Witness Seminar on Community Action for Health in India

The case of Decentralization and Health reforms in Kerala

First of Three Witness Seminars

Held online via Zoom on 30th June 2021

HeaL
Health equity action Lab

The George Institute
for Global Health

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Contents

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Publishing

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Acknowledgements

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Please cite the publication as a whole as: Sreejini Jaya, Gloria Benny, Hari Sankar, Manu Madhavan, Misimi Kakoti, Siddharth Srivastava, Shraddha Mishra, Devaki Nambiar (eds), The case of Decentralization and Health reforms in Kerala. Transcript of a Witness Seminar. Delhi: The George Institute for Global Health India, 2021)

References to direct quotations from this Witness Seminar should follow the format below:

[Witness name], in the case of Decentralization and Health reforms in Kerala. Transcript of a Witness Seminar, held 30 June 2021, (Kerala: The George Institute for Global Health India, 2021) www.georgeinstitute.org/witness-seminar-reports, [page number of reference]

Acronyms

ASHA	Accredited Social Health Activist	**NFHS**	National Family Health Survey
AYUSH	Ayurveda Yoga & Neuropathy Unani Siddha and Homeopathy	**NGO**	Non-Governmental Organization
CBNP	Community Based Nutrition Programme	**NHG**	Neighbourhood Groups
CHC	Community Health Centre	**NHM**	National Health Mission
CPI (M)	Communist Party of India (Marxist)	**NQAS**	National Quality Assurance Standards
DMO	District Medical Officer	**NRHM**	National Rural Health Mission
FHC	Family Health Centre	**NUHM**	National Urban Health Mission
HIV	Human Immunodeficiency Virus	**PHC**	Primary Health Centre
HLEG	High Level Expert Group	**PIS**	Participant Information Sheet
ICPD	International Conference on Population and Development	**PPC**	People's Plan Campaign
IRTC	Integrated Rural Technology Centre	**RKS**	Rogi Kalyan Samiti
JHI	Junior Health Inspector	**RRT**	Rapid Response Team
JPHN/ JHN	Junior Public Health Nurse	**SDG**	Sustainable Development Goal
KILA	Kerala Institute of Local Administration	**SHG**	Self-help Group
KRP	Key Resource Person	**UBSP**	Urban Basic Services Programme
KSSP	Kerala Sasthra Sahithya Parishad	**UDF**	United Democratic Front
LDF	Left Democratic Front	**UHC**	Universal Health Coverage
LSGI	Local Self Government Institution	**UPA**	United Progressive Alliance
MGP	Modernizing Government Programme	**UPHC**	Urban Primary Health Centre
NABH	National Accreditation Board for Hospitals and Healthcare Providers	**WHO**	World Health Organization
NCD	Non-Communicable Disease	**WHSNC**	Ward Health Sanitation and Nutrition Committee

Background and Purpose

Community participation in health in India[1]—key antecedents

Various global developments, including the Alma Ata declaration, the establishment of the People's Health Movement in 2000, and the International Conference on Population and Development (ICPD), have shaped the discourse around social participation in health. More broadly, the geopolitical context of Non-Aligned Movement, the New International Economic Order, and attempts to create an alternative paradigm for global development have centre-staged social participation, redistribution of power, and a rights-based approach for health.

Such has also been the case in India, where community participation in health and health reform precedes Independence. A range of individuals, institutions, and collectives set the stage for community action for health.[1] Building on these was the National Rural Health Mission (NRHM), launched in 2005 and widely lauded as a major health policy achievement, particularly for its emphasis on the role of community participation, and for resulting in major gains in India's advancement with the Millennium Development Goals.[2] NRHM created several institutional arrangements for community ownership and leadership in health. These included one of the world's largest community health worker programs, village- and facility-level committees with delegated financial powers, community monitoring, an action group tasked with supporting community action nationwide, and more.[3, 4]

NRHM itself was designed to promote bureaucratic or programmatic decentralisation in the health sector: decentralisation of funds, functions, and functionaries to subnational government levels were part of the operational framework.[5] NRHM also recognized the importance of decentralisation and district management of health programs, conceiving the district[2] as the core unit of planning, budgeting, and implementation.[6] In each state or union territory of India, however, existing contexts, path-dependent processes, and stakeholders were imbricated in the 'communitization' process in unique ways. We sought to understand these processes and history at the national and state levels using the Witness Seminar methodology.

Our methodological annexure is detailed in on our project landing page.

This section is reproduced in each of five Witness Seminars that were carried out in 2021 with a focus on community participation in NRHM

In Indian administrative scenario, the nation is subdivided into states and each state is further divided into districts. The districts are then made into smaller subdivisions of village and blocks in rural areas and urban local bodies exist in urban areas.

Kerala's decentralization journey[3]

In the 1990s, the momentum around decentralisation was strong given the introduction of India's 73rd and 74th Constitutional Amendments in India, both of which mandated local self-governance with functional devolution of provision of services in education, health, water, sanitation, transport and roads and more to village leadership structures, called Panchayats and urban local bodies in cities.[7,8] At the same time, micro-level efforts and experiments put forward by civil society organizations, predominantly by the Kerala Sasthra Sahithya Parishad (KSSP), were in full swing.[8,9] KSSP emphasized various developmental issues, as well as local-level resource mapping, drawing from work done in the 1970s on developing institutional frameworks for local planning. These efforts culminated in the much-lauded 1996 People's Plan

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2   In Indian administrative scenario, the nation is subdivided into states and each state is further divided into districts. The districts are then made into smaller subdivisions of village and blocks in rural areas and urban local bodies exist in urban areas.

3   This section is reproduced in each of three Kerala-focused Witness Seminars that were carried out in 2021 with a focus on community participation in NRHM.

Campaign (PPC) in Kerala, also known as Janakeeya Asoothranam.[8,9,10]

Within the Campaign, Primary Health Centers (PHCs) and their referring sub-centers were brought under the authority of villages. Further, communities were brought together to decide which health topics were significant and needed attention. This was done in an attempt to engage more closely with the community, identify and implement effective changes, respond to local health needs, and encourage of use of these centers as the first point of care.[11] Thus, decentralisation was aimed at bringing health care providers and community members to work together to identify and address local priorities.

A decade or so on, there emerged criticisms regarding the campaigning mode of PPC for raising people's expectations beyond the system's erstwhile capacity. The inability of health institutions to manage resource allocation processes and the general lack of technical skills to respond to health needs with workable strategies were seen as barriers.[11,12] Moreover, the village-level institution in local self-government in India, called Panchayats, faced administrative and organizational challenges such that the allocations to health were disproportionately higher compared to those made for other sectors, with lack of clarity on gains achieved.[11,12]

Meanwhile, national reforms, which also sought to 'communitize' health planning and service delivery under the aegis of the NRHM were underway. This introduced new contexts, considerations, expectations, and roles and actor dynamics pertaining to decentralisation and community action for health. There has been limited academic exploration of decentralisation in the period following the launch of NRHM, with notable but rare exceptions.[13]

Twenty-five years after decentralisation reforms began, we placed our emphasis on the journey of decentralized planning for health in Kerala,

with particular reference to the post NRHM period. We sought to more deeply understand perspectives on the contexts, actors, approaches, key developments, and implementation of decentralisation in the health sector, along with reflections on what did and did not work.

This section is reproduced in each of three Kerala-focused Witness Seminars that were carried out in 2021 with a focus on community participation in NRHM.

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Witness Biographies

Note: Biography information reflects the position of witnesses at the time of the seminar. Some designations and/or roles may have changed.

CHAIR:

Dr. Ramankutty V.

A pioneer of the People's Health Movement in Kerala, Dr. Ramankutty is a health economist, epidemiologist and a public health expert currently serving as the Honorary Chairman, Health Action by People (HAP) and the Research Director, of Amala Cancer Research Centre. He is a former Professor at Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST), and former Head, Achutha Menon Centre for Health Science Studies. He was an Emeritus Professor of SCTIMIST as well.

WITNESSES:

Shri. S.M. Vijayanand IAS (Retd.)

Shri Vijayanand is former Chief Secretary of Kerala who played a key role in the devolution of funds, powers and personnel to the LSGIs, besides serving as Member-Secretary of the Sen Committee and member of the State Finance Commission. He is currently the Chairman at the Center for Management Development, Kerala. He also holds the position of Chairman of the Sixth State Finance Commission of Kerala.

Dr. Joy Elamon

Dr. Elamon is currently the Director General, Kerala Institute of Local Administration (KILA). A public health expert, he is one of the core team members of the People's Plan Campaign in Kerala. He was a National Resource Person at the Ministry of Panchayati Raj, Government of India for decentralized participatory planning. Dr. Elamon is a former Vice President of Kerala Sasthra Sahithya Parishad and State Convenor of Jan Swasthya Abhiyan in Kerala

Shri. N. Jagajeevan

Mr. Jagajeevan is currently Consultant—Waste Disposal Management of Haritha Keralam Mission and part of the Kerala Sasthra Sahithya Parishad. He has an array of experience in domains such as Ernakulam Literacy, Kerala Complete Literacy Resource Map Construction, Panchayat Level Development Project (PLDP), People's Planning, and Kudumbashree.

Dr. K. Vijayakumar

Dr. Vijayakumar is currently the Secretary, Health Action by People (HAP) and Professor and Head of the Department, Amrita Institute of Medical Sciences. He is also the former Professor and Head of the Department of Community Medicine, Government Medical College Thiruvananthapuram. He is extensively involved in research and practice in the field of decentralization efforts in Kerala.

Dr. K.P. Aravindan

Dr. Aravindan is Scientist Emeritus at the Indian Council of Medical Research. He is currently the Medical Director, Micro Health Laboratories, Kozhikode. He was the Professor and Head, Department of Pathology at Government Medical College, Kozhikode. He is also former President of the Kerala Sasthra Sahithya Parishad.

Dr. C.K. Jagadeesan

Dr. Jagadeesan is Deputy Director of Health Services (Planning) and the State Nodal Officer for the Aardram Mission, Government of Kerala. He is an experienced medical doctor and involved with planning and administration in health services in Kerala.

Dr. Jose Chathakulam

Dr. Jose is the Director, Centre for Rural Management. He is a researcher and national level consultant working on Panchayati Raj and Local Level Planning. He was closely involved with the Literacy Movement, resource mapping, and People's Planning Campaign (PPC) in Kerala. He has published extensively on decentralization and carried out research on the Kerala's People's Plan over the years.

MODERATOR:

Dr. Sreejini J.

Dr. Sreejini served as a Senior Consultant at the George Institute for Global Health, India. She completed her PhD from the Achutha Menon Centre for Health Science Studies at the Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST). She is a DAAD scholarship recipient and works on Health Systems Research as well as participatory research.

Proceedings of the Witness Seminar

Proceedings start

Sreejini J: Let's start the meeting. The other three participants will join very soon. Good evening and greetings to each one of you present today. It gives me immense warmth and great pleasure to grace all of your presence in this occasion and extend my warm wishes on behalf of the George Institute for Global Health India. Before we begin this seminar, I would like to express my heartfelt gratitude to all of you, who sincerely committed to this event to make it a success.

I welcome SM Vijayanand (SM) Sir, retired IAS officer, Chairman, Centre for Management Development, Dr. M. Vijayakumar Sir (VK), Secretary, Health Action by people, Dr. C.K Jagadeesan (CJ) Sir, Deputy Director of Health Services (Planning), Dr. Jose Chathukulam (JC), Director, Centre for Rural Management. We are waiting for Joy Elamon Sir (JE), N. Jagjeevan (NJ) Sir and KP Aravindan Sir (KP) to join us soon. I welcome everyone to this seminar whole heartedly. The chair for the session is Dr. V. Ramankutty (RK), who doesn't require an introduction. But I take this opportunity to formally introduce him, who is currently the Honorary Chairman of Health Action by People (HAP) and the Research Director of Amala Cancer Research Centre. He is retired Professor of Sree Chitra Thirunal Institute for Medical Sciences and Technology, and former Head of the Department at Achutha Menon Centre for Health Science Studies. Welcome, Sir. We all have gathered today to attend this Witness Seminar on community action in health, with special reference to decentralization efforts in Kerala. We are focusing on the post NRHM[4] era. Today, through this Witness Seminar, we place our emphasis on specific models of decentralized planning in Kerala, understand the contexts, the actors, the approaches, what were the key developments which happened as well as reflections on what worked and what didn't and this is a very new even for me, it's a very innovative kind of study where it is the first time, I'm exposed to such a methodology.

