6–8

Perceptual mapping is done in three steps – attribute elicitation, scoring, and mapping.

Step 1: Attribute Elicitation. The purpose of this step is to extract the meaningful attributes with which people construe specific objects. For example, if people are asked to list a significant attribute pertaining to “IFA tablets,” some may point to “awful taste” as the primary attribute. For others, IFA tables may represent the idea of “medication for a better tomorrow” or “healthy” as the primary attribute. Knowing these key attributes will help us craft meaningful messages during the intervention phase. For example, we may be tempted to develop messages about IFA uptake on the assumption that it represents “no anemia” in the minds of participants. It may well be, however, that the primary attribute pertaining to taking IFA supplements for certain women may center around issues of forgetfulness or something whose impact is not easily visible. If this is the case, then our messages about IFA supplementation would be far less effective than those that tackle the issue from the perspective of linking it with more immediate positive outcomes.

For attribute elicitation, we will provide two images (on two cards), one being a reference object, of particular objects and ask people to tell us how similar or different the two are from each other (on any dimension that the participant uses). Subsequently, the reference object will be kept the same, but another second object will be shown and the same comparison will be solicited. This process will be done for all permutations of all object pairs. We anticipate having 12 objects, for a total of 55 comparisons. The objects we have currently chosen (but subject to further discussion) include: IFA pill; clinic; kiosk; SHG; traditional healer; physicians; fatigue; prenatal care; green vegetables; meat; money; and nausea/diarrhea.

Step 2: Scoring. A handful of attributes are thus identified for each primary behavior of interest. Respondents are then asked to rate the importance of each attribute for each behavior or object.

Step 3: Mapping. Step 2 results in a p (number of attributes) \times q (number of behaviors or objects) matrix that is then used to model the relative distances between behaviors or objects on a p -dimensional plane, thus showing the relative distances among behaviors or objects. Two behaviors or objects close to each other on a particular attribute signify their conceptual proximity. This mapping provides an understanding about how the primary behaviors or objects of interest are understood by the audience; it also specifies the relative distances among objects.

Three perceptual mapping exercises will be conducted: one among women of reproductive age (including pregnant women), one among men (who constitute the support group for the women), and one among mothers/mothers-in-law and sisters or

sisters-in-law. Approximately 30 individuals per group will participate in the mapping exercise, for a total of 90 individuals.

Rapid PEER. We will also conduct Rapid Participatory Ethnographic Evaluation and Research interviews (Rapid PEER), which will enable us to gain local insights into the beliefs and behaviors of beneficiaries, in the full context of their lived experience. This unique ‘insider perspective’ will ensure intervention is truly designed with the user in mind. We will train ‘ordinary’ members of the target group, in this case pregnant women and women of reproductive age, their spouses, and their mothers/mothers-in-law, after which they will serve as Peer Interviewers^{58,59}.

A key feature of Rapid PEER is that all interviews will be conducted in the third person. Interviewees will not be asked to talk about themselves. They will be asked to talk about “other people they know” or what other people in their social network say. The use of third person interviewing techniques will help to avoid a normative response bias, where interviewees give replies that reflect what they feel they should say rather than identifying what people actually say and do.

Thus, to execute the Rapid PEER, Peer Interviewers will be trained to carry out in-depth conversational interviews designed to obtain targeted information from others in their own social group. Five key questions that form the structure of the conversational interview process will be developed and agreed on by the Peer Interviewers. The Peer Interviewers themselves will suggest how to form the questions from formal Odia language into a more conversational format. Non-literate Peer Interviewers will draw pictures to represent each of the five questions. The same questions will be asked at each site by the Peer Interviewers to at least two interviewees from his/her social group. The informal wording and pictures to remember and ask the question may vary to suit the preference of the Peer Interviewers.

Data collection will be carried out over a one-day period, wherein the PEER interviewers will hold conversations with two same-sex friends who fit the inclusion criteria (pregnant women, women in the reproductive age group, their spouses or mothers/mothers-in-law, all living in the community, 15 years of age or older who speak Odia). Within 24 hours, the PEER interviewers will be debriefed by the research team to obtain detailed in-depth information from each PEER interviewer on what was said by each of the friends they interviewed. During the debriefing process, the research team will probe PEER interviewers for broader contextual information regarding the responses during the interview. A final workshop with PEER interviewers will explore their experiences of assisting with the formative research and will use role plays to gain further contextual understanding of issues raised during debriefing sessions.

The Rapid PEER process will take 4 days at each site:

Day 1	<ul style="list-style-type: none"> • Rapid PEER training workshop with Peer Interviewers
Day 2	<ul style="list-style-type: none"> • Peer Interviewers interview their friends
Day 3	<ul style="list-style-type: none"> • Peer interviewers interview their friends; Rapid PEER specialist de-briefs Peer Interviewers
Day 4	<ul style="list-style-type: none"> • Rapid PEER specialist debriefs remaining Peer Interviewers • Final workshop with Peer Interviewers
Following days	<ul style="list-style-type: none"> • Rapid PEER specialist undertakes desk-based data coding and analysis

Evidence-informed policy dialogue

As part of the formative stage of the program, we will conduct an evidence-informed policy dialogue process. The goal is to identify approaches that can be leveraged by the Odisha Ministry of Health and other local actors and stakeholders. To achieve this, will build a policy dialogue platform based on the lessons learned from several previously mentioned social science theories including diffusion of innovation theory^{42,43} comparative policy and political science studies^{44,45}, knowledge utilization theory and evaluation influence studies^{46–48}, and the science of team science⁴⁵. The goal is to learn about factors that affect how policymaking and normative change mutually reinforce each other.

