

Witness Seminar on Community Action for Health in India

The case of Decentralization and Health reforms in Kerala

Third of Three Witness Seminars

Held online via Zoom on 25th August 2021



The George Institute
for Global Health



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In support of an ongoing research collaboration with the Civil Society Engagement Mechanism (CSEM) for UHC2030 globally, the George Institute for Global Health India conducted Witness Seminars to document community action and social participation for health in India using internal funds.

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Instructions for Citation

If you are using this document in your own writing, our preferred citation is:

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Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BP	Blood Pressure
BPL	Below Poverty Line
CapDecK	Capacity Development for Decentralization in Kerala
CHC	Community Health Center
CHP	Comprehensive Health Plan
CMD	Center for Management Development
COSTFORD	Center of Science and Technology for Rural Development
DMOs	District Medical Officers
DRHP	District Health Reproductive Program
FHC	Family Health Center
GH	General Hospital
HMC	Hospital Management Committees
IAS	Indian Administrative Service
IEC	Information, education, and communication
IMG	Institute of Management in Government
IP	Inpatient
IPD	Integrated Population Development
JPHNs	Junior Public Health Nurses
JSY	Janani Suraksha Yojana
KILA	Kerala Institute of Local Administration
KUHAS	Kerala University of Health Sciences
KSSP	Kerala Sasthra Sahithya Parishad

LSG	Local Self Government
LSGD	Local Self Government Department
MBBS	Bachelor of Medicine and Bachelor of Surgery
MP	Member of Parliament
MLA	Member of Legislative Assembly
MO	Medical Officer
NCD	Non-Communicable diseases
NGO	Non-Government Organization
NHM	National Health Mission
NREGA	National Rural Employment Guarantee Act, 2005
NRHM	National Rural Health Mission
OP	Outpatient
ORS	Oral Rehydration Solution
PG	Post Graduate
PMC	Palliative Management Care
PPE	Personal Protective Equipment
RCH	Reproductive and Child Health
RHTC	Rural Health Training Center
RNTCP	Revised National Tuberculosis Control Programme
RRT	Rapid Response Teams
SDG	Sustainable Development Goals
UHTC	Urban Health Training Center
UNFPA	United Nations Population Fund
WHO	World Health Organization

Background and Purpose

Community participation in health in India^a—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^b 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

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

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

b. In the 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.

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 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:

Mr. S.M. Vijayanand IAS (Retd)

S.M. Vijayanand, a 1981-batch IAS officer and the former Chief Secretary of Kerala, is one of the architects of the democratic decentralization initiative. He played a key role in the devolution of funds, powers, and personnel to the local government institutions, besides serving as Member-Secretary of the Sen Committee on Democratic Decentralization and member of the State Finance Commission. He is currently the Chairman of the Center for Management Development.



Mr. Ramchandran VV.

Ramchandran VV is a retired as Joint Development Commissioner from the local self-government department of Kerala and worked in National Health Mission as a consultant in the Comprehensive Health Program, which was designed to improve the participation of Local Self Governments (LSGs) in the health sector.



Mr. Suresh K

Suresh K is the state admin and human resource manager for state program management unit of National Health Mission Kerala. Mr. Suresh has been part of the state level core team since the initial years of NHM in Kerala.



WITNESSES:

Dr. Mathews Numpeli

Dr. Mathews Numpeli is a medical doctor working in Kerala's Department of Health and has extensive work experience in palliative care programs. Currently, he works as District Program Manager of the National Health Mission in Ernakulam district.



Dr. Divya V.S.

Dr. Divya V.S. is a medical doctor working in the Kerala Department of Health, and is currently deputed as Nodal Officer for Capacity Building in NHM. Dr Divya was part of the team that designed and implemented the "Aardram mission" in the state.



Dr. Sanjeev S.

Dr. Sanjeev S. is a medical doctor with extensive experience in primary health care, and he worked with Kerala's Department of Health. Post-retirement from the Department, Dr. Sanjeev continues to work as a Medical Officer in an Urban PHC in Thiruvananthapuram.



Dr. Sairu Philip

Dr. Sairu Philip is Vice Principal as well as Professor and Head of the Department of Community Medicine at Government TD Medical College, Alappuzha, Kerala. She is a Bernard Lown Scholar in Cardiovascular Health at the department of Global Health and Population, Harvard T.H. Chan School of Public Health. She has thirty years of experience in public health and has implemented innovative projects with LSGs and introduced curriculum innovative initiatives in Community Medicine.



Mrs. Seena K.M.

Seena K.M. is currently the State Consultant of the Social Development Division in NHM and was part of the state-level program management unit since the inception of the Program. Ms. Seena handled the community health worker "ASHA" program of NHM from the early days of the program in Kerala.



Dr. Jayakrishnan T. Thayyil

Dr Jayakrishnan T. Thayyil is a professor of the Community Medicine Department of Kozhikode Medical College with extensive experience associating with Kerala Institute for Local Administration, Kerala Sasthra Sahitya Parishad, PPC, and other community health movements in the state.



Dr. Preethi P.T.

Dr. Preethi P.T. is an Assistant Surgeon in the Kerala Department of Health. She is presently working as a Medical Officer in PHC Purakkad, in the coastal area of Alappuzha. Dr Preethi, a graduate in family medicine, is closely associated with the communities and LSGs. She qualified NQAS certification of PHC Purakkad with a mark of 96% in 2019.