A Witness Seminar is form of oral history, where those who have experienced an event in a historical period, share their first-person account of it, and from this we develop a transcript, which becomes an important historical reference document, so that is what we are going to start and this is going to be a history or beginning—we can call it that if we want. All the participants have gone through the participant information sheet and the participation is purely voluntary. We received the written informed consent indicating the acceptance. Thank you all for the efforts taken in this, you know, in the midst of all these busy schedules, you have taken time to give me that acceptance letter. Thank you. We will be recording the entire seminar on the Zoom platform and during the meeting—because everyone has their own perspective—during the meeting if any disagreements arise from the discussion between the participants, we will refrain from moving towards a resolution. There may be different perspectives as part of the historical record because it depends upon these different perspectives. And after the seminar is over, there are certain procedures to be followed regarding the transcript we generate from the Witness Seminar, like immediately after the Witness Seminar electronic data and audio files from the interview will be stored electronically on a shared server at the George Institute for Global Health. But, the main important thing of this particular Witness Seminar is that the transcript will not remain anonymous. A verbatim transcript will be created, and the witness review transcripts will be sent to all the participants

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4   The National Rural Health Mission (NRHM) is a centrally sponsored scheme of the Government of India, launched in 2005 to provide affordable, equitable and quality health care to the rural population. The thrust of the scheme has been on setting up a community-owned and decentralized healthcare delivery system with inter-sectoral convergence to address determinants of health such as water, sanitation, education, nutrition, and gender equality. It is now integrated under the overarching National Health Mission (NHM) since 2013 alongside the National Urban Health Mission (NUHM). See Government of India (n.d.). National Rural Health Mission: Framework for Implementation (2005-12). Ministry of Health & Family Welfare. https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf.

with an option to send each witness's response only as they prefer. So once the transcript is created, we will send the original verbatim transcript to all the participants. Here, the witness at this point can exercise their right to delete, edit or redact portions of an interview, ability to add clarification and correct mistakes.

Participants are given a very innovative technology, where they can modify the comments, add or further reframe it anyway. The participants will be requested to complete this procedure within a week, or within two weeks because I know everyone is busy at the time. So, based on that, the final report will be shared to the participants for another round of editing, revision and approval as required. Participants can use any language of their preference—if at all possible, English or Malayalam. And so, these are the points to be noted. These are the general points to be noted for this Witness Seminar and regarding the actual, regarding, what needs to be covered or you know, all the other things will be covered by our Chair. Now, over to the Chair, Sir.

Ramankutty V: Good afternoon, everyone. I can remove these contraptions and talk directly, that may be better. What about now?

Sreejini J: Now, it's clear Sir.

Ramankutty V: I think [pause] I must record my appreciation of Apple, because its audio is much better than all these contraptions [laughs]. So, good afternoon and first of all let me thank the George Institute and the organizers Dr. Devaki and Dr. Sreejini, who has been our student. It's a great initiative. I have had the pleasure of working with the George Institute in the past also, even then they were very serious about what they do.

As Sreejini mentioned, the Witness Seminar is something which even I have not been very much a part of, but I think ...it makes sense because it's very difficult to get the experienced and knowledgeable people together in one forum and get their opinion recorded which is a way of documenting history.

Yes, so, in that sense, it is very important. Many of the things that we know personally, there has been no documentation. That is one of the major drawbacks of so much about public space. So, I think this will make a difference and decentralization is always something which I have been keeping very close to my heart for my very policy perspective and also from my days as an activist and I think it's a very important aspect of Kerala's development. We have had many ups and downs, we have struggled through, but I believe that we have made some change. And personally, and also on behalf of my organization, Health Action by People[5]—which is an NGO, which is actually working in health sector—, we have been very much interested in decentralization and currently, we do have another project. We are studying the decentralization process in the last 25 years in Kerala, especially in its impact on the health sector, whether all the initial objectives are being met or what remains to be done, etc. In that context, it gives me great pleasure to focus on this seminar, which is for community interactions in health, which is very, very important. And I like the fact what Sreejini said, focusing on particularly on NRHM, which came after several years of decentralization initiatives in Kerala. So, NRHM has been celebrated as one of the initiatives for decentralization where there are local committees, but we have had an experience of doing that for several years when NRHM came in and personally—of course it's not an objective evaluation—but personally my opinion has been that it has actually introduced kind of a complication or something which has been going smoothly and a spanner has been thrown into its course. Of course, I think top people like Dr. Jagadeesan will be able to talk about that better. I mean, I'm not saying this as an opinion, but this is just the impression that I had, whatever it is, may or may not be true.

So anyway, these are important aspects, which are to be documented and I won't say much further. We have around one and half hours, but I think even that might be too tight because there are so many people with so much of experience and interest in

5   Health Action by People (HAP) is a not-for-profit organisation working on research on health-related problems, health education, public health research and health policy interventions in Kerala. See http://hapkerala.org/.

the subject that people might keep on talking. But I would request everyone to try to make your points briefly and also prioritize what you want to say in the sense that is most important you say first. You can put in the most important ideas ahead. With that, I think, I don't know what the format for this is, but, I believe, I can call on each of these experts to talk. In which case I will definitely call on Shri S.M. Vijayanand, a very senior bureaucrat, former Chief Secretary, many years in the LSG departments and one of the great champions of decentralization in Kerala. Unlike many other senior officers who were not very pleased to the idea of power being decentralized to the Panchayats[6], but he has been a great supporter of this idea. And also, a person who has always stood for the marginalized population, like tribals and others. So, it's a great pleasure to invite him to talk and I am sure he will have a lot to say on this. Shri Vijayanand…

S.M. Vijayanand: One clarification. Do I need to cover all the questions or some general points for and how long time? Seven, eight minutes?

Ramankutty V: I think, if you can make it within 10 minutes, it will be fine. And also, you know, say what you feel mostly about first. It's not necessary that you should cover every single question. Whatever you feel soundly you say, and even if it exceeds 10 minutes that is fine. Because you know we want to hear people like you.

S.M. Vijayanand: I was associated directly with People's Plan from day one for fifteen years across four Governments and since 2011. I have been in constant touch and as Chairman of the Sixth State Finance Commission[7] since 1st November 2019, I am looking at Kerala's decentralization with a critical lens. Right at the beginning of People's Plan Campaign[8], Government set up a Committee on Decentralization of Powers[9] under the Chairmanship of late Dr. S.B. Sen (though Dr. Sen passed away within two months of giving the Interim Report in August 1996, the Committee is still popularly known as Sen Committee). It was the Sen Committee which laid down the key principles of decentralization and radically amended the laws. Though the Primary Health Centres were transferred on 2nd October 1995, the District Hospitals and the District Medical Officers were transferred to the District Panchayats based on the recommendations of the Sen Committee in 1999.

At the outset, it is necessary to have an idea of the philosophical foundations of decentralization, which is essentially based on the Gandhian[10] concept of village democracy and local economic development with a special focus on the active participation of the poorest of the poor. Also, Paulo Freire's[11] belief that people, ordinarily treated as mere objects, known and acted upon, are capable of becoming subjects of their destiny, knowing and acting. Though Kerala was not known for its strong local governments, its decentralization efforts are a continuum of its political and development history, particularly the long tradition of public action and deep social capital, matched by vibrant democratic

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6   Panchayat is an institution of local self-government in India given constitutional status through the 73rd Constitutional Amendment of 1992 to devolve decentralized power at the local level. See https://www.india.gov.in/my-government/constitution-india/amendments/constitution-india-seventy-third-amendment-act-1992

7   State Finance Commissions are constituted by the Government of Kerala (as part of a constitutional mandate) to review the financial status of Panchayats and Municipalities, and make recommendations relating to governance and to strengthen their financial position. For reports and more on Kerala's Finance Commissions, see http://finance.kerala.gov.in/sfc.jsp

8   Decentralized planning in Kerala took the form of the People's Plan Campaign (PPC) was launched in 1996. Under this campaign the Government took the process of decentralized planning as the entry point to drive all reforms at the local government level. See https://plan.lsgkerala.gov.in/planning.aspx and https://thekudumbashreestory.info/index.php/history-and-evolution/the-kudumbashree-idea/the-peoples-plan-movement.

9   In 1996, the Government of Kerala constituted the Committee on Decentralization of Power (also known as the Sen Committee) for recommendations on measures for effective and decentralized devolution of power to the Local Self-government Institutions. The committee was chaired by Dr. Satyabrata Sen. See Isaac, T. M. T., & Franke, R. W. (2002). Local Democracy and Development: The Kerala People's Campaign for Decentralized Planning. Rowman & Littlefield.

10   See Joshi, D. (2002). Gandhiji on Villages. Mumbai: Mani Bhavan Gandhi Sangrahalaya; http://www.mkgandhi.org/ebks/Gandhionvillages.pdf .

11   Paulo Freire—a native of Brazil—was a philosopher and proponent of critical pedagogy who has been a major influence in the fields of education and development globally. See: https://www.freire.org/paulo-freire-biography

politics. For a long time, the State consciously has been following a rights-based concept of welfare and development. In order to ensure that the benefits reach the people, particularly the poor, there was extensive social mobilization, barring certain outlier groups like tribals and fisher-folk, and this was largely done by political parties and social organizations.

With the Literacy Movement[12] initiated in 1989, Government entered into social mobilization on a large scale, and a cooperative form of public action came into being. The relative success of this exercise gave confidence to the Governments to launch the highly participatory and deeply democratic People's Plan through a well-orchestrated campaign. So, Kerala boldly went in for a big bang decentralization, reversing the conventional sequence by giving responsibilities and then building capacity, giving powers, and then creating systems and giving resources, and then setting up accountability arrangements.

Kerala's decentralization aimed to create formal spaces for participation by lay citizens and, equally important, by non-government professionals and activists. EMS[13] enunciated the concept of Voluntary Technical Corps[14] of such professionals, willing to support local governments. At a time when rolling back the State was very fashionable, Kerala attempted a humanization of the State and taking it to the doorsteps of the citizens by democratizing and activating the front line.

People's Plan owes a lot to the Kerala Sasthra Sahithya Parishad [KSSP][15], a people's science group focusing on equitable and sustainable development. KSSP piloted the Kalliasseri village level plan[16] in the early 1990s. People's Plan was an adoption of this methodology. In the initial years, the KSSP volunteers worked enthusiastically with the local governments at different levels under the visionary leadership of Dr. M.P. Parameswaran[17] to realize the concept of people's planning. Of course, gradually, for different reasons, involvement of KSSP started coming down irrespective of the Government in power. What is perhaps needed now is a coalition or a loose collective of similar people's groups, civil society organizations, and voluntary professionals to work voluntarily with the local governments.

One of the notable features of Kerala's decentralization was the clarity in devolution of functions. In health, primary health was devolved to the cutting-edge level local governments, i.e., Village Panchayats, Municipalities and Corporations, and secondary health was given to the District Panchayats in the form of District Hospitals and the District Medical Officers being under the District Panchayats. The first referral units, namely, the Community Health Centres and Taluk[18] Hospitals, were given to the Block Panchayats, Municipalities and Corporations.