To accomplish this, we plan to answer the following operational questions:

- (1) Who are the main stakeholders involved in innovative policy ideas related to the issues at stake in the Odisha program’s context?
- (2) What type of data, information and evidence do they use when deciding to adopt new policy ideas?
- (3) What are the generic features that are preferred by key State-level actors and stakeholders in dissemination and policy dialogue efforts to date?
- (4) What are the features of data, information, and evidence that are influential in driving adoption of new knowledge in policy design in the State of Odisha in the areas of interest?
- (5) What are the characteristics of the policy and program context for IFA supplementation and related public policy components?

These questions will be addressed through three complementary methods: (1) Creation of a roster of key actors and stakeholders; (2) Discussions with a small group of influential stakeholders (including The Ministry of Health and local NGO’s that work in this field); and, (3) document review of key policy documents.

Finally, we plan to include key stakeholders throughout this study to ensure that our work is not only adding value to existing initiatives but that the decisions we make will lead to sustainable programs that could be adopted locally. Based on these assessments, a process of evidence-informed policy engagement will be developed for implementation throughout the entirety of the research process.

Data collection

Training

We will hold an in-person training followed by a pilot study in Bhubaneswar, Odisha. Qualitative researchers from the George Washington University will conduct the training alongside research staff from the DCOR Consulting. Trained researchers from DCOR Consulting will collect all data in person.

We will match interviewer/moderator by gender whenever possible to build interviewer rapport⁶⁰. Interviews will primarily be conducted in the local language (Odia) or English, as appropriate. Interviews and focus groups will be held in locations selected by our local research partners in collaboration with local officials. Each interview and focus group will be audio recorded. DCOR consulting will transcribe the interviews and focus groups from Odia to English.

Instrument development

We designed the data collection instruments ([Supplementary File 1–Supplementary File 4](#)) based on the TNSB, a review of the literature on barriers and facilitators to IFA use, and feedback from the expert panel on our team. To explore IFA norms in a less personal and threatening way and to reduce social desirability bias within the focus groups, we will use vignettes, short stories about hypothetical characters who live in a rural village in Odisha. Vignettes are a simple way to explore social norms relating to a behavior⁶¹. During the pilot study, we will test and revise all of the instruments as needed to ensure that the questions flow well, are culturally relevant, and capture the relevant constructs. The pilot study will also help to identify regional lexicon, which will inform revisions of the formative data collection instruments.

Site selection

Within the state of Odisha, we plan to work in Angul district. We chose Angul for several reasons: 1) it is within three hours of Bhubaneswar, the capital of Odisha, where our research partner organization is based 2) There are many existing SHGs 3) IFA supplements are available (as this is primarily a behavioral/demand side study); and 4) malaria rates are average compared to the rest of India. We will also conduct the randomized control trial and intervention in Angul but in different villages from the formative research. To ensure that our formative research findings are applicable in a different village, we will choose villages that have similar key demographic variables to the formative research village.

Sample selection

Inclusion criteria are that participants must reside in the selected village because many of the questions pertain to norms in their communities. They must also speak either Odia or English, and they must be at least 15 years old.

Sampling

The population will include: WRA (both pregnant and not pregnant), husbands, mothers/mothers-in-law, SHG leaders & members, Odisha Health Officials, and health providers. We plan to use purposive sampling, a strategy where particular settings, persons or activities are selected deliberately to provide information that is particularly relevant to questions and goals which cannot be understood as well from other choices⁶². For example, we will ensure that we have participants along the spectrum of IFA use from women who take them daily to women who have never taken them.

Among the key informant interviews, we plan to specifically employ critical case or “reputational” sampling where cases will be chosen based on specialized knowledge or expertise. These interviews will be conducted with individuals who have expertise with respect to a specific perspective on this issue⁶³. Therefore, we will conduct key informant interviews with SHG leaders, ANC clinic providers who serve pregnant and reproductive age women, health officials who work on anemia or IFA distribution/education in Odisha and front line IFA dispensary workers. This sampling strategy will ensure that we interview the most knowledgeable key informants. Our sampling strategy will be refined in consultation with our local partners who will recommend key informants who meet these criteria.

For the perceptual mapping exercise, we will convene a representative sample (at the village level) using probability sampling techniques.

We will conduct Rapid PEER interviews in two villages within the selected district. In each site we will purposively choose six PEER interviewers (one each from women of reproductive age (15 – 25 years old), women of reproductive age (26 – 49 years old), pregnant women (15 – 49 years old), younger married men (15 – 25 years old), older married men (26–49 years old) and mothers-in-law). Each interviewer will interview or hold conversations with two interviewees (with same-sex friends who fit the previously discussed inclusion criteria). Within the two villages, we will train 12 PEER interviewers who will conduct 24-interviews.

