

Witness Seminar on Community Action for Health in India

The case of Decentralization and Health reforms in Kerala

Appendix and supplementary material



The George Institute
for Global Health

Appendix One

WITNESS SEMINAR ON COMMUNITY ACTION FOR HEALTH IN INDIA THE CASE OF DECENTRALIZATION AND HEALTH REFORMS IN KERALA

Methodology

We have employed Witness Seminar methodology, an oral history approach developed by British medical historian, Professor Tilli Tansey, in the 1990s. (1) 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.¹ 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.²

In 2021 undertook five Witness Seminars, three related to decentralisation reforms in Kerala and two related to community action in the context of India's National Rural Health Mission. Seminars were supplemented by one on one interviews for those who could not attend the proceedings; these were included in our overall reports and transcripts. 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, described hereunder.

Preparatory phase

The groundwork of the Witness Seminar began with preparing the timeline of the evolution of decentralization in Kerala. Initially, we started documenting relevant developments from 1865

onwards, eventually placing emphasis on 1958 onwards. To develop our base timeline and background note further, we conducted a series of individual preparatory meetings with potential witnesses. We identified potential witnesses through snowballing techniques and suggestions from individuals who were publicly known to be a part of decentralization efforts and community participation in health at that period of time.

This process narrowed down our timeline to focus on significant drivers of decentralization in Kerala – the Kerala Sasthra Sahithya Parishad (KSSP), the NRHM, political will, etc. The timeline was divided into - before decentralization, the decentralization era, and Post People's campaign. We also noted what documentation and resources existed about these various periods of time. Based on our consultation in this phase, we noted that documentation was particularly sparse for the period of NRHM onwards – we decided to place our emphasis here while ensuring there was space for describing and acknowledging the antecedents of this period. Discussions within the team led to the decision to conduct three Witness Seminars that placed emphasis on different types of perspectives pertaining to this period: Policymakers operating at the state level, implementers at the field level across the state, and implementers who were involved either at in between or on both levels. Participants included people working with the state health system, administrative officials, policymakers, academicians, activists, doctors, civil society organizations, health inspectors, researchers and Panchayat presidents. Many of the participants fell into more than one of these categories. We selected the Chair from among the participants for each level, based on their acceptance level amongst other participants. Scheduling the dates of the Witness Seminar was subject to the availability of the Chair. Once the Chair was confirmed, we created a Doodle poll survey platform, shared it with participants and asked them to indicate a suitable date and time for

- 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

the Witness Seminar from the available options. Once the date of the Witness Seminar got fixed, we informed the participants and shared the Agenda of the Witness Seminar two days before the seminar. We conducted preparatory meetings with the Chair of each Witness Seminar and discussed how the session should proceed (this was left to the Chair's discretion/prerogative).

We also circulated Participant Information Sheets (PIS), consent forms, as well as key questions. Participants were informed in advance about the Witness Seminar through phone/e-mail, and we shared all the essential documents.

Seminar phase

We planned three Witness Seminars and expected each to last about in the range of one and a half to two hours, given that these would be held virtually (whereas Witness Seminars that we had read about had been up to five hours in duration). The shorter duration of Witness Seminars was a significant factor that allowed many participants to accept our invitation in the first instance. Given that these were carried out during COVID moreover, using a virtual mode allowed us to advance our work.

Although we aimed to recruit not more than ten participants per seminar, scheduling and technological constraints resulted in there being 7 participants in the first seminar, 5 in the second and 9 in the third. The participants who could not attend were interviewed separately from the Seminar via a one-to-one meeting.

We reminded the participants through individual call alerts/SMS alerts/what's app on the day of the Witness Seminar. We conducted the seminar via the Zoom platform, the link for which was shared via calendar invite in advance and on email the day of the meeting.

Participants were encouraged to use languages of their preference – English or Malayalam. Apart from the Chair, a moderator/facilitator was present, who at the beginning of each Witness Seminar briefed and explained the Witness Seminar format, other proceedings and the transcript creation process after that. We followed a classic pattern where the Chair informs the participants and calls the participants to speak up for around ten minutes in no particular order. We gave additional time for the talk after the end of the first round of discussion. Many of the participants tried to follow this, but there where cases were

participants exceeded the time limit. As the session wound down, a thank you message was conveyed by a member of the research team to the Chair and participants.

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 (with an option to send only each witness response, as they prefer). Witnesses at this point were allowed to 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, but practically this too also got extended. On the one hand, most of the participants used this opportunity to brush up and clarify what they had said on the day, while many did not make any major edits to the transcripts. The transcript was then annotated with biographical and bibliographical information. 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 next version of the report [this version] annotated with biographical and bibliographical information and published online was shared with participants for their approval. The final report was published and shared with all participants and submitted to relevant repositories and archives in the state, including the Kerala Institute of Local Administration (KILA).

Appendix Two

WITNESS SEMINAR ON COMMUNITY ACTION FOR HEALTH IN INDIA THE CASE OF DECENTRALIZATION AND HEALTH REFORMS IN KERALA

Guiding Questions

1. Around the time that NRHM came to Kerala, what was happening with decentralization and health in the state? What place/priority was health given in the context of decentralization more generally?
 - Specific: How did decentralization efforts particularly in health, evolve post people's campaign?
2. Who were the key players involved with decentralization in the health context? Around 2007, what was the role of KSSP in health and decentralization? What about other institutions and actors involved with decentralization – what was their role?
 - Specific: How were the key players organized - were there formal or informal networks, linkages to parties etc.? What were the shifts, if any, in the roles and positions of key players? What was the role of women in decentralization for health? How far the role Self-health groups (SHGs) has grasped as a classic example of democratic decentralization?
3. What were the key principles on which the decentralization of health sector in Kerala was based? What were the main debates in this whole process of decentralization and health in Kerala?
 - Specific: In Kerala, the constitutional amendments and other decentralization processes were often known by the name 'Janakeeya asoothranam' – how do these relate to terminologies like 'decentralization' and 'LSGs'? Any comment?
4. Given the changed relationship with the centre post NRHM, what were the significant changes that happened throughout the process of decentralization in the health sector post 2007 or so?
 - Specific: How did the fund flow of NRHM relate to the devolution of funds and functionaries concerning decentralization? How does decentralization link to Aardram? With the ongoing COVID-19 pandemic, how far the LSGs have involved with the situation intersected to decentralization?
5. What were the positive impacts of decentralization on Kerala's population health in Kerala (particularly in the period 2007 onwards)?
 - Specific: What were successful experiences of decentralized planning in health (e.g. Pain and palliative care, diabetic care (KIRAN) - SHSRCK documentation)? How do we define "success" here? The Reserve Bank of India in its annual report 'State Finances – A Study of Budgets of 2020-21' praised Kerala health sector and local self-government and gave 10 on 10 for Kerala – would you agree? Why / why not?
6. What were the contentious or unsuccessful experiences/examples?
 - Specific: What are the limitations or targets we did not achieve as planned initially? What went wrong? Decentralization initially had great momentum – do you feel this was sustained in the past decade and a half? Why or why not?
7. What was the role of political parties/shifts in governance on the continuity and impact of decentralization in health?
 - Specific: Any examples/content/process which stand out?
8. What is unique about Kerala that allowed decentralization in health to play out the way it did?
 - Specific: Could this model be replicated in other states? If yes, how and what adaptations would be required? What advice would you give for those in other states / Other countries / to the Civil Society Engagement Mechanisms (CSEM) for UHC?