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12 The Total Literacy Programme (TLP) was launched in the late 1980's in Ernakulam district and Kottayam Municipality of Kerala as a drive against mass illiteracy. The aim was to achieve total literacy through people's participation, the scope of which was later expanded to cover the entire state. See https://kerala.gov.in/total-literacy and http://literacymissionkerala.org/.

13 E.M.S. Namboodiripad was the Chief Minister of Kerala from 1957 to 1959 and 1967 to 1969.

14 The Kerala State Planning Board introduced the Voluntary Technical Corps (VTC) programme in the 1990s. In the VTC, a roster of retired and non-active experts in the state is prepared. From this roster, those willing may spend at least one day a week to do voluntary work to help Panchayats enrolled in the programme. From Bandyopadhyay, D. (1997). People's Participation in Planning: Kerala Experiment. Economic and Political Weekly, 32(39), 2450–2454.

15 Founded in 1962, Kerala Sasthra Sahithya Parishad (KSSP) emerged as a progressive people's science movement consisting of science writers and teachers with an interest in science from a social perspective. Their goal was to popularise science, literacy, and science literacy. See https://kssp.in/.

16 In Kalliasseri Panchayat in the 1990s, the KSSP mobilised a group of volunteers who drafted plans to improve drainage, create a small village forest reserve, and protect slopes from erosion. Volunteers also designed and conducted a socio-economic survey, women's cooperatives were set up, and there was mass mobilisation through civil society organisations to dig the 825-metre-long 'People's Canal' that reclaimed 40 acres of rice land and reduced the area's mosquito hazard. This is considered an exemplar of local participatory planning. From Franke, R. W., & Chasin, B. H. (2000, May). The Kerala decentralisation experiment: Achievements, origins and implications. International Conference on Democratic Decentralization, Kerala. https://msuweb.montclair.edu/~franker/KeralaPapers/FrankeChasinMay2000ConferencePaper.pdf.

17 Dr. M.P. Parameswaran is one of the founders of the Kerala Sasthra Sahithya Parishad (KSSP) and former Director of the Integrated Rural Technology Centre, Kerala.

18 Each district in India is divided into sub-districts, referred to as Taluks or blocks.

Another interesting feature of Kerala's decentralization is that along with 'work', the 'worker' was also transferred. Thus, the entire establishment of the Health Department at the district level came under the control of the local governments, and 'control' needs to be clarified:

- Assigning work
- Providing funds and seeking accounts and accountability
- Review of performance including inspection
- Disciplinary action up to minor penalties for non-performance

But recruitment and placement are done by the Government and salaries continued to be paid from the State. Also, policy is set by the State along with standards. Schemes like NHM[19] are implemented by the State through the same institutions. Thus, there is a kind of 'dual control'. New institutions can be set up, and new staff created, only by the Government, though of late, local governments are given the freedom to appoint doctors on contract, if the salaries can be paid by the local governments for improving service delivery. Though the essential consumables are provided by the Government, local governments supplement them substantially; in many hospitals, up to one-third.

Since 2004, the maintenance of health institutions is almost solely the responsibility of the local governments for which the State Government gives an untied non-road maintenance fund (which covers other institutions transferred to local governments like Schools, Veterinary Hospitals,

Anganwadis[20], etc.) of 2.5% of State's Own Tax Revenue of around Rs. 50,000 crores.

The most important feature of Kerala's decentralization is the practically untied grant devolved to the local governments in the form of Development Fund[21], which constitutes more than 25% of the State's Plan Outlay [though India gave up planning[22] at the end of 12th Five Year Plan, Kerala is the only State which decided to move ahead[23] with planning including Five Year Plans].

Since the Development Fund and Maintenance Fund18 are relatively untied, there is a competition for resources among institutions and sectors. This motivates many institution heads to propose new ideas and improve performance to attract more funds. This authority through the fiscal route has been more effective in practice than the formal powers.

An interesting observation in Kerala's decentralization is that, right from the beginning, Veterinary Doctors and the AYUSH[24] Doctors proactively co-operated with the local governments, whereas vast majority of Allopathic Doctors were less enthusiastic and probably skeptic. At the state level, barring the Department of Local Self Government, other Departments also did not push to achieve the potential of decentralization for quite some time.

It is the absence of guidance from above which made many local governments go in for new infrastructures in the form of new wards. At the end of ten years, there were so many unutilized buildings in hospitals. For putting them to use,

19 The National Health Mission (NHM) was launched by the Government of India in 2013. It encompasses the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The main programmatic components of NHM are health system strengthening, Reproductive Maternal Neonatal Child and Adolescent (RMNCH+A) health, and communicable and non-communicable diseases. See https://nhm.gov.in/.

20 'Anganwadi' Centres (or creches) were started by the Government of India in 1975 as part of the Integrated Child Development Services (ICDS) Programme to address child hunger and malnutrition. Anganwadis are the focal point for implementation of all the health, nutrition and early learning interventions under the ICDS programme. From https://womenchild.maharashtra.gov.in/content/innerpage/anganwadi-functions.php.

21 More information on untied funds may be obtained from Chapter 2 'Revenue of Grama Panchayats' from Government of Kerala (2017). Manual on Finance Management—1: Revenue for Grama Panchayats in Kerala. Kerala Institute of Local Administration. https://klgsdp.org/wp-content/uploads/2017/12/Manual-on-Finance-Management-1-Revenue-for-Grama-Panchayats-in-Kerala.pdf.

22 Five Year Plans were discontinued by the Government of India from 2017 with the end of the 12th Five Year Plan period. See https://doe.gov.in/sites/default/files/12thFiveyearplan23022017.pdf

23 Kerala decided to continue using Five Year Plans even when this was discontinued at the national level in 2017. See https://spb.kerala.gov.in/sites/default/files/2021-04/13th%20Plan%20English%20Final%20%283%29.pdf

24 AYUSH is the acronym of the medical systems practiced in India consisting of Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy. In 2014, the national government set up an AYUSH ministry. See https://www.nhp.gov.in/ayush_ms.

additional staff was necessary, which could be created only by Government which had to bear the burden of salary. But during this time, Hospital Development Committees (now called Hospital Management Committees[25]) got activated. In general, responsiveness of the public health institutions improved and, particularly after 2004, the doctors realized that if they work closely with the local governments, they can improve their institutions or at least keep them in good repair. Medicines could be supplemented, and useful equipment could be purchased. This could be done just by giving a proposal to the local government and convincing them. In the earlier scenario, even such simple things would have involved a tortuous bureaucratic movement right up to the Directorate of Health Services, which most Doctors do not have the capacity or tenacity to pursue. With this, cooperation began to improve.

In 2003, Modernizing Government Programme (MGP)[26] was initiated in the State with emphasis on improving service delivery. About 10% of all the hospitals were selected and detailed action plan was prepared in a scientific manner, but unfortunately ill-informed criticism from political parties smothered this potentially game-changing initiative.

Also, a great opportunity was lost mainly due to bureaucratic apathy, if not antipathy, when the National Rural Health Mission (NRHM) was launched. Kerala was the only State which could have prepared meaningful health plans from below with the involvement of the people. But a decision was taken—pushed by top bureaucracy unopposed politically—to keep NRHM as a separate vertical, losing opportunities for synergy. In May 2006, an unusual procedure was followed by Government of India. A joint letter was written by the Union Health and Panchayati Raj Secretaries to their State counterparts to bring about the involvement of Panchayats in primary health. Surprisingly, it got no traction in Kerala.

But after five years, at the behest of the Health Secretary and certain committed health professionals, when an epidemic[27] broke out in Alappuzha, the services of the local governments were harnessed, and this proved a success. An interesting innovation was the Award instituted by the Health Department called 'Arogyashree[28]' for best-performing local governments. This generated a lot of interest. With the launch of 'Aardram Mission'[29] in 2016, joint action with local governments became a reality. Both local governments and the Health Department realized the importance of cooperation and consciously pushed for it. Local governments, especially the Grama Panchayats[30], took pride in improving the facilities of the hospitals under their control, outreach improved, and Non-communicable Diseases (NCD) and new communicable diseases became the focus of action.

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25 Rogi Kalyan Samitis (RKSs) or Hospital Management Committees (HMCs) were introduced under NRHM as a forum to improve the functioning and service provision in public health facilities, and to enhance community participation and accountability from health services. From Government of India. (n.d.). Guidelines for Rogi Kalyan Samitis in Public Health Facilities. Ministry of Health and Family Welfare. https://nhm.gov.in/New_Updates_2018/communization/RKS/Guidelines_for_Rogi_Kalyan_Samities_in_Public_Health_Facilities.pdf.

26 The Modernizing Government Programme (MGP) in Kerala was carried out with the financial and technical assistance from the Asian Development Bank (ADB) starting in 2002. The main objectives of the programme include achieving fiscal sustainability, improving the quality, equity and 'value for money' of services offered by the government, improving the targeting of poverty reduction schemes, and strengthening functions of the government at the state and local levels. See ADB's report here: https://www.adb.org/projects/documents/modernizing-government-and-fiscal-reform-kerala-program-subprogram-1-rrp

27 The Chikungunya epidemic of 2006 in India affected Kerala severely, especially the district of Alappuzha. See: https://nvbdcp.gov.in/index4.php?lang=1&level=0&linkid=491&lid=3769.

28 Refers to Arogya Keralam Puraskaram, which is an award instituted by the Government of Kerala to recognise local bodies for effective implementation of health projects. See https://arogyakeralam.gov.in/2020/04/01/arogyakeralam-puraskaram/ (The award is now called Aardram Keralam Puraskaram. See https://www.thehindu.com/news/national/kerala/kollam-local-bodies-bag-top-health-awards/article27401855.ece)

29 Aardram Mission was launched in 2017 to transform the public health system of Kerala in alignment with the Sustainable Development Goals (SDG Goal 3). The programme aims at providing 'people-friendly' outpatient services and access to comprehensive health services for the marginalised, converting Primary Health Centres (PHCs) to Family Health Centres (FHCs), and standardising services from primary care settings to tertiary settings. See https://arogyakeralam.gov.in/2020/04/01/aardram/

30 The Panchayat system (see note 3) is a form of government at the village. It covers the village level, i.e., a Grama Panchayat, clusters of villages (Block Panchayat), and the district level (District Panchayat).

When NRHM was launched, it was obviously meant for states with very poor facilities and human resources. Health problems of the State were second-generation ones, and there was a widespread feeling that NRHM was irrelevant in Kerala, but soon, through pragmatic planning and significant policy pressure from the State, the NRHM resources came to be put to good use, particularly for addressing shortage of human resources. The pleasant surprise was the functioning of ASHA[31] workers, whom initially many thought would be redundant in Kerala, because the State had already a good front line system in health. Mainly due to the push from local governments, ASHA workers have carved out a niche area at the cutting-edge level. The additional funds from NRHM improved the quality of spending on health as Kerala was fiscally stressed and could not afford many resources other than salaries.

The successive years of flood in 2018 and 2019 made local governments, willy-nilly, the front line of governance. There were huge fears about epidemics breaking out post flood. Local governments handled them very well and finally the COVID pandemic has further enhanced the stature of local governments, as they are acknowledged to be the key feature of Kerala's relative successes[32] in managing the pandemic through convergent community action.

Kerala's SHG [Self-Help Group] system called 'Kudumbashree'[33] is a unique model as the SHGs or Neighbourhood Groups (NHGs)30, as they are called in the State, work in partnership with local governments. Nearly very close to 60% of the families covering the bottom-half of the population—barring perhaps the tribals and fisher-folk—are part of the network. This provides huge opportunities for outreach and feedback. Kudumbashree originated in the Urban Basic Services Programme (UBSP)[34] in Alappuzha Municipality in the early 1990s, and in the Community Based Nutrition Programme (CBNP)[35] in Malappuram District in mid-1990s. Interestingly, in both these pilots, public health, especially maternal and child health, received special focus, and in the early days of Kudumbashree, trained volunteers from SHGs provided home-based care, particularly for the elderly. This has a great potential for scaling up.