Analysis

We will use an iterative approach to data collection and data analysis, whereby analysis and data collection will happen concurrently. This will allow us to determine when thematic saturation occurs and no new themes are emerging from the data⁴⁹. Initially, we will read transcripts and create memos, written logs used to capture reflection and analytic insights (Groenewald,

2008)⁶⁴. Findings from all data collection sources, semi-structured interviews, Rapid PEER interviews, focus groups, observation, and perceptual mapping, will be triangulated to examine whether or not these different methods support the same identified themes. Using different data sources will also allow us to gain information about different aspects of the phenomenon⁶⁵.

Following the procedures outlined by Guest *et al.*, 2011⁶⁶, we will conduct applied thematic analysis to characterize the knowledge, attitudes and behaviors relevant to IFA use. We chose applied thematic analysis because our overall study aim, to inform an anemia reduction intervention, is applied in nature. Experienced qualitative researchers will independently review transcripts to develop an initial codebook and modify the codebook as themes emerge. We will use both inductive and deductive coding to categorize concepts. Specific a priori codes will be used to identify text related to our research questions and additional codes will be added to the codebook based on new themes that emerge during coding. Using NVivo v.11, we will identify themes by comparing codes and content across sources, and by running specific word queries, associations between themes, and creating hierarchal visual displays of codes to identify linkages and patterns in the data.

We will analyze perceptual mapping data with multidimensional scaling techniques, which seek commonalities in responses that can be clustered together into groups, much like factor analysis, that have low intra-group and high intergroup variances. First, we will map clusters on a multiplane axis and iteratively identify the underlying dimension. Next, we will compare emerging dimensions with themes emerging from the qualitative analysis. Lastly, we will discuss and identify the underlying dimension with the highest validity and intervention utility.

Finally, we will use matrix analysis as a tool to display and further develop our results. Identified themes will be organized using descriptive matrix analyses that visually display the range of related responses⁶⁷. This will allow for a comprehensive analysis of the data and ensure that we not only focus on the majority responses among participants, but also the outliers.

The Odisha based research team will analyze the Rapid PEER interviews following these steps:

- To keep the conversation flowing, the Peer Interviewers will not take notes during the interviews but simply remember the conversation. Shortly after the interviews (the same day or the next day), the facilitator from the study team will meet and ask the Peer Interviewers about what their friends said about the topic. The facilitator will take detailed notes during these de-briefing sessions.
- The notes (originally written in Odia) will be translated verbatim in English. After translation, the research team will read all of the notes and identify the primary themes that emerged from the interviews. Next, they will assign themes to text segments.

- They will then identify relevant barriers and facilitators to IFA use and select illustrative quotes to include in a final report.

To test the validity of our findings and the existence of potential threats to those conclusions, we will conduct several validity checks including:

- *Long-term involvement in the community.* Our formative research is planned to continue for six months to provide adequate time to pilot test and tailor the data collection instruments, to return to follow up on initial findings, to provide adequate time to complete data collection and to reach thematic saturation.
- *Rich data.* We will use verbatim transcripts of the interviews and focus groups as well as descriptive notes for the perceptual mapping and observation.
- *Respondent validation.* We will hold a convening in Odisha to present and get feedback on our findings from participants, key stakeholders and research partners.
- *Triangulation.* We will triangulate our data by collecting data from a diverse range of individuals and use a variety of data collection methods. Additionally, our research teams have diverse backgrounds and bring multiple perspectives to the data analysis. Researchers from both GWU and DCOR consulting will co-analyze data.

Throughout the design, data collection and analysis, we will refer to the consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups to ensure study rigor and credibility⁶⁸. The quality of study reporting has been improved through formal reporting frameworks, like the COREQ⁶⁹.

Supplementary material

(1) Focus Group Guide (2) Key Informant Interview Guide (3) Structured Observation Check Lists and (4) Perceptual Mapping Questionnaire.

[Click here to access the data.](#)

Strengths and limitations of this study

- This study will provide evidence-based recommendations to guide the development of a social norms-based anemia reduction intervention.
- This study will explore multilevel (individual, interpersonal, community, and environment) barriers and facilitators to iron and folic acid uptake and compliance.
- This efficacy trial will be conducted in one state in India. Therefore, generalizability may be limited.

Ethics and dissemination

This Institutional Review Board at The George Washington University approved this study and it is currently under review at a local Odisha based Institutional Review Board. All participants will go through a verbal and written informed consent process before data collection. We will disseminate study findings locally in Odisha, at international conferences and publish in peer-reviewed journals.

Data availability

No data is associated with this article.

Competing interests

The authors have no competing interests to report.

Grant information

This work was supported by The Bill and Melinda Gates Foundation grant number ECNS91245N.

