

# Witness Seminar on Community Action for Health in India

**'Communitization' and community-  
based accountability mechanisms  
under the National Rural Health  
Mission (NRHM)**

**Appendix and supplementary material**



# Appendix One

## WITNESS SEMINAR ON COMMUNITY ACTION FOR HEALTH IN INDIA

### 'Communitization' and community-based accountability mechanisms under the National Rural Health Mission (NRHM)

#### Detailed Methodology

##### The method of the Witness Seminar:

We have adopted the Witness Seminar methodology, an oral history approach developed by British medical historian, Professor Tilli Tansey, in the 1990s.<sup>1</sup> Witness Seminars involve a group of participants interacting with each other and seminar convenors to discuss, debate, agree, and/or disagree about their reminiscences and significance of circumstances or events in recent history to which they have borne witness.<sup>1</sup> The emphasis is placed on stakeholders who are witnesses and thus the seminar itself is seen as an important contribution to history. This method has been used to describe scientific discoveries, the setting up of institutions (e.g. the UK's National Health Service), crucial themes related to movements in health (e.g. Human Immunodeficiency Virus (HIV) and women, HIV, and criminalization), as well as the contributions of key public health figures and leaders. In India, the method has been used to document the contemporary history of the regulation of formal private healthcare providers in Maharashtra, as well as on the status of the private healthcare sector in Mumbai and Pune since 1980s.<sup>2</sup>

In 2021, we organised five Witness Seminars, three related to decentralisation reforms in Kerala and two on the community based accountability mechanisms institutionalized nationally under the National Rural Health Mission (NRHM). The process was approved by the Institutional Ethics Committee of the George Institute for Global Health (27/2020). Our process comprised three phases: a preparatory phase, a seminar phase, and a transcript and annotation phase. We describe below the process we adopted for the two witness seminars at the national level:

##### Preparatory phase

###### *Background, timeline and initial consultations:*

The groundwork of the Witness Seminar began with preparing a timeline supported with a background note on the history of community participation in India. We started documenting antecedent events to the NRHM starting from the 1970s, arriving at 2005 when the NRHM was launched and leading up to the current period of Universal Health Coverage (UHC). We held a series of individual conversations with a few potential witnesses and the timeline and background note was finalized - after a few iterations - in consultation with them. We decided to place our emphasis on the formative years of NRHM including the CBMP pilot (2005-2008) while ensuring space for describing and acknowledging the antecedents of this period. We were guided by the witnesses in terms of defining thematic areas, and these areas were (a) emergence; (b) evolution and institutionalisation; and (c) evaluation and impact of the community-based accountability processes institutionalised under NRHM.

###### *Witness sampling and selection of a chairperson:*

We identified potential witnesses through publicly available sources using snowballing technique, and those from our networks who were involved with community participation and accountability mechanisms and processes under the National Rural Health Mission (NRHM) at the national level. This included civil society members, retired government officials, researchers, practitioners, and advisors. We selected a chairperson, who has closely been involved with health systems and policy processes in the Indian context, to steer the seminar proceedings.

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1. Tansey EM. Witnessing the witnesses: Potentials and pitfalls of the witness seminar in the history of twentieth-century medicine. In: *The Historiography of Contemporary Science, Technology, and Medicine* [Internet]. Routledge; 2006 [cited 2020 Oct 30]. p. 276–94. Available from: <https://www.taylorfrancis.com/>

2. Chakravarthi, I, Hunter BM. Private Healthcare Sector in Pune and Mumbai since the 1980s [Internet]. Pune: SATHI-CEHAT/Kings College; 2019. Available from: [http://sathicehat.org/wp-content/uploads/2019/09/1.Witness-Seminar\\_Private-HC-Sector.pdf](http://sathicehat.org/wp-content/uploads/2019/09/1.Witness-Seminar_Private-HC-Sector.pdf)

**Structuring the witness seminars:** We organized the seminars in a series of two on the aforementioned topic with two cohorts of witnesses. The date and time the seminars were finalised in consultation with the witnesses and the duration was for 1.5 hours each. We loosely structured the sessions by listing 9 questions i.e., 3 questions for each of the thematic areas and slotting witnesses against the questions according to relevance to their experience. This format for the session was shared as part of the agenda with the witnesses in advance to help orient them in preparation and the chair with steering the session. The agenda for each session was prepared in consultation with the chairperson. We had also circulated the Participant Information Sheet (PIS) and consent form with the witnesses in advance of the seminars.