Kerala is undoubtedly the leader in India with respect to palliative care, initiated by proactive members from the governmental system in the early 1990s, and enriched by civil society contribution. It took off in 2009 under the leadership of local governments. All local governments appointed a palliative care nurse in their institution, and used Kudumbashree for the initial identification and planning process. They also succeeded in mobilizing the local civil society for outreach and material support. This has lot of lessons for further scaling up and involvement of local governments in other health aspects.

Another innovation related to the field of health is the care of mentally challenged children through

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31 One of the key instruments under NRHM is to provide every village in the country with a trained female 'health activist' i.e., the Accredited Social Health Activist (ASHA). ASHAs are trained to work as an interface between the community and the public health system. See https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226

32 The core element of Kerala's response to the pandemic was the active involvement of the Local Governments, nested in larger social mobilisation. See Sadanandan, R. (2020). Kerala's response to COVID-19. Indian Journal of Public Health, 64 (Supplement), S99–S101. https://doi.org/10.4103/ijph.IJPH_459_20. Also, see https://www.who.int/india/news/feature-stories/detail/responding-to-covid-19—-learnings-from-kerala

33 Kudumbashree is a poverty eradication and women's empowerment programme, set up in 1997, and implemented by the State Poverty Eradication Mission (SPEM) of the Government of Kerala. See https://www.kudumbashree.org/pages/171. Also, see note 31 and 32.

34 The Urban Basic Services Programme was launched in 1986 and is funded by the central and state governments in partnership with UNICEF. It later became the Urban Basic Services for the Poor (UBSP) programme and was integrated with other urban poverty reduction programmes to form the Swarna Jayanti Shahari Rozgar (SJSRY) Programme in 1996. It is complemented by the National Slum Development Programme (NDSP) launched in 1996. See de Cleene, S., & Tayler, K. (n.d.). Kerala Community Development Society Alleppey (Working Paper No 105). The Development Planning Unit: University College London. https://www.ucl.ac.uk/bartlett/development/sites/bartlett/files/migrated-files/wp105_0.pdf. Kudumbashree evolved from the UBSP programme implemented in Alappuzha Municipality in 1992. See https://www.kudumbashree.org/storage/files/bhtbe_brochure.pdf and https://kudumbashree.org/pages/73.

35 In 1991, the Government of Kerala, with assistance from UNICEF, initiated the Community Based Nutrition Programme (CBNP) in Alappuzha Municipality, and expanded to Malappuram in 1994. This was implemented through the Community Development Society (CDS) system and led to the emergence of Kudumbashree in subsequent years. See https://www.kudumbashree.org/storage/files/bhtbe_brochure.pdf.

community-based institutions called 'BUDS[36] Schools'. The idea was firmed up in 2003. These schools are run by the local governments and have been fairly successful in the inclusion of the mentally challenged children.

Kerala entered into a MoU with Banyan[37], a leading NGO in mental health to run the 'Home Again'[38] programme, which provides homes to mental health patients who do not have to stay on in hospitals and who are not yet in a position to get integrated with their families. Now local governments are getting involved, and this is a huge scope for expansion.

Decentralization is essentially political. The vision of Shri E.M.S. Namboodiripad10, the leadership of Shri Paloli Mohammed Kutty[39], the dynamic push given by Dr. T.M. Thomas Isaac[40], and the resolute unwillingness to roll back decentralization - in spite of tremendous pressure, political and official—by Shri A.K. Antony[41], all contributed to the grounding and sustainability of decentralization in Kerala. They could not only provide leadership but also shape decentralization in a non-partisan manner on the basis of clear norms and criteria to make them politically acceptable. For example, since 1st April 1997, every single rupee going to local governments is devolved according to a transparent formula. This non-discretionary, normative, and fair allocation of resources in a strongly adversarial political situation at the State level contributed to the political buy-in and, over the years, local governments have brought about substantial local level development—essentially in providing basic minimum needs, infrastructure, improving the facilities in public institutions, and performing very well in programmes of care and compassion, including poverty reduction.

In the last twenty-five years, the percentage of people using public health facilities in Kerala has increased from 28% in the mid-1990s to 67.5% in 2015-16, to over 75% in 2019-20, post COVID it would exceed these figures.

But decentralization is still work in progress. Kerala's performance is outstanding only in relation to other states of the country. Going back to the expectations of mid-1990s, there is a long way to go. In respect to health, the most important need is to prepare a Health Plan from below, converging all the resources available from local governments and the State and Central Governments, prepared in a participatory manner with the active involvement of non-government professionals and volunteers. Further, there has to be multi-level integration across tiers as it is unscientific to compartmentalize primary, secondary and tertiary health. Further, the social determinants of health, most of which are provided by the local governments, need to be consciously linked to the Health Plan. And most importantly, the planning has to be based on sound validated data owned and accepted by the community.

The vast network of women SHGs can be more formally involved in planning for health and in delivery of different health and nutrition services through social enterprises. They can also be involved in community-based monitoring and feedback.

Advice to other States.... though it would be presumptuous to advise other States, there are a lot of learnings from Kerala, which could be summed up as follows:

1. Initial political buy-in
2. Clarity on what local governments is expected to do
3. Seconding the functionaries required to carry

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36 BUDS Schools are free and open special schools for children with mental disability from poor families. The first BUDS school in Kerala was started in 2004 in Venganoor Panchayat, Thiruvananthapuram district. See https://www.kudumbashree.org/pages/85

37 More information on Banyan and this partnership is available at: https://www.mhinnovation.net/organisations/banyan

38 Information about the 'Home Again' program is available at https://www.thehindu.com/news/national/tamil-nadu/the-banyan-scales-up-home-again-programme/article36008301.ece

39 Paloli Mohammed Kutty is a leader of the Communist Party of India (CPI) who has served in Kerala——as District Secretary of the CPI (Marxist) [CPI(M)] in Malappuram, and as the Minister of Local Self Government and Rural Development in Kerala, among other positions.

40 (Dr) T.M. Thomas Isaac served as Kerala's Minister of Finance for terms in 2006-10 and 2015-21. He has served as a Member of the Legislative Assemble (MLA) from the constituencies of Mararikulam and Alappuzha.

41 AK Antony is a three-time Chief Minister of Kerala who was also the Union Minister of Defence from 2006 to 2014.

out the functions devolved to local governments and giving them functional control

4. Provision of untied grants in a transparent and formula-based manner

5. Adopting a participatory planning methodology with a campaign to get popular support and push the agenda, incorporating accountability, especially social accountability measures

6. Creating strong support systems from the civil society, professionals, and the academia

7. Continuous capacity building, particularly of elected representatives

Ramankutty V: Thank you. That was very comprehensive. Especially, Mr. Vijayanand pointed about some other things especially about, when we started with NRHM what happened in the initial time and the missed opportunity. Within the health sector itself, in modern medicine, the sector was somewhat slow in moving to the opportunity of decentralization where other parallel streams used policy change very effectively for their activities. I think these are important things that we tend to forget.

I think now we have…like most of the invitees are here, maybe I should, I don't know, there is any particular order that Sreejini wants?

Sreejini J: No Sir, there's no particular order.

Ramankutty V: I think I will call Dr. Jagadeesh, who is the senior physician doctor in the health services and administration, has very many years of experience, and [is] also somebody working very closely with the department during the years of the decentralization. So, Jagadeesh could you please talk about.

C.K. Jagadeesan: Am I audible?

Ramankutty V: Yes.

C.K. Jagadeesan: So, in eight to 10 minutes, I will discuss the four areas that are expected from my side: decentralization in general in the health sector, interphase of decentralization with NRHM

implementation, Aardram Mission, and COVID-19.

I generally agree with what S.M. Vijayanand Sir said. Initial years, there were some problems with the health department, especially from the doctors' side. They were a bit skeptical about decentralization. There were change management issues that we can expect from a category of staff like medical doctors. Over the years, we could overcome that. That is the positive side.

General improvement in the infrastructure was happening even in the initial years. I don't fully agree with the statement that in initial years there was not much input from LSG. At that time, the Panchayat President could only think about starting an inpatient facility. There was infrastructure improvement focusing on initiation of inpatient facilities in PHCs [which never materialized—and it was not expected everywhere at that level], and also there was support for conduction of field level medical camps and other public health programme. But those days, the point that how exactly a primary health care institution to be developed further was not clear. Now, when we look back at this point, at this period of Aardram Mission implementation, the framework for institutional development is clear. We know how exactly a Primary Health Centre should be modified into or to be developed into. At that point in time, they were not having that clarity. However, in general, there was support for medical camps, support for field-level programmes, and support for additional drug purchase from the beginning.

There were some conflicts somewhere along the way especially during initial years. Some of those issues are mostly related to the administrative control of health care institutions, including the minor disciplinary procedures, attendance verification, etc. These types of activities are not happening these days. At some places, this type of activities created confusion and similar instances.

One area, which I would specifically want to highlight, is that decentralization has given avenues for innovations in health care. And in fact, community-based Pain and Palliative

Care programme[42], and afterwards the NCD programme[43], started at the Panchayat level, especially in northern Kerala—we consider it as innovation. The Calicut Medical College team developed institution-based palliative care. Afterwards, community-based palliative care was formulated and implemented in many of the north Kerala districts. It was mostly in the form of Panchayat projects. Then, afterwards, it was upgraded as an NRHM project at the state level. Similarly, screening and ensuring drug provision for non-communicable diseases was also subsequently followed at some places. Even before the state level and NHM level NCD programme, many of the Panchayats started it. For community-level programme, there were so much of enthusiasm and energy at many places.

With the introduction of NRHM, though it was started in 2005, activities mostly started in 2006 and '07. The way I understand [this particular point was specifically referred to me by Dr. Ramankutty Sir], I could see there is some facilitatory role for decentralization through the NRHM, especially in some community-based programmes as [recently I was going through some old documents of NRHM] Vijayanand Sir talked about the ASHA programme. Similarly, Ward Health and Sanitation Nutrition Committees (WHSNCs)[44] were formed. I know that, compared to many other states, we have better functioning WHSNC committees here in Kerala. Though the full scope of it we haven't explored so far.

Fund provision through NRHM was also a significant factor. For WHSNC there was NRHM fund provision of Rs. 10000, and Rs. 10000 through Suchitwa Mission[45], and Rs. 5000 from own fund of Panchayats. Altogether there is annual fund provision of Rs. 25000. Not just that fund alone, untied funds [not just the LSG untied fund] NRHM untied fund was also started being given to sub-centres, PHCs and CHCs. The revised Rogi Kalyan Samiti22 order of LSG department was issued only in 2010. In 2007 itself, a revised Hospital Development Committee order was issued through state NHM, and RKS (Rogi Kalyan Samiti) fund was made available. So, for the community-level interventions and programmes, there was some scope in the NHM implementation framework.

May be because it was started at the time of first UPA government[46] and that there were some inputs from public health experts at the national level by those who were really committed for the people's health and understanding the potential of decentralization. We got some opportunity to incorporate non-conventional programmes as part of NRHM additionally using NRHM untied fund. There were interventions for sickle cell anaemia project, Aravindan Sir is here, and we started special tribal health programmes. He could speak more about these interventions.