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

References

1. Broadway-Duren JB, Klaassen H: **Anemias.** *Crit Care Nurs Clin North Am.* 2013; **25**(4): 411–26.
[PubMed Abstract](#) | [Publisher Full Text](#)
2. Scholl TO, Hediger ML, Fischer RL, *et al.*: **Anemia vs iron deficiency: increased risk of preterm delivery in a prospective study.** *Am J Clin Nutr.* 1992; **55**(5): 985–8.
[PubMed Abstract](#) | [Publisher Full Text](#)
3. World Health Organization: **Global anaemia prevalence and number of individuals affected.**
[Reference Source](#)
4. Horton S, Ross J: **The economics of iron deficiency.** *Food policy.* 2003; **28**(1): 51–75.
[PubMed Abstract](#) | [Publisher Full Text](#)
5. Preziosi P, Prual A, Galan P, *et al.*: **Effect of iron supplementation on the iron status of pregnant women: Consequences for newborns.** *Am J Clin Nutr.* 1997; **66**(5): 1178–82.
[PubMed Abstract](#) | [Publisher Full Text](#)
6. Casey GJ, Phuc TQ, MacGregor L, *et al.*: **A free weekly iron-folic acid supplementation and regular deworming program is associated with improved hemoglobin and iron status indicators in Vietnamese women.** *BMC Public Health.*