### **Seminar phase**

Owing to the COVID-19 pandemic, we organized the seminars online via Zoom. The virtual mode and shorter duration of the seminar allowed for participants to conveniently accept our invitation. We checked in with the participants sharing the zoom link and for any other assistance they required on the day of the seminar. Both the seminars were held in English. The moderator (from the team) explained the requisites for the session followed by the chair taking lead in prompting participants to share their narrative. To manage the time constraints posed by the shorter duration of the session, each witness had to limit their verbatim to 8-10 minutes.

Additional one-on-one interviews were held with witnesses who wished to elaborate on the narratives they had put forward during the main session.

### **Transcription and annotation phase**

Following the seminar phase, electronic data and audio files from interviews were stored electronically on a shared network drive at The George Institute for Global Health under both firewall and password protection, with access limited to study investigators. We engaged a professional agency which abided by a confidentiality protocol and transcribed the audio recordings to create a verbatim transcript for each seminar. The verbatim transcript was created and circulated to all participants. Witnesses at this point could exercise their right to delete, restrict,

and or redact portions of an interview as they saw fit. They were requested to complete this within a week and up to 10 days. The transcript was then annotated with biographical and bibliographical information and turned into a report. Annotations took the form of footnotes added in the appropriate places, for example, to provide complete references to publications or give brief descriptions of technical terms/events/persons/organizations. The draft report was then shared with participants for further edits if there were any and post their approval, it was prepared for publication. The final report is published and shared with all participants and efforts are underway for it to be submitted to relevant repositories and archives in the country.

## Appendix Two

### WITNESS SEMINAR ON COMMUNITY ACTION FOR HEALTH IN INDIA

#### 'Communitization' and community-based accountability mechanisms under the National Rural Health Mission (NRHM)

**Note: Witnesses may choose across these categories of questions and present their reflections as they deem appropriate**

##### A. Emergence

1. What was the role of community action and voice in the genesis of NRHM in 2005?
2. How was the "communitization" – more specifically, the community based accountability framework – brought into NRHM? Who were the key players? Key institutions?
3. How was the initial design of and the institutional support mechanisms for community action in health evolved (e.g. Community Based Monitoring Process (CBMP) pilots, Advisory Group on Community Action (AGCA) and others, Village Health, Sanitation and Nutrition Committees (VHSNC), Hospital Management Committees/Rogi Kalyan Samitis (RKS), Mahila Arogya Samitis (MAS))?

##### B. Evolution and Institutionalisation

1. What were the experiences from implementing the pilot and scaling it up across states (considering different contexts of states)? Were goals achieved? What were the challenges? Lessons learned? Key variations in approach across states?
2. How were community-accountability processes received/carried forward by state implementers? What were notable experiences/episodes?
3. With regard to perspectives of communities, what were key experiences/episodes in the years after the basic model was rolled out? What about civil society organisations? Other community formations?

##### C. Evaluation and Impact

1. What were the key successes and failures of the CBMP process under NRHM? How is the success measured and defined? What implications did the integration of NUHM with NRHM into NHM have on 'communitization'?
2. Has power sharing and participation among the stakeholders (civil society/government/community) been impacted due to these shifts? How?
3. What is the legacy of community action for health in NRHM? What are the lessons and insights for India in the current phase of Pradhan Mantri Atmanirbhar Swasth Bharat Yojana (PMASBY)? For the world?