Based on the first Palliative Care Policy, when this programme was taken up for state-level implementation in southern Kerala, it was difficult to expand the programme and hence it was taken up as an NHM component. Also, it is to be stated that we got so much of flexibility for our ASHA programme. From the second module onwards [now they have eight or 10 modules training completed], state specific issues like NCD, palliative care was brought in. So, that way, we were getting

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42 Information about the Pain and Palliative Care Policy of Kerala is available at: https://kerala.gov.in/documents/10180/46696/Pain%20 and%20palliative%20care%20policy%202008

43 The state-level NRHM in Kerala has designed a Non Communicable Diseases (NCD) Control Programme called Amrutham Arogyam, in line with the national programme. See http://arogyakeralam.gov.in/2020/03/23/ncd-non-communicable-diseases-control-programme/

44 The Village Health, Sanitation and Nutrition Committee (VHSNC) is a key intervention introduced under NRHM to facilitate community participation in supporting, implementing, and monitoring projects related to health and its social determinants. It is typically formed at the level of revenue village; if the population of the revenue village is more than 4000, a Ward Health, Sanitation and Nutrition Committee (WHSNC) can be formed at the level of the Ward Panchayat. This is commonly the case in Kerala. See: Government of India. (n.d.). Handbook for members of Village Health Nutrition and Sanitation Committee. Ministry of Health and Family Welfare Retrieved from http://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=149&lid=225#:~:text=One%20of%20the%20key%20elements,and%20Nutrition%20 committee%20(VHSNC).&text=They%20are%20particularly%20envisaged%20as,process%20of%20Decentralised%20Health%20Planning.

45 Suchitwa Mission is the Technical Support Group (TSG) in Waste Management sector under the Department of Local Self Government, Government of Kerala. See http://sanitation.kerala.gov.in/profile/.

46 The United Progressive Alliance (UPA) is a coalition of political parties in India formed after the 2004 general election. The largest party in the UPA alliance is the Indian National Congress. See: https://journals.sagepub.com/doi/10.1177/0974928416654367?icid=int.sj-abstract. similar-articles.1

some flexibility from the national level. Specifically, because of the early demographic transition of the state and the changed morbidity pattern with ageing population, it was very much needed, and it was useful and helped even in formulating national-level innovative programmers. I don't know whether the whole potential for decentralization could be explored—agreeing with Vijayanand Sir, the real potential for further deepening and exploring the highest level of decentralization possible through NRHM has not happened.

Since 2012, we are giving 'Arogya Keralam Puraskaram'25 for better performing LSGI [Local Self Government Institutions] in health care decentralization. Through an objective assessment system, we are giving awards for the District Panchayat, Block Panchayat, Grama Panchayat, Municipality, and Corporation. State awards and district-level awards are provided. Some synergy between decentralization and NRHM was happening. In 2007 and 2008, compulsory rural service of doctors was done using the NHM fund. So, additional human resources were provided through this scheme. Otherwise, through Panchayat, it was not possible to post additional staff. During that period, Panchayat-level plan fund also was not available for contractual appointment of staff. And NUHM[47] is another area which contributed to developing primary health care system in urban area. Otherwise, in urban area, primary care decentralization has not succeeded much [other than the epidemic control palliative care and contingency interventions]. Now we have 83 UPHCs in Kerala under NUHM, and they played a very critical role during the COVID time, though it is a temporary arrangement with contractual staffs like JPHN, JHI, Medical Officers, other paramedical staff. Because of the time constraints, I am not going into further details.

Aardram Mission, of course, again we got this scope

for further deepening decentralization. In fact, for me, it is a continuation of decentralization in health care. As Vijayanand Sir correctly pointed out, there is scope for appointing contractual doctors through Panchayats and other local bodies. So, it is working well. The most critical point is that Aardram Mission put forward specific guidelines and standards for each category of institutions. For the health team and Panchayat representatives there is clarity on how to develop a PHC or CHC, in Kerala.

For me, just Decentralization is not a sufficient condition. It should be there, it's mandatory, at the same time there should be top-down departmental intervention programme. Some of the areas, Panchayat alone cannot do anything like preparing treatment guidelines and standards, state-wide purchase system of drugs and equipment, etc. So, it's the synergy of both bottom-up and top-down approach that is needed in highly technical areas like health and medical care where, by wishful thinking alone, we cannot change the scenario.

Start of the decentralization, it was the time of globalization, and resource constraints were there at different levels. Some efforts for shunting all the responsibilities to the Panchayat also happening at that time. As a district-level and state-level officer, I remember many instances. So altogether saying that, there are many other requirements like financial requirements, increasing the human resource, institutional development framework, and public health programme plan suitable for the epidemiological and demographic peculiarities of the state, etc. All those things are very critical.

One point I missed during the discussion is bringing in the quality dimension. It was during the NHM time that we started the quality improvement programmes in an organized manner. We posted the quality officers, and biomedical engineers and NABH[48] accreditation for institution Kerala

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47 The National Urban Health Mission (NUHM) is a 'sub-mission' of the National Health Mission (NHM) aimed at addressing health care needs of the urban population, with a focus on the urban poor aiming to heighten access to essential primary health care services and reducing out-of-pocket expenditure on treatment. The NHM was launched by the Government of India in 2013 encompassing the NRHM and the NUHM. See http://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=970&lid=137.

48 The National Accreditation Board for Hospitals (NABH) is responsible for the establishment and operation of India's accreditation program for healthcare organisations. See: https://www.nabh.co/introduction.aspx

Accreditation Standards for Hospitals (KASH)[49] was initiated. The programme is still continuing. Now, we have more than 120 NQAS[50] accredited health care institutions.

During COVID time of course, all these efforts of decentralization got consolidated at lower level that made a real change in the intervention at the local level. I am not elaborating as I took around 10 minutes. COVID is a well-discussed area. So, I am stopping here for the time being. If there is more time, I could speak at the end and clarify any doubts.

Ramankutty V: Thank you, Dr. Jagadeesh, and I think it was very great, especially the point made that, healthcare being a very technical subject, it is very important to have people with the technical knowledge, and also to advise and form policies at the top, so that it is not just left to the local level authorities to do whatever they like. And I think this is especially true. And so Jagadeesh rightly pointed out: with experience as a doctor and administrator in the health service, during these years of change has that—it is notable that Dr. Jagadeesh represents the generational change. Of course, he's a senior person, but he does represent a generational change in the health service. There was a lot of emphasis on clinical care and development of specialties in the beginning, but nowadays we will find that a lot of youngsters are very, very keen on public health initiatives and being at the head of that kind of a transformation which is very satisfactory, and I think decentralization has been one of the platform Mr. Jagadeesh would act. Now, I will call Dr. Vijayakumar. He is a Senior Community Medicine Professor. Academics have generally kept away from Decentralization, especially in the healthcare sector. He's one of the persons, was actually being at the thick of it. I mean, he is already in the forefront training of doctors and asking them or advocating them, exhorting them to use this opportunity both for studying the processes [and] also to make better initiatives at the Panchayat level.

I would request Dr. Vijayakumar to talk about his experience.

K. Vijayakumar: Whether I can speak at the end or are there any specific questions? I can speak on that basis, basically because S.M. Vijayanand and Dr. Jagadeesh has spoken.

Ramankutty V: Your voice is little feeble. I don't know.

K. Vijayakumar: Thank you for inviting me. I prefer to speak at the end of the session, or if there are specific questions are put to me, I can respond to it. Basically, because once Shri S.M. Vijayanand and Dr. Jagadeesh has spoken, more or less all dimensions are brought out. Then I can speak, or I will wait 'til the end after Jagajeevan, Aravindran, Joy everybody.

Ramankutty V: Okay, if you want to do that, that is fine. I thought you might have something to say as a teacher or an academic. So, we will wait for the end or the later part of the session to hear your views.

Maybe, the next person I will call is Aravindan. Being an academic at the medical college but at the same time very much an activist and social, a very part of the Kerala Sasthra Sahithya Parishad12, which was being very much, very champion for decentralization right from the beginning. When the whole official policy change came, Parishad was advocating for decentralization. Kerala already had a previous bill which was actually lot of Parishad's activity, very much involved in shaping that, the district council legislation and even in the People's Planning Campaign, many of us were very much part of the team. So, in that sense, he has been the head of the—President of the Parishad—in the past. So, you'd be able to speak authoritatively about this.

K.P. Aravindan: I was not directly involved in the People's Plan process in any way. So, I will basically limit myself to just two things. First, about the People's Planning Campaign in general, and

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49 The Kerala Accreditation Standards for Hospitals (KASH) is the state-level healthcare organisation accreditation program within Kerala. See: https://arogyakeralam.gov.in/2020/04/23/kash/

50 The National Quality Assurance Standards (NQAS) were developed to help public health care providers "assess their own quality for improvement through pre defined standards and to bring up their facilities for certification." See: https://arogyakeralam.gov.in/2020/04/01/nqas/

secondly a few words about NRHM. Regarding the impact of decentralization on health care system in Kerala, personally I feel that what makes Kerala different is the perspective given to People's Plan in the state. Amongst its many stated objectives, some of the real objectives were achieved and some not. At the ground level, it was a mixed bag. The real achievement of this huge campaign was the considerable attention it brought to the process of decentralization, making it the focus of the entire state for quite some time. The actual people involved in the process were numerous. The erstwhile sleepy 10-to-5 Planning Board office suddenly transformed into a 24-hour hub of activity, with people working 'round the clock, some involved in intense discussions, yet others in furious writing, and some others in packing and binding the various 'laghulekhas'[51]. The whole thing which began as a campaign had its impact at the lowest level, the fruits of which we see only now. It was during the floods of 2019 in Kerala, that the full impact of the decentralization was there for all to see and feel. With all due credit to the political leadership which managed the flood situation very well, it was the real, solid support from the local level that made all the difference. People could be mobilised in no time for voluntary work to help out in the rescue and relief work. This is the contribution of the People's Plan Movement and the synergy it generated.

Similar is the case in the COVID pandemic situation. The RRT[52]s and ward-level teams were fully geared up to the task of facing the crisis. The Chief Minister announces one day in his daily evening press conference that no person is to go hungry due to the lockdown, and distribution of free food is to be started immediately. Overnight, common kitchens[53] for preparing food spring up in every Panchayat.

This kind of mechanism did not spring up in a day, but was put in place over the years, starting with the People's Plan Campaign. Initially, there was some conflict between the doctors and the local self-government bodies and the politicians, who considered each other as adversaries. But soon, such doctors realised the benefits of the cooperation of the local self-government bodies. Particularly, those doctors with a background of political or social activism in their student days or after could appreciate the merits of this system and make many meaningful transformations. Coming to the role of NRHM, which came into being in 2004, it gave the much-needed financial boost to the health sector for its functioning. The resources provided by NRHM, in spite of its rigid regulations, were something unheard of 'til then. My personal experience in the case of Wayanad and Attappady comprehensive sickle cell care project[54] is worth mentioning. This was a project funded by the European Union for one year. But for the subsequent support from the NRHM, this project would never have gone forward. Even today, a unit of the project is functioning in Calicut Medical College, and the funds of NRHM supports the work in Wayanad and Attappady. The NRHM was a big boon to the health sector in Kerala and it meshed in well with the decentralization process in the state. As many people have pointed out, NRHM could have been utilised much better. There is yet time to make it happen and I hope it will happen. These two cannot be seen in isolation, but only along with other grassroots movements like the Kudumbashree. Both decentralization and NRHM have played a crucial role in the heath sector of Kerala, for which we receive so many accolades. The benefits received by the state from these two projects can never be underestimated.

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51 Laghulekha is a Malayalam word for pamphlet or leaflet.

52 In the context of Kerala's COVID-19 pandemic response, the Rapid Response Teams (RRTs) were deployed for surveillance and contract tracing in the state. See 3.7 of the Government Order at https://arogyakeralam.gov.in/wp-content/uploads/2020/03/GORT872-2020-Health-Covid19Jagratha.pdf

53 Kudumbashree, in collaboration with the Local Government, had started Community Kitchens in all local bodies where food was being cooked, and home delivered to those under home quarantine and the ones in need during the COVID-19 pandemic. From https://kudumbashree.org/pages/826.

54 The project 'Comprehensive Health Care for Sickle cell disease in a primary health care setting' was funded by the European Commission in 2006-07 and implemented by Medical College, Calicut in Wayanad, Malappuram and Attappady districts. From 2007-08 onwards, the project was being funded by the Government of Kerala through NRHM. From https://www.govtmedicalcollegekozhikode.ac.in/academics/medical-college/pathology. It is classified under the 'tribal health' projects of the Government. See https://arogyakeralam.gov.in/2020/03/27/tribal-health/

Ramankutty V: Thank you, Dr. Aravindan. It was a very…may be a little different viewpoint that he put forward. Now we have another serious researcher on decentralization with us who has lot of experience, Dr. Jose. I would invite Dr. Jose to give his views on these questions.