- Health*. 2009; **9**: 261.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
7. Haas JD, Brownlie T 4th: **Iron deficiency and reduced work capacity: A critical review of the research to determine a causal relationship.** *J Nutr*. 2001; **131**(2S-2): 676S-688S; discussion 688S-690S.
[PubMed Abstract](#) | [Publisher Full Text](#)
 8. Beard JL, Connor JR: **Iron status and neural functioning.** *Annu Rev Nutr*. 2003; **23**: 41-58.
[PubMed Abstract](#) | [Publisher Full Text](#)
 9. Kennedy BC, Wallin DJ, Tran PV, *et al.*: **Long-Term Brain and Behavioral Consequences of Early-Life Iron Deficiency.** In: Reissland N, Kisilevsky BS, editors. *Fetal Development: Research on Brain and Behavior, Environmental Influences, and Emerging Technologies.* Springer International Publishing; 2016; 295-316.
[Publisher Full Text](#)
 10. World Health Organization: **Strategies to prevent anaemia: Recommendations from an Expert Group Consultation.** New Delhi, India. 2016.
[Reference Source](#)
 11. Raykar N, Majumder M, Laxminarayan R: **India Health Report: Nutrition 2015.** New Delhi, India: Public Health Foundation of India and International Food Policy Research Institute (IFPRI). 2015.
[Reference Source](#)
 12. World Health Organization: **Comprehensive implementation plan on maternal, infant and young child nutrition.** Geneva, Switzerland: Department of Nutrition for Health and Development. 2014.
[Reference Source](#)
 13. Berger J, Dillon JC: **[Control of iron deficiency in developing countries].** *Sante*. 2002; **12**(1): 22-30.
[PubMed Abstract](#)
 14. World Health Organization: **Global nutrition targets 2025: anaemia policy brief.** Geneva, Switzerland: Department of Nutrition for Health and Development. 2014.
[Reference Source](#)
 15. Kumar A: **National nutritional anaemia control programme in India.** *Indian J Public Health*. 1999; **43**(1): 3-5, 16.
[PubMed Abstract](#)
 16. India Ministry of Health and Family Welfare: **Guidelines for control of iron deficiency anaemia. National Iron Plus Initiative.** New Delhi, India: Government of India. 2013.
[Reference Source](#)
 17. Aguayo VM, Paintal K, Singh G: **The Adolescent Girls' Anaemia Control Programme: a decade of programming experience to break the inter-generational cycle of malnutrition in India.** *Public Health Nutr*. 2013; **16**(9): 1667-76.
[PubMed Abstract](#) | [Publisher Full Text](#)
 18. Dongre AR, Deshmukh PR, Garg BS: **Community-led initiative for control of anemia among children 6 to 35 months of age and unmarried adolescent girls in rural Wardha, India.** *Food Nutr Bull*. 2011; **32**(4): 315-323.
[PubMed Abstract](#) | [Publisher Full Text](#)
 19. Kadiyala S, Morgan EH, Cyriac S, *et al.*: **Adapting Agriculture Platforms for Nutrition: A Case Study of a Participatory, Video-Based Agricultural Extension Platform in India.** *PLoS One*. 2016; **11**(10): e0164002.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 20. Noronha JA, Bhaduri A, Bhat HV, *et al.*: **Interventional study to strengthen the health promoting behaviours of pregnant women to prevent anaemia in southern India.** *Midwifery*. 2013; **29**(7): e35-e41.
[PubMed Abstract](#) | [Publisher Full Text](#)
 21. Shet AS, Zwarenstein M, Mascarenhas M, *et al.*: **The Karnataka Anemia Project 2-design and evaluation of a community-based parental intervention to improve childhood anemia cure rates: study protocol for a cluster randomized controlled trial.** *Trials*. 2015; **16**(1): 599.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 22. Kimiye J, Ahoya B, Kavle J, *et al.*: **Barriers to Maternal Iron, Folic Acid Supplementation & Compliance in Kisumu and Migori, Kenya.** Nairobi, Kenya: USAID Maternal and Child Survival Program. 2017.
[Reference Source](#)
 23. Rai SS, Ratanasiri T, Arkaravichien T, *et al.*: **Compliance and its Determinants Regarding Iron and Folic Acid Supplementation during Pregnancy in Kathmandu, Nepal.** *Kathmandu Univ Med J*. 2016; **14**(56): 311-7.
[PubMed Abstract](#)
 24. Bentley P, Prakh A: **Perceptions of Anemia and Health Seeking Behavior among Women in Four Indian States.** Technical Working Paper #9. *Mother Care/John Snow Inc*. 1998.
[Reference Source](#)
 25. Chatterjee N, Fernandes G: **'This is normal during pregnancy': A qualitative study of anaemia-related perceptions and practices among pregnant women in Mumbai, India.** *Midwifery*. 2014; **30**(3): e56-e63.
[PubMed Abstract](#) | [Publisher Full Text](#)
 26. Priya SH, Datta S, Bahurupi YA, *et al.*: **Factors influencing weekly iron folic acid supplementation programme among school children: Where to focus our attention?** *Saudi J Health Sci*. 2016; **5**(1): 28-33.
[Publisher Full Text](#)
 27. Bhatt RJ, Mehta HK, Khatri V, *et al.*: **A study of access and compliance of iron and folic acid tablets for prevention and cure of anaemia among adolescent age group females in Ahmedabad district of India surveyed under multi indicator cluster survey 2011.** *Glob J Med Public Health*. 2013; **2**(4): 1-6.
[Reference Source](#)
 28. Nagata JM, Gatti LR, Barg FK: **Social determinants of iron supplementation among women of reproductive age: a systematic review of qualitative data.** *Matern Child Nutr*. 2012; **8**(1): 1-18.
[PubMed Abstract](#) | [Publisher Full Text](#)
 29. Malhotra S, Yadav K, Kusuma YS, *et al.*: **Challenges in scaling up successful public health interventions: Lessons learnt from resistance to a nationwide roll-out of the weekly iron-folic acid supplementation programme for adolescents in India.** *Natl Med J India*. 2015; **28**(2): 81-5.
[PubMed Abstract](#)
 30. Galloway R, Dusch E, Elder L, *et al.*: **Women's perceptions of iron deficiency and anemia prevention and control in eight developing countries.** *Soc Sci Med*. 2002; **55**(4): 529-544.
[PubMed Abstract](#) | [Publisher Full Text](#)
 31. Ghanekar J, Kanani S, Patel S: **Toward better compliance with iron-folic acid supplements: understanding the behavior of poor urban pregnant women through ethnographic decision models in Vadodara, India.** *Food Nutr Bull*. 2002; **23**(1): 65-72.
[PubMed Abstract](#) | [Publisher Full Text](#)
 32. Wiradnyani LA, Khusun H, Achadi EL, *et al.*: **Role of family support and women's knowledge on pregnancy-related risks in adherence to maternal iron-folic acid supplementation in Indonesia.** *Public Health Nutr*. 2016; **19**(15): 2818-2828.
[PubMed Abstract](#) | [Publisher Full Text](#)
 33. Alam A, Rasheed S, Khan NU, *et al.*: **How can formative research inform the design of an iron-folic acid supplementation intervention starting in first trimester of pregnancy in Bangladesh? BMC Public Health.** 2015; **15**(1): 374.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 34. Nguyen PH, Sanghvi T, Kim SS, *et al.*: **Factors influencing maternal nutrition practices in a large scale maternal, newborn and child health program in Bangladesh.** *PLoS One*. 2017; **12**(7): e0179873.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 35. Tinago CB, Annang Ingram L, Blake CE, *et al.*: **Individual and structural environmental influences on utilization of iron and folic acid supplementation among pregnant women in Harare, Zimbabwe.** *Matern Child Nutr*. 2017; **13**(3): e12350.
[PubMed Abstract](#) | [Publisher Full Text](#)
 36. Lapinski MK, Rimal RN: **An explication of social norms.** *Commun Theory*. 2005; **15**(2): 127-147.
[Publisher Full Text](#)
 37. Rimal RN, Lapinski MK: **A Re-Explication of Social Norms, Ten Years Later.** *Commun Theory*. 2015; **25**(4): 393-409.
[Publisher Full Text](#)
 38. Miller DT, Prentice DA: **Changing Norms to Change Behavior.** *Annu Rev Psychol*. 2016; **67**(1): 339-361.
[PubMed Abstract](#) | [Publisher Full Text](#)
 39. Stokols D, Misra S, Moser RP, *et al.*: **The ecology of team science: understanding contextual influences on transdisciplinary collaboration.** *Am J Prev Med*. 2008; **35**(2 Suppl): S96-S115.
[PubMed Abstract](#) | [Publisher Full Text](#)
 40. Rogers PJ: **Implications of complicated and complex characteristics for key tasks in evaluation.** In Forss K, Marra M, Schwartz R, editors. *Evaluating the Complex: Attribution, Contribution, and Beyond.* Comparative Policy Evaluation. New Brunswick, NJ: Transaction Publishers; 2011; 33-52.
[Reference Source](#)
 41. Greenhalgh T, Robert G, Macfarlane F, *et al.*: **Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations.** *Milbank Q*. 2004; **82**(4): 581-629.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 42. Greenhalgh T, Robert G, Bate P, *et al.*: **How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.** London: University College; 2004.
[Reference Source](#)
 43. Weyland K: **Theories of policy diffusion Lessons from Latin American Pension Reform.** *World Polit*. 2005; **57**(2): 262-95.
[Publisher Full Text](#)
 44. Shiffman J: **A social explanation for the rise and fall of global health issues.** *Bull World Health Organ*. 2009; **87**(8): 608-13.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 45. Dearing JW, Kreuter MW: **Designing for diffusion: how can we increase uptake of cancer communication innovations? Patient Educ Couns.** 2010; **81** Suppl: S100-10.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
 46. Dobbins M, Ciliska D, Cockerill R, *et al.*: **A Framework for the Dissemination and Utilization of Research for Health-Care Policy and Practice.** *Online J Knowl Synth Nurs*. 2002; **9**(1): 7.
[PubMed Abstract](#) | [Publisher Full Text](#)
 47. Henry GT, Mark MM: **Beyond use: Understanding evaluation's influence on attitudes and actions.** *Am J Eval*. 2003; **24**(3): 293-314.
[Publisher Full Text](#)
 48. Rimal RN, Real K: **How Behaviors are Influenced by Perceived Norms: A Test of**