Jose Chathakulam: I will concentrate on the political parties and…this aspect you take. [audio unclear] Then I will speak after some time. There may be a problem. Yeah.

Ramankutty V: Yeah, it's fine if you wanted to talk later, we can ask somebody else to talk now. So, please be on hold. I will ask Jagajeevan now. Jagajeevan was also very active in the decentralization movement and also officially part of the health department also. So, both ways he can talk about this experience. He is also part of KSSP from a long time. He had been the Secretary of the organization. I will call upon Jagajeevan to give his views.

N. Jagajeevan: I will quickly touch upon things I wanted to tell. Firstly, the initiatives [that] came after decentralization in Kerala was mainly that communicable disease, NCD, old age and mental health became programmes in the local government initiatives. The second most important thing was: the changes that happened for factors that influence health like housing, drinking water, toilet, rural connectivity, etc. might have impacted improvement in health indicators. The quality of nutrition programmes at Anganwadi and schools were improved. That also likely have impacted improvement in our health indicators. Another important factor is the partnership between Kudumbashree and Panchayat system that helped, especially to upgrade health skill. That also has helped. Another important thing is, local government at different places managed additional resource mobilization to improve basic infrastructure at primary health centre, community health centre and Taluk Hospital. But, when we speak about these changes, the environment for this was formed only after the social movements in Kerala's history and followed by the development

movements like Literacy, People's Plan Campaign, Kudumbashree, etc. These development movements in Kerala actually paved the way for improving public health system.

At the same time, we should also be mindful about the limitations. One of the important limitations were, even after having these many community institutions and social institutions, we could not integrate these institutions to develop a primary health care system. We could not develop it as a part of the official system. The second important limitation is that the health department scheme is still functioning as a vertical scheme. A transformation—like state makes target, and health plans are set accordingly in the local level and the state schemes, becoming its subcomponents—is not yet made to the local health plan. The third limitation is that the convergence is very weak. If we consider many of these state and national schemes, a lot of them are adaptable to our public system. And we could not converge it effectively as we could. So, we have limitations of that kind.

At the same time, the implementation of the Aardram programme brought a lot of quality changes to the services. This interface allowed associating with the local body. I am not sure about this due to the lack of clear evidence. Perhaps NRHM—its provision for participatory planning and association with the local government, community centric programmes like ASHA, Palliative Care, etc., which came along with NRHM—, perhaps this environment, initiated a transformation in the health system. Health system had a quality change to work together with the local government. If we compare this with a situation 10 years back, we can understand this change.

Now, NRHM also has a problem. NRHM is existing as a vertical structure [programme] outside the health system and, due to this, the local government convergence through a correct departmental convergence could not be made effective. If we take Palliative Care, NRHM is only doing a technical handholding, it is actually being run by local government. There are gaps like this. NRHM should be actually giving complete freedom

for the states to make planning after NRHM fixes targets for the state. Instead of this, NRHM should not be setting a scheme at the national level. When we point out of positive aspects of ASHAs, as an activist in this field I would say, the associations formed in Kerala like Kudumbashree, Resident Associations or it could be Palliative Movement, or it may be different local collectives—when we do tie up with these collectives, ASHAs model might not be relevant for Kerala. States need that kind of professional freedom for planning programmes.

In fact, Kerala needs decentralized health planning and National Health Mission should take an appropriate approach for this. So, in Kerala's context, the state needs to be part of national health programme in this pattern. But the resources are required for Kerala. A policy change is needed to accommodate this pattern. Finally, I wanted to mention that if Kudumbashree, Employment Guarantee Scheme[55], Social Security Mission[56], and People's Plan Programme get integrated, then we can bring forth a better innovative primary health service system.

Ramankutty V: Thank you, Jagajeevan. I think he has made very significant points, especially what I liked was he pointed that all these years we have not really developed a primary care comprehensive system where every household has access to a primary care system where, you know, you can go to your care giver or primary care giver is identified as somebody or a centre or whatever. So, I think we do need to really develop systems like that. Now I would request Dr. Joy Elamon, who is the Director of KILA and has also been part of decentralization movement from the beginning. So, Dr. Joy.

Joy Elamon: Shall I start?

Ramankutty V: Yeah, yeah. Are you travelling?

Joy Elamon: Actually, I am travelling, but I think I will be able to manage. First of all, thank you for this opportunity. Not only opportunity but bringing up this agenda. That is one of the important parts of this programme. I will actually try to go back to history starting from today. So, at the moment, we in KILA, the Kerala Institute of Local Administration— the nodal training institute for local governance in Kerala—, we are actually conducting training programmes for the various standing committees at the local governments. They have been elected just recently. So, this is first of their training programmes. Within the standing committees there are Health and Education Standing Committees[57]. And here we work together with the Health Department, its various divisions including NHM, and various missions and other things within the Health Department. So, what does it mean? It means that, slowly, over the last 25 years, all of us were able to develop that spirit of togetherness; we need to work together because there is a win-win situation. It's not just for health, but also for strengthening and deepening local democracy. That is the point of time we were talking. But again a little bit back or the ongoing COVID-19 situation, where we can see in Kerala, the entire COVID-19 management activities were led by the local government. But all the actors, all the players, whether it is the Primary Health Centre Medical Officers or doctors or the JHNs, JPHNs to ASHAs, have been together working with various other actors like Anganwadi workers and all. What does this mean again? It's also the Panchayat, becomes the convergent point. And local governments are able to provide the point of convergence, bringing everyone together which is important for the health sector. Because determinants of health and management of health cannot exist in siloes. This is provided by the local governments and act as the local government. Again, little bit backwards in 2018

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55   Kerala Rural Employment Guarantee Scheme is the state's operationalisation of the Mahatma Gandhi National Rural Employment Guarantee Act (launched in 2005). The scheme aims at enhancing the livelihood security of households in India's rural areas by providing at least 100 days of guaranteed wage employment in every financial year to every household whose adult members volunteer to do unskilled manual work; see http://www.Sird.kerala.gov.in/index.php/schemes/33-mahatma-gandhi-national-rural-employment-guarantee-scheme-nregs. For more, see http://nregs.kerala.gov.in/en/home/.

56   Kerala Social Security Mission (KSSM) identifies populations facing marginalisation in Kerala and undertakes and implements social security initiatives for them. See http://www.socialsecuritymission.gov.in/article_info.php?id=MTAz.

57   Distinct Standing Committees for Health and Education respectively in a District Panchayat are a platform for decentralised decision-making on these critical welfare domains. See https://www.panchayat.gov.in/documents/20126/0/Kerala+Panchayati+Raj+Act+1994+and+Rules.pdf/18190ecc-55b0-0b61-bf1e-f6925eb98145?t=1554879157643.

when we had the floods, the local government took the leadership, though officially they were not people mandated to manage the disasters. The local government actually took the lead and coordinated the entire activities and post-flood activities also. And again, bringing together, I don't know about other departments, but bringing together health professionals and doctors together. Again, what we find is that the local governments are able to bring people together and that's one of the important characteristics or components of managing a disaster. [audio unclear] so the line of communication has to be uniform, and you have to have coordination and that happened. And again, going back, some of the people have mentioned various models, which we have developed, led to policy changes within the state. That is also very important or impacted various health policies in the state. Especially if I go back to the various models, I would see, for example, the BUDS school for the differently abled[58] children. It was developed by a local government and then it became part of the entire state. Palliative care programme, it was actually started in a different way. But then slowly it was found that through the local government system we can actually move forward—or you start with. So, the mental health started from Ponnani[59] Panchayat, and then it was spread across the state, and it became part of the policy changes and all.

Again, I go back to the 1996-97 situations where the People's Plan Campaign started and there again that provided a platform for all these changes to happen. But then I will again go back to another paper[60] written by none other than Dr. Ramankutty. Probably he has lost that paper and we also don't have access to that historical document. I would say, where he had mentioned about the status of health care situations in the state… If I remember it correctly, 90% of the money meant for health was used for so-called establishments expenses, and for development hardly 10%, which means the health system was in stagnation at that time. I was just trying to go back to the history and from there it started. So, there was this thing of absence of resources, and also if you can go little bit back, we were also into the globalization and liberalization[61] mood. The state was supposed to withdraw from the sectors like health and education, so that there was a stagnation in growth or even deterioration. That's all the paper has mentioned. The deterioration in the development of the health system and so it was not just like the resources crunch. It was also the policy issue. The entire public health system was in a question mark. You would also see a little bit backward, in 1987, the KSSP and the IRTC[62] did the study[63] where Dr. Ramankutty, Dr. Aravindan, Dr. Thankappan[64], and all others were part of it, where it mentions about the percentage of people using public health care system, and you can see what has happened in the COVID situation, the change which has happened. So, what does this mean? I'm only trying to say that the decentralization or the Panchayat Raj process started with the People's Plan Campaign where more money, functions and all were transferred.

That actually brought back this agenda of public health—I won't say anything about the qualitative aspects of the change. But the agenda of public, and for that matter even education, have been added to the policy discourse of the state, and the

58 In Kerala, it is common to use the term "differently-abled" to describe persons with disabilities. According to the United Nations, persons with disabilities are those "who have long-term sensory, physical, psychosocial, intellectual, or other impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others." For more information, see: https://www.un.org/sites/un2.un.org/files/disability-inclusive_communications_guidelines_-_march_2022.pdf

59 Ponnani is a municipality in Malappuram district of Kerala where, for the first time in the country, a people's initiative on suicide prevention was started at the Panchayat level in January 2000. See https://frontline.thehindu.com/social-issues/article30253788.ece

60 See Kutty, V. R. (2000). Historical analysis of the development of health care facilities in Kerala State, India. Health Policy and Planning, 15(1), 103–109. https://doi.org/10.1093/heapol/15.1.103

61 Refers to the 'New Economic Policy' of the 1991 neoliberal economic reforms in India. Much has been written about these reforms. A useful reference is Nigam, A., & Menon, N. (2007). Power and Contestation: India since 1989. New Delhi: Zed books.

62 Integrated Rural Technology Centre (IRTC) is an autonomous research and development institution founded by the KSSP. For more, see https://www.irtc.org.in/

63 See Kannan, K. P. et al. (1991). Health and Development in Rural Kerala: A Study of the Linkages Between Socioeconomic Status and Health Status. Integrated Rural Technology Centre of the Kerala Sasthra Sahitya Parishad.

64 Dr. Thankappan KR is retired as a Professor from Sree Chitra Tirunal Institute for Medical Science and Technology, Trivandrum

welfarist concepts of the state were addressed. But then in 2006, I think if the year is correct, NRHM started. What change has it made? Of course, somebody was mentioning about a resources issue which was addressed, but initially when it was started [audio unclear] many of them had a decentralization element. So many of the plans had to start from the local level and all kinds of things, but then local governments were missed. And so naturally, it started with a parallel kind of an approach where it had nothing to do with the local government system, though it was a decentralized programme [the NRHM when it started].

But it was also about conceiving and implementing the programme. But slowly, the NRHM and the public health system in the state, I would say understood the need for working together with the local government system and the state also. I mean, there are still gaps, but I would say, over the years, especially over the last five years, there has been a dramatic change in the entire system. The NHM, is closely working together with the local government system in many of its activities and actions. And the Aardram Mission, conceived by the state, together with the NHM...they are working together. I mean, the local governments are complementing and supplementing the NRHM, and the NRHM is also complementing and supplementing what the local government systems want. So, what I would say is that we have reached a particular situation, where the NHM or a centralized scheme can actually work with a decentralized system, and how it is a win-win situation for both.

But here I would say that when we talk about the decentralization process, see decentralization in thought, in Kerala, or everywhere, doesn't mean everything is given to someone else and then we say everything is done. Actually, the kind of decentralization we expect is based on the principle of subsidiarity, or which can be done at that particular level should be done at that level. That was the kind of approach, and the principle of subsidiarity was our main concern. And it was designed in such a way that everybody had something to do with it. See, that is where we missed it. Because when the People's Plan

Campaign was launched, especially in the sectors like health where the professionals are in plenty, they understood that the power is lost. But what I would say is that power is strengthened, because at each level, there is a particular role. When things happen at a very local level, the next higher level—for example, the DMO (District Medical Officer)—should actively cater to the specializing of the institutional capacity of the state. So, those should be your response force and likewise upwards. This is the kind of change that should have happened. But, NHM actually [audio unclear] proved that they are proved through the NHM or NRHM, and that actually contributed to the development of the health sector and the local system.

So, again I conclude by saying that it has actually reached a particular level of win-win situation. However, as a programme, NRHM is still to really converge with the local government system, which is mandatory or required, and also the efficiency and efficacy. It has also mentioned about the role of ASHAs. See, now if I look at the present COVID-19 situation, ASHAs are in the forefront in the local level, in the ward committees, because now they work together with the local government system and emerged as frontline warriors. This was not the case earlier, and ASHAs were kind of a particular system that was developed entirely through the NRHM but could not become 'the' healthcare activist at the local level. Whereas, at the moment, they have become the fulcrum of our activities simply because the system works together. As Jagajeevan mentioned about Kudumbashree, ASHAs and all other local workers could have emerged even earlier as leaders of the area. But now it is getting better. So, that is the kind of change we should work towards in the future. It's a win-win situation. This is how we can use a centralized scheme or programme to the use of a local health system development. I conclude here, and thanks once again. Thank you.

Ramankutty V: Thank you, thank you. Very comprehensive evaluation, Dr. Joy. And I think you made some very significant points, especially about the NRHM part, which is the focus of the discussion.

As a person who was involved from the beginning, I think those were very valuable observations. Thank you very much. Maybe at this point I can call Dr. Jose again?

Jose Chathakulam: I will talk something on the role of political parties. See, what is taking place in the local government is nothing but an extension of the coalition politics practised at the state level. In other words, it is just an extension of what is happening at the state level in the sense that the power is alternated in every five years between a coalition of LDF[65] and UDF[66] in every Panchayat or urban level government. When we analyse the style of coalition politics, there is a damaging kind of political atmosphere at the local government. That is, in the majority of the local governments, a frequent pattern of shift in the key positions in local governments is taking place, and even if it is practiced, it is done in such a manner that the key positions are given to members of the party that have secured the majority. As a result, continuity of office of a person for the prescribed tenure is under threat. Finally, what happens: the very governance has to suffer. Such adjustments under coalition politics taking place at each local government is a very critical issue. Suppose we take the case of CPI (M)[67], the biggest ally in LDF, may have the absolute majority. So, what normally happens is that one person from CPI (M) will be selected as the Panchayat President or Mayor. But, within the same political party, the power change is taking place; that is, one person from CPI (M) for one or two years, and then again, another person from CPI (M) for the remaining years, and the remaining allies are not given plum positions under this exercise. And it is actually extended even in the formation of Standing Committees, and you can see a certain gap period because one has to resign; then, the Election Commission or somebody has to chart the next election. Then the transfer of power may take place from one to another person. This is something which the political parties have to take

very seriously. Almost every local government, what they have to do is that they have to share positions among the partners within the LDF or the UDF. So, the point is that one year or sometimes or two years maximum, a person is taking the office as the president, mayor, or chairperson of the local government concerned. Then he or she has to step down, then another person within the coalition party will come and take charge of it. I can quote you some examples of the five chairpersons for a period of five years duration. And there's a similar situation with the Standing Committees also. In Kottayam Municipality, I did some work last year and it was observed that three times there was a change in all the Standing Committees including Health Standing Committee.

And again, coming back to the political parties and role of political parties, I would like to say there is some amount of majoritarian politics which is taking place in certain Panchayats, and because of that what happens is that all political parties are not getting representation in the local government according to their size or strength, simply because we are following kind of a first-past-the-post electoral system. So, instead of that I would like to say that here, we can think of a proportional kind of electoral system to the local government. Why I am arguing for [this] is that electoral system is more suited to the decentralized planning, and very particularly the planning of health sector also. All the political parties, whatever may be at the local level, they used to get a representation according to their size—their vote size. That is what. So, an electoral system of proportional representation may be a suited electoral mechanism for enabling a kind of a participatory and decentralized planning system.

And number two, I would like to say that, for example, the urban governments are very particular in the issue of health. For example, you take the case of Kochi Corporation. I have a list of staff pattern as far as health is concerned. There should

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65 Left-wing political parties in the state of Kerala, India have allied to form the Left Democratic Front (LDF).

66 Centre to centre-left political parties in the state of Kerala, India have allied to form the United Democratic Front (UDF) which is affiliated, at the national level, to the Congress Party..

67 The Communist Party of India (Marxist) [CPI(M)] is the largest communist political party within India, in terms of both membership and number of electoral seats. The Communist Party of India (CPI) split in November 1964 to form the CPI(M) and other communist parties.

be a health officer, but that post has been lying vacant for a long period. The health officer post is vacant, in the sense that doctors are not in a position to come and occupy that post. Even if a doctor comes, he or she is not in a position to continue for a long period because of that kind of resistance—a pressure from the other non-medical staff, starting from the Health Inspector[68], Health Inspector Grade 2, Junior Health Inspector, Junior Health Inspector Grade 2, and finally the Sanitary Workers (770 permanent and temporary workers of around up to 485). How can we [people] think about the service of health in the absence of qualified health officer of a municipality, a corporation? What you can expect from non-medical personnel? How can the local government get technical support from an army of non-health professional?

This is not the case of Kochi Corporation alone; in the majority of corporations the situation is the same. And in the municipalities also the situation remains the same. Again, you take the major technical qualification of the Health Inspectors, or whatever maybe the grade, I am sure that the majority of them have got some kind of a certificate course from some other states, and they are actually occupying the important post [position]. One has to seriously look into the issues of the governance of urban health and its delivery of services.

But at the same time, there may be commendable service of doctors from the centrally sponsored scheme of the Urban National Health Mission43. But the point is that they are not properly integrated in the health system of the municipalities or the corporations. It's a very serious issue. Then you see very particularly, this health aspect is concerned,

and major example, is the NRHM. About NRHM what I would like to say is that we got benefit from them, the financial part and the human resource part of the local government is developed in such a fashion. No doubt at all. But we failed to integrate—to graft—these CSS schemes in a proper planning fashion with the decentralized planning experience. By and large what happened? It takes some kind of a 'standalone' from these planning processes.

And very particularly, as far as COVID-19 is concerned, I have not seen, in my own field experience, any proper documentation of data. There is no proper data collection in connection with death related to COVID-19. If you go to any municipality or corporation and ask the concerned person in the Standing Committee[69], the key political functionary and the bureaucrats, they are not aware of the number of deaths related to COVID-19, how many positive [cases]. Even in the Panchayats the situation is same. No data management, no analysis, and there is no ownership of any figure related to COVID-19. Of course, there is no policy formulation.

I would like to say one important point. You take the National Disaster Act[70] and the provisions. Come to Kerala and you take the districts. Actually, what is happening? You have a District Disaster Management Authority. Before the last local government elections, I could get some information from the District Panchayat Presidents. Majority of them are not aware that they are the co-chairpersons of the District Disaster Management Authority. Actually, according to the Act—according to the Kerala situation also—the District Panchayat Presidents are the co-chairpersons of the District Disaster Management Authority[71]. But what happened? Without any formal sitting of the

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68   A Health Inspector (commonly referred to as HI) has responsibility over family health centre and their assigned population at the field level. As the person who has responsibilities in the Local Self Government (LSG), he must also coordinate LSG activities, social gestures, women and child development, agriculture, veterinary care, and education. He must also address the social determinants of health through coordination of these departments at the LSG level. See (information available in Malayalam only): https://shsrc.kerala.gov.in/pdf/1182018H&FWD.pdf

69   There are various Standing Committees at the level of Local Self Government Institutions (LSGIs) in Kerala; see https://cag.gov.in/uploads/download_audit_report/2009/Kerala_TL_Local_Self_Government_Institutions_2009-10_APPENDICES.pdf

70   National Disaster Management Act 2005 is national legislation intended to provide a legal framework for effective management of disasters and relief activities; see https://www.indiacode.nic.in/handle/123456789/2045?locale=en and https://ndma.gov.in/.

71   Information on the District Disaster Management Authority is available here: https://sdma.kerala.gov.in/members-of-ddma/

District Disaster Management Authority, the entire power is vested with the District Collector[72]. I can quote some of the examples of Kerala—some of the districts where the District Collectors are actually making some kind of back door entry in the management of the District Hospitals. Not just the District Hospitals, even the Medical Colleges also. And the District Collectors never allowed the District Disaster Management Authority to function as per the envisaged manner. As I mentioned, the District Collector is the chairman, District Panchayat President is the co-chairperson. There is district health official, and other important officials are there as members. If it takes place as a committee, everyone can express their views. Even the medical experts can express their opinions; maybe a dissenting note if the committee take places as a formal one. But in the present situation, in majority of the districts, District Disaster Management Authority as such is not functioning as a 'committee'. The institution of 'District Disaster Management Authority' is not seen in any of the districts in Kerala. This is one thing which needs serious attention. And the entire mechanism is in his/her [District Collector] pocket. In Kerala, the District Disaster Management Authority is nothing but the office of the District Collector. It is the case as far as Kerala and its districts are concerned.

And you see, you take the word/concept of 'district administration'. What do you mean by district administration? District Administration means the collector, police superintendent, and the revenue department. The District Panchayat President or the District Panchayat has no place in the concept of 'district administration'. In a democratic system, the political figure of the district—the District Panchayat President—should be headed by the district administration. So, my point is that there are a lot of ramifications and issues as far as health or health sector is concerned, directly and indirectly.

The thing is that there—and somebody mentioned that decentralized planning is nothing but a kind of multilevel planning—…and health also has to be planned at the multilevel, which is not taking place

in the real sense, which is a serious issue needing urgent attention.

In the similar style, when the other side is also there—for example, you take the palliative care and BUDS school, and very particularly in the northern side like Malappuram and Calicut districts—I have seen that in some Panchayats, the palliative care governance is excellent and BUDS schools are performing in a better fashion. And because of that, I have seen some kind of migration of families which is taking place in certain Panchayats to other Panchayats in search of better services from the BUDS school or the palliative care units. I would like to say that this is nothing but similar to a pattern of 'vote by feet'. It is actually an example of the best performance showcased by such Panchayats. It is actually an acid test of performance of achievement. Yeah, these are some of the points that I would like to place here. Thank you.

Ramankutty V: Thank you, Dr. Jose, for that very different viewpoint. I think he brought out very significant points to think about. I think two of the most important things he said, one is about the transfer of the political rivalries to the local level and the consequences of that which may affect how decentralization focusses. And secondly, he talked about the rural and urban health sector not being effective, which is very true. Urban infrastructure is mostly concentrated on the big hospitals. So, the primary level institutions were not there, which mainly to some extent are now making amends, but I don't think it is complete. And there is huge understaffing also. That's a very important point, and of course you also talked about how the district level administration is still with the bureaucrats and not very much with the local elected representatives. What we see during any crisis, say COVID, and I don't know whether it is good or bad, but the Collector remains a very key person. I remember the days when it was said that the Collector will act as a Secretary to the District Panchayat, but that is not what we see now. He or she continues to be the head of the district administration. So, to what extent we have

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72 The District Collector is the executive head of the district administration with responsibilities in the sphere of revenue, civil administration, development, Panchayat, local bodies, and more.

decentralized is something which we should be asking. So Vijayakumar, would you like to speak, because you have—before he says, I mean I really don't know—after that I don't think there are any more speakers. So, is there any particular process afterwards, Sreejini? Please explain at this point. I would also like to say that personally, we have run out of time, and I really don't want to stay much longer. Let me make that very clear.