- the Theory of Normative Social Behavior.** *Commun Res.* 2005; **32**(3): 389–414.
[Publisher Full Text](#)
49. Cialdini RB, Trost MR: **Social influence: Social norms, conformity and compliance.** In D. T. Gilbert, S. T. Fiske & G. Lindzey (Eds.): *The handbook of social psychology.* New York: McGraw-Hill. 1998; 151–192.
[Reference Source](#)
50. Cialdini RB, Goldstein NJ: **Social Influence: Compliance and Conformity.** *Annu Rev Psychol.* 2004; **55**(1): 591–621.
[PubMed Abstract](#) | [Publisher Full Text](#)
51. Thomas D, Sarangi BL, Garg A, *et al.*: **Closing the health and nutrition gap in Odisha, India: A case study of how transforming the health system is achieving greater equity.** *Soc Sci Med.* 2015; **145**: 154–162.
[PubMed Abstract](#) | [Publisher Full Text](#)
52. Greenhalgh T, Annandale E, Ashcroft R, *et al.*: **An open letter to The BMJ editors on qualitative research.** *BMJ.* 2016; **352**: i563.
[PubMed Abstract](#) | [Publisher Full Text](#)
53. Sedlander E: **A Qualitative Study to Understand Guideline Discordant use of Imaging to Stage Prostate Cancer: Beyond the Abstract.** *Urotoday.* 2016.
[Reference Source](#)
54. Rimal RN, Lapinski MK, Cook RJ, *et al.*: **Moving Toward a Theory of Normative Influences: How Perceived Benefits and Similarity Moderate the Impact of Descriptive Norms on Behaviors.** *J Health Commun.* 2005; **10**(5): 433–450.
[PubMed Abstract](#) | [Publisher Full Text](#)
55. Priebe CS, Spink KS: **Using Messages Promoting Descriptive Norms to Increase Physical Activity.** *Health Commun.* 2012; **27**(3): 284–291.
[PubMed Abstract](#) | [Publisher Full Text](#)
56. Chung A, Rimal RN: **Social norms: A review.** *Review of Communication Research.* 2016; **4**: 1–29.
[Publisher Full Text](#)
57. Bradley EH, Curry LA, Devers KJ: **Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory.** *Health Serv Res.* 2007; **42**(4): 1758–1772.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
58. Elmusharaf K, Byrne E, Manandhar M, *et al.*: **Participatory Ethnographic Evaluation and Research: Reflections on the Research Approach Used to Understand the Complexity of Maternal Health Issues in South Sudan.** *Qual Health Res.* 2017; **27**(9): 1345–1358.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
59. Price N, Hawkins K: **Researching sexual and reproductive behaviour: a peer ethnographic approach.** *Soc Sci Med.* 2002; **55**(8): 1325–1336.
[PubMed Abstract](#) | [Publisher Full Text](#)
60. Manderson L, Bennett E, Andajani-Sutjahjo S: **The social dynamics of the interview: age, class, and gender.** *Qual Health Res.* 2006; **16**(10): 1317–1334.
[PubMed Abstract](#) | [Publisher Full Text](#)
61. Gourlay A, Mshana G, Birdthistle I, *et al.*: **Using vignettes in qualitative research to explore barriers and facilitating factors to the uptake of prevention of mother-to-child transmission services in rural Tanzania: a critical analysis.** *BMC Med Res Methodol.* 2014; **14**(1): 21.
[Publisher Full Text](#)
62. Palys T: **Purposive sampling.** In LM. Given (Ed.) *The Sage Encyclopedia of Qualitative Research Methods.* Los Angeles, California: Sage Publications. 2008; **2**: 697–8.
[Reference Source](#)
63. Patton MQ: **Enhancing the quality and credibility of qualitative analysis.** *Health Serv Res.* 1999; **34**(5 Pt 2): 1189–1208.
[PubMed Abstract](#) | [Free Full Text](#)
64. Given LM (Ed.): **The Sage encyclopedia of qualitative research methods.** Thousand Oaks, California: Sage Publications. 2008.
[Publisher Full Text](#)
65. Creswell JW, Poth CN: **Philosophical, Paradigm, and Interpretive Frameworks.** In *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, California: Sage publications. 2012.
66. Guest G, MacQueen KM, Namey EE: **Applied Thematic Analysis.** Thousand Oaks, California: Sage Publications, Inc. 2012; 320.
[Publisher Full Text](#)
67. Averill JB: **Matrix analysis as a complementary analytic strategy in qualitative inquiry.** *Qual Health Res.* 2002; **12**(6): 855–866.
[PubMed Abstract](#) | [Publisher Full Text](#)
68. Tong A, Sainsbury P, Craig J: **Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups.** *Int J Qual Health Care.* 2007; **19**(6): 349–357.
[PubMed Abstract](#) | [Publisher Full Text](#)
69. Moher D, Jones A, Lepage L, *et al.*: **Use of the CONSORT statement and quality of reports of randomized trials: a comparative before-and-after evaluation.** *JAMA.* 2001; **285**(15): 1992–1995.
[PubMed Abstract](#) | [Publisher Full Text](#)