Sreejini J: Sir, actually after the final speaker, if anyone wants to comment or give clarification, they can do so, which can also be done later in the transcript if they want to add something more. If time permits, we can discuss. Otherwise, like it's 5:35 PM, so after Vijayakumar Sir speaks, we can wind up.

Ramankutty V: Very urgent clarifications can be done. But we know, if we start discussing it can go on for many—several hours in fact. And I have seen that, especially with these Zoom meetings, people tend to lose track of time. Unfortunately, today, on this particular day, I am not in a position to do that. I have to rush off. So please, Vijayakumar, and afterwards we will spend a little time on anything which urgently comes up.

K. Vijayakumar: Thank you, Sir. First of all, I am happy to be here with all these illustrious individuals. As I mentioned before, if there is a specific question, it would be easier for me to answer. Secondly, if you could let me know the time I am allowed to take, I can adjust and speak accordingly. This is the last lap of the journey.

Ramankutty V: You can take up to ten minutes.

K. Vijayakumar: Does anyone have any specific question? Sreejini? Hari? Anyone? Am I supposed to answer based on the questions that were sent?

Ramankutty V: Yeah, based on that. But whatever you feel strongly about in those questions, you speak first.

K. Vijayakumar: So, what's first asked is about the evolution post the 9th Five Year Plan[73]. We had great dreams then, about participatory democracy and related ideas. Although their implementation had started at the time, if you look at the evolution, the governments which came afterwards actually took a stand against it. As in: they did not completely destroy it, but they took steps to eliminate the spirit and essence of what was seen during the 9th Plan. Even the following government—and I am not speaking politics—, it was a Left government, even in the 11th Five Year Plan, when the NRHM came into being, it was kept as a parallel system in which the Panchayats were kept at a distance, in my opinion. In fact, it went to one extent that —don't know how many of you remember—in 2007, 2008, and 2009, when the land was filled with chikungunya, dengue cases, a few friends and I conducted a programme to boost preparedness among the Panchayats. For that, the government of the time suspended me along with a rural development officer. Jagajeevan is here. He conducted a brilliant programme at Karakulam, and he was suspended from the health service.

So, what I am saying is, there is a difference in perspectives here. But towards the end, you know in 2010, there was a turnaround. So, for a period of ten years, you could say that there was a period of dark age for decentralization, as one would say there was a dark age of Europe. This turnaround was especially brought by developing a unique plan to intervene and control the epidemics in Alappuzha district and its Panchayats. It is from that point that the awards and recognitions started coming in. Aardram and the formation of FHCs were in fact a culmination of all this. And I am happy to have played a small part in this.

An important thing which I wish to say is that the Working Groups, Gram Sabhas[74], problem identification, projectization, etc. which were mentioned in the 9th Plan, when I now look back, no longer exist as they were then mentioned. In many places, there is not even a project. In place

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73   The State Planning Board, Government of Kerala publishes Kerala's Five Year Plans accessible at https://spb.kerala.gov.in/ and http://14.139.60.153/browse?type=author&value=State+Planning+Board+Thiruvanthapuram

74   Gram (Grama) Sabha is a constitutionally recognised institution of direct democracy in India through which people participate in decentralized decision-making at the village level. See powers and functions of a Gram Sabha in Kerala in Government of India. (n.d.). The Kerala Panchayat Raj Act & Rules. Ministry of Panchayati Raj. Retrieved from https://www.panchayat.gov.in/documents/20126/0/Kerala+Panchayati+Raj+Act+1994+and+Rules.pdf/18190ecc-55b0-0b61-bf1e-f6925eb98145?t=1554879157643.

of the project, they just write a word and allot an amount to it, because the government has created a software, so if you need to just fill it. But this doesn't mean that all places are like this. Even then, if you ask whether the project's concepts are expanded in the Gram Sabhas, then the Sabhas themselves are not convening at many places, and if they do there are no minutes [of meetings]. We have reached a point that sometimes the president or the chairperson of the Standing Committees keep the project on the last day, and the next day they develop it. But even then, the type of decentralization that we practice today has contributed immensely to the health sector. We have to see that. I'm not saying anything negatively, but it is a fact that things are happening much differently from how they were conceived, and that is saddening. When we personally look into it—from an academic or public health perspective—, in the beginning when I was in field, people didn't know what community medicine was and there was a need to explain it. But today when I say somewhere 'community medicine' or 'public health', they say it's a special genius kind, and nowadays there are people in Kerala who believe it as one of a kind. Before 9th Plan, no one actually needed 'public health', but today it has become the concern of the society and it has grown and I believe it will be good for the society. Now, to answer how key players were organized, in the 9th Plan, there were grand organizations and plans. Before the 9th Plan itself, Parishad and we all, mainly myself—the peripheral part was worked by Jagajeevan and KRP linked projects which included four to five Panchayats—, worked and gained a lot of things. Based on that, we realize that the Parishad had worked as a backbone for the 9th Plan.

When you ask about the fund flow of the NRHM, as I mentioned earlier, they had good amounts of funds during the period from 2005-2010, and we could have diversified and made the system efficient. But I remember how Jagajeevan and I had gone to invite a bureaucrat for an event, and how he responded. I got scared. Not scared but looked at him ridiculously. Like how someone once said, 'Indira is India, and India is Indira', he told us, 'I am the NRHM'. These are the exact words he used. And he said that we have to take his permission if we want to speak about the NRHM. That was the times then. So, even when such a situation was prevalent, Dr. Rajan[75] [Dr. Rajan Khobragade] was in charge, we were able to create and implement a unique intervention against AIDS stigma by involving the Panchayats. At that time, it was not like today—AIDS was a stigma. The AIDS Control Society[76] used to be involved in this and then it was not the main Health Services. The AIDS Control Society, they wanted something from the local people to actually fight the stigma, resource mobilization, and people's involvement. Naturally he [Dr. Rajan Khobragade] exploited it as well as got associated with it and that was a turning point. At the same time, the mainstream health system watched on helplessly. You could say that people like Dr. Jagajeevan, Dr. Biju[77], and I were enemies of the health system. We became its friends after the turnaround post 2010.

So, if we look at the constraints on its functioning, the change in quality, reach, acceptability, and compare what was seen before 9th Plan, there have definitely been a lot of changes since the situation then. More concepts and creativity have come up. When the central government wanted to start the NCD control programme in four districts, but we started in fourteen districts, it is only because of the lessons we learnt during decentralization that the administration was able to do so. Therefore, we need to recognize the advantages. Due to the constraints of time, I am stopping here. If there are more questions, I will answer. What was told to me were not these questions that were sent. I was told to recount my personal experiences. If I have to answer the questions that were sent, there are enough things to write a book.

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75   Dr Rajan N. Khobragade is the Principal Secretary in the Department of Health and Family Welfare (Government of Kerala). He was formerly the Chief at the National Technical Support Unit of National AIDS Control Organisation, and the Project Director of Kerala State AIDS Control Society (KSACS).

76   The Kerala State AIDS Control Society (KSACS) supports Kerala's strategy in addressing the HIV/AIDS epidemic. KSACS was formed to implement the National AIDS Control Programme (NACP) in the state. See https://ksacs.kerala.gov.in/.

77   Dr. Biju Soman is Professor at Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.

Jose Chathakulam: I need to make a couple more points. I will just take a minute. Can you hear me? One: Dr. Ramankutty asked whether it is good or bad that the Collector has a centralizing role. My point is that we have heard of bureaucrat [elite] capture. My point is that the state power [administration] is capturing the local government through this mechanism, this tendency has already started in Kerala. So, they have started using the institutions such as that of the District Collector. I even see the Aardram project as part of this. Number two, something was mentioned about software. There is not just one software, but a number of them in fact. As a result of these software, there is some form of disempowerment which has started coming up in the local governments. Very particularly, among the elected functionaries. And I am using the term elected functionaries, not representatives. The elected functionaries are by and large becoming disempowered by the use of such software and other such technological innovations. The elected functionaries stay away from policy decisions; they are actually becoming a kind of public relations officers of the local government. These are the two dangerous trends developing as far as the Kerala local government is concerned. One is that of the capture of the local government by the State machinery, and number two, the starting of some amount of disempowerment by these sorts of software and other technological innovations. Thank you.

S.M. Vijayanand: I want to add two points. One, we should look at the origins of Kudumbashree. In 1994, pre-decentralization, it focused on maternal and child health, and not thrift and credit. And then they worked with local governments. The second point is, in fact—I forgot to mention—, is one of the gaps: that we have primary health, secondary and tertiary. And health system cannot be sliced at the local government level. So, this vertical and downward level planning, what they call multi-

level planning could actually be—to use an old jargon—iterative planning. Not the bottom-up and top-down; it goes up and down 'til you arrive at an optimum plan. I think that is what should be aimed at. And just a question of statistics on outcomes, I think when the Parishad did their study[78] in the nineties, about 28% of the people used public health facilities. In 2015-16 NFHS[79], it went up to 67.5%, and in 2019-20, it reached 76%. Now, it would have crossed this figure. So, that shows decentralization and independent assessment of outcomes.

Ramankutty V: Okay, thank you very much. All these are very important points. Unfortunately, we have run out of time. I would have very much liked to have more time. Unfortunately, I am not in a position to continue any longer. Anything urgent anybody wants to mention, which they have forgotten?

So, shall we wind up, Sreejini?

Sreejini J: Yes, Sir. We can wind up.

Ramankutty V: So, shall I say that this will be circulated, and anybody who wants to make other comments can add them in writing, and they will definitely take note of that?

Sreejini J: And we can also have a discussion on a one-to-one basis. That can come in our entire report. Because we are just exploring this kind of a thing, which was not documented before. Actually, we can wind up. The thank-you note will be given by our Programme Coordinator, Devaki Nambiar.

Devaki Nambiar: Yeah, and I'll make it very quick. I just wanted to thank you, Professor Ramankutty, for steering us through this and being generous with your time. We've actually gone over a fair bit. And I think...just really heartfelt thanks to you. We've learned so much and we wanted some of my youngest scholars also here to be part of this.

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78   See Arunima, G., (2006). Keralapadanam: Keralam Engane Jeevikunnu? Keralam Engane Chinthikunnu?. Kozhikode: Kerala Sasthra Sahithya Parishad.

79   The National Family Health Survey (NFHS) is a large scale, multi-round survey conducted in a representative sample of households across India providing state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, and utilisation and quality of health and family planning services. See http://rchiips.org/nfhs/

It feels very momentous. So, thank you. I think Professor Vijayakumar has done, has employed the strategy of Witness Seminar that works best, which is, just throw out any concepts—MGP, this, that. Because now when we do the transcript, anything you would have said that requires further conversation, we will be coming back to you and bugging you and doing desk research also to fill out and annotate this transcript. So, we're very committed to making this as detailed as possible and a repository of knowledge for everyone.

And just in closing, I will quickly say that Sreejini and I—the starting point for this was actually looking through, "What do healthier societies mean?" Sreejini and I were involved with the project on that, and we started with the Alma Ata, and the fourth article actually talks about what you all have been talking about. But the candour with which you've talked about failure, the details with which you've talked about the operational aspect of actual decentralization, and I think the open-mindedness that we've seen, is really inspiring for people at our stage of career. So, thank you so much for taking us along on this journey. We will be following up and we'll be in touch with you. Thanks again, have a wonderful day. I think we will sign off for now.

Ramankutty V: Thank you very much, Devaki.

Devaki Nambiar: Thank you, professor. We will follow up with you.

Proceeding ends.

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