Open Peer Review

Current Peer Review Status:  

Version 1

Reviewer Report 10 April 2018

<https://doi.org/10.21956/gatesopenres.13875.r26323>

© 2018 Alam A. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution Licence](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Ashrafal Alam 

Sydney School of Public Health, University of Sydney, Sydney, NSW, Australia

The paper presents a plan of a formative research aiming to generate contextual evidence for designing and implementing a feasible and efficient intervention to reduce iron-deficiency anemia among women of reproductive age and pregnant women in Odisha, India. The authors will use qualitative methods (interviews, discussions, observation and visual tool) to collect the data. The paper addresses an important health issue particularly relevant to low-income settings and the populations with certain dietary perceptions and practices hindering iron-rich food intake, such as many Indian communities. At the research approach level, the study will benefit the public health researchers and program implementers by providing with conceptual and methodological insights into designing formative research to inform culturally appropriate community-based intervention to improve maternal nutrition. Overall, the protocol is well-designed that provides details of every step of the research. I have a few comments that the authors may consider to improve the research protocol.

1. Page 1. Abstract. The authors say that to improve adoption and sustainability of the intervention, they "will conduct policy dialogue with stakeholders throughout the formative research." Formative research will be conducted prior to the start of the intervention. How the dialogue during the formative research will improve the intervention adoption? The authors may like to elaborate on this.
2. Page 6. Observational Data. Observation provides very useful data on actual behaviors. At the same time, the method poses immense danger of data distortion caused by the presence of the observer and study populations' prior awareness of the observation. The authors should articulate a strategy of minimizing the bias, in particular how they will conceal the observation schedule from the clinic staff/clients, and what measures they will take to refrain the staff from improved performance to 'satisfy' the observers (i.e. communications about anemia and/or IFA supplementation).

3. Pg 8. Site selection. Please provide the reason for selecting the formative research villages from outside the panned RCT villages. In my view, the RCT villages would provide more relevant data to inform the RCT design.
4. There are too many passive sentences in the paper that make it difficult to understand about the actor. Please turn as many passive sentences as possible into active sentences so the readers understand who will do what.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Partly

Are the datasets clearly presented in a useable and accessible format?

Not applicable

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 29 March 2018

<https://doi.org/10.21956/gatesopenres.13875.r26325>

© 2018 Chatterjee N et al. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution Licence](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Nilesh Chatterjee

Water and Sanitation Program, World Bank, New Delhi, Delhi, India

Genevie Fernandes

Usher Institute of Population Health Sciences & Informatics, University of Edinburgh, Edinburgh, UK

General comments:

Authors provide a detailed description and rationale of the qualitative research protocol. Article can be accepted with minor revisions or changes.

The aim of this formative assessment study is to gather data and information that will help in the design, testing, and refinement of an intervention that can be feasibly and effectively implemented to reduce iron-deficiency anemia among women of reproductive age and pregnant women in Odisha, India.

To achieve the above, the formative assessment aims to do the following:

1. At the community level, to identify key contextual, administrative, policy, and service environments that either facilitate or hinder access to and use of IFA supplements among women of reproductive age and pregnant women.
2. At the interpersonal and individual levels, to identify norms, referent groups, and the extent to which they act as barriers or facilitators to IFA use and compliance among reproductive age women and pregnant women
3. Finally, to design, pilot test, and subsequently modify and finalize an intervention to increase IFA use and compliance and to reduce anemia among reproductive age women (with a focus on transforming harmful norms and promoting beneficial norms).

In this formative assessment, the researchers will use various methods to gather qualitative data such as in-depth interviews, focus groups, Participatory Ethnographic Evaluation and Research (PEER) interviews, and observations in various venues. The authors propose to not only analyze the information emerging or coming in from various methods but also triangulate the information from these different methods to arrive at an understanding of the phenomenon. This can take some time.

However, the authors state that the formative assessment will be conducted from March to December, 2018. And within this time duration not only will there be data collection using various methods but also a convening workshop to be conducted in July, where, a first draft of the intervention plan is to be formulated; and pilot testing of various components of the intervention to determine its feasibility and effectiveness. The results of these pilot evaluations will inform and refine the final intervention, which is to be developed by December, 2018. While we find that the formative assessment is meticulously planned, we also request the authors to re-examine and re-visit the proposed time duration for all of these activities. Addressing anemia in women of reproductive age is critical. This is an important project and the authors/ research team have spent time in thinking through various components; made an elaborate plan to gather data and the formative phase must be done in the best possible manner even if that means increasing the time allocated.

Specific comments are provided below for each section of the article. The authors may use this to re-examine the article and make some minor revisions.

Comments on the Introduction section:

1. Please cite appropriate references for the below-mentioned sentences on page 3, column 1, paragraph 3, line 3.

Reasons for these are multifactorial and include consumption of a predominantly plant based diet; micronutrient deficiencies, such as vitamin B12; and hookworm and malarial infections. Physical and cognitive productivity losses associated with anemia in India are estimated to be 6% of Gross Domestic Product (GDP).

2. It would be helpful if the authors stated the year in which the Ministry of Health and Family Welfare launched the National Iron+ Initiative Program and the Adolescent Girls Anemia Control Program (see page 3). Were there programs before this? Is it possible to provide readers a historical sense of government initiatives for addressing anemia.
3. Please cite appropriate reference for the below given sentence on page 3, column 2, paragraph 3.

Data from the 2015–2016 cycle of the India Demographic Health Data show that 91 percent of pregnant mothers reported that they received IFA supplements during their last pregnancy but only

37 percent consumed them for more than 100 days during pregnancy.

4. Check the link for reference number 24 – Bentley and Parekh 1998. It appears to be unavailable. In the reference list, revise the spelling 'Prakh' to Parekh.
5. On page 3, column 2, last paragraph, please specify that the qualitative study was conducted in developing countries.

Comments on Research methods and analysis:

1. On page 4, please cite appropriate references for sentences under *research setting*.
2. On page 4, under research settings, it will be helpful to include data for percentage of women that received antenatal check-ups and institutional deliveries in the state, to get a sense of women's access to government health services.
3. Authors have stated on Page 8 (lines 10 and 11) that a pilot study will be conducted in Bhubaneswar, Could the authors describe this in more detail?
4. Also for the geographic locations of the formative assessment as well as the planned intervention; it will be helpful to have a map or some such graphic illustration of the state and the selected locations for the formative assessment.
5. Since the state of Odisha has a sizeable tribal population, it would be interesting to see how the researchers have incorporated inputs from tribal leaders or other key informants in this group.
6. In general, for all groups or villages, are local panchayati raj institution (PRI) members covered under government representatives?
7. The authors have included two different age groups of women and men for focus groups (younger and older). This is helpful in the formative phase.
8. We understand that observing private providers is important in the Indian context where a large portion of health care accessed by households is privatized? However, the authors could explain this process in slightly more detail in the paper.
9. Could the authors provide an approximate number of planned observations for each of the four venues? Also, it will be helpful to describe where these venues are? What is the catchment area?
10. Could the authors cite any study where the method of perceptual mapping has been used; this will provide the readers with an example of the process and efficacy of this research method.

Comments on Evidence-informed policy dialogue:

1. On page 8, add 'we' in the following sentence:

To achieve this, we will build a policy dialogue platform based.....

Comments on Site selection:

1. There is one concern about the selected site of Angul district. The selected district 'Angul' is stated to be three hours away from the capital city of Bhubaneswar. Furthermore, as per findings from

NFHS (2016) (hyperlinked report), almost 70% of pregnant women in this district had 4 ANC visits, 90% of women had institutional deliveries, and 92% of births have been conducted by a skilled birth attendant. Because of proximity to a major city and the NFHS findings, there is a concern this site may not be representative. We understand that representativeness may not always be a major criterion in qualitative research; however, the attributes of this district, the ideation, intention and behaviors of the people in this district may not match that of other districts in the interior of the state. Will the findings of this study then be applicable in the context of rural villages and districts or the entire state? However, despite a concern about access to better information and maybe health care services or providers, 44% of all women and 58% of pregnant women in Angul were reported as anemic in the same NFHS data; and only 38% of pregnant women reported consuming IFA tablets. It is possible that Angul was selected because it represents both sides of Odisha – the proximity to urban and urban-facing part as well as the rural-facing part. The authors may want to explain the site selection in a more nuanced manner.

Comments on Data collection instruments:

1. In the focus group guide, authors may want to include a few questions on aspirations of women and men. This will give an insight into possible motivations for behaviors around pregnancy and childbirth. There is a general trend towards an aspirational and more consumerism-driven lifestyle in many parts of India, especially in the smaller (rapidly growing) cities and towns.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Yes

Are the datasets clearly presented in a useable and accessible format?

Not applicable

Competing Interests: No competing interests were disclosed.

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.