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: Namaskaram. Good evening and greetings to each one present here today. Actually, we called all the participants on short notice, and it gives me great pleasure that all have agreed. I called ten of the participants and all have agreed to participate in this meeting. On behalf of The George Institute for Global Health, I extend my warm wishes to all of you who are present here. I welcome our witnesses, Dr. Sanjeev, who is currently the Medical Officer NHM, Chalai, Dr. Divya V.S., Nodal Officer,⁰¹ Training NHM, Dr. Mathews Numpelli, DPM-NHM Ernakulam. He is also the Head of Social Development NHM and SNO national program for palliative care. I will also name the other witnesses, like Mr. Ramachandran Sir, who is also present here. Mr. Ramachandran Sir is a formal Nodal Officer, Social Development Consultant, NRHM. I will also introduce the other witnesses who we have called. Dr. Jayakrishnan P. Thayil, Professor in Department of Community Medicine, Government Medical College, Calicut; Dr. Sairu Philip, who is the Professor, Head of the Department of Community Medicine, Government PG Medical College, Alappuzha; Mr. Suresh K. State HR and Administration Manager, NHM; Dr Sahir Shah, Superintendent, Taluk Headquarters Hospital, Punalur; Ms. Seema, Senior Consultant—I think ma'am has joined right now—she is a Senior Consultant of Social Development, NHM; Dr. Preethi P.T., Medical Officer, Purakkad, Alappuzha.

I welcome all of you to this seminar. The chair for the session is Sri S.M. Vijayanand Sir, who is a retired IAS officer. He is currently the Director,

Centre of Management Development. As you all know, Vijayanand Sir is one of the key architects of the democratic decentralization initiative. And we consider it as an honor that he agreed to be part [of this]. He was also a part of our earlier Witness Seminar, and he agreed to be the Chair for the session. He is a 1981-batch IAS officer, and he was a former Chief Secretary of Kerala. Mr. Vijayanand Sir has played a very key role in the devolution of funds, powers, and personnel to the local government institutions besides serving as a member secretary for the famous Sen Committee Report on Democratic Decentralization⁰² and he was also a member of the State Finance Commission⁰³. Welcome, Sir.

S. M. Vijayanand: Thank you. Because it is a Witness Seminar, one correction: you have put me as Director, Centre for Development Management. Actually, I am Chairman, Centre for Management Development.

Sreejini J: Thank you, thank you for the correction.

Ramachandran V. V: Yes, Chairman. (Laughs). Great gap, I think.

S. M. Vijayanand: Witness seminars, we shouldn't get the names wrong.

Sreejini J: Thank you, Sir, Thank you for the correction. I will note it down.

S. M. Vijayanand: Good that we have gotten such a mix of experts who have had direct experience of decentralization. Some of them recent, some of them right from the beginning. I don't want to take

01 Nodal Officer is a commonly used designation in the National Health Mission (formerly, the National Rural Health Mission) that denotes responsibility for a particular area of work. "Nodal" responsibilities are indicated in various government guidance documents. For an example see: <https://darp.gov.in/sites/default/files/National%20Health%20Mission.pdf>

02 The Committee on Decentralization (Popularly called Sen Committee after its first Chairman S.B. Sen), appointed around the launch of the People's Plan Campaign, recommended the necessary institutional reforms (activity mapping, performance audit, ombudsman, state development council, right to information, citizens charter, etc.) and legislative framework for functional, financial, and administrative autonomy. See: <http://14.139.60.153/bitstream/123456789/5038/1/Report%20of%20the%20Committee%20for%20Evaluation%20of%20Decentralized%20Planning%20and%20Development.pdf>

03 A State Finance Commission reviews the financial position of the Panchayats in a state, and makes recommendations to the Governor about the principles that should govern the distribution of tax proceeds, i.e., taxes, duties, levies, toll fees collected by the state between the state and its Panchayati Raj Institutions at all three levels (village level, block level and district level). See: <https://www.Panchayat.gov.in/en/web/guest/state-finance-commission>

much time but just want them to reflect on their area of work. Starting from what they have done specifically and moving on to general principles of how it is linked to Kerala's decentralization. Both the hits and misses; don't just talk about the positives, but also the concerns and the way forward. Particularly, we would request you to look into what exactly in decentralization helped your area of work and what didn't. So, from that, we get an idea of the way forward. And particularly, unless it is embarrassing to you, what was the push for decentralization from within the department and within the National Health Mission (NHM)⁰⁴, or was there nothing? And the push for decentralization of Panchayats⁰⁵ health [care sector] and all that. And how exactly we can sustain the "gains" of COVID which has pushed the local governments to the center or in the forward position in this. Particularly in my long experience with decentralization, I find that in the convergence part between NHM, the state plan, and the Panchayats or the local governments' contribution, there is still a long way to go. It depends totally on the doctor. The doctor can converge, but there is no other process. And something which is missing. The big opportunity that NHM lost, NRHM lost in 2005s... particularly in 2006 is that we didn't go from below—scientific planning from below. Aardram⁰⁶ envisaged that. But I don't think anybody planned for health from below. Then of course COVID put a strain on all our ambitions. So, with these opening remarks, I think, whom should I call first? Is it left to me?

Sreejini J: Yes, Sir.

S. M. Vijayanand: Ok. So, I will call Dr. Mathews? You can.

Mathews Numpeli: Sir.

S. M. Vijayanand: And I think both Malayalam and English are okay, no?

Mathews Numpeli: Malayalam would be fine, Sir. (Laughs)

Sreejini J: Yes, Sir. Any language is good.

Mathews Numpeli: You can hear me right, Sir?

S. M. Vijayanand: Yes, you can proceed.

Mathews Numpeli: Well, for me, I have two experiences.

S. M. Vijayanand: And one more thing. It's ten minutes allotted maximum per person. So only to the point.

Mathews Numpeli: So, is it like I should speak for ten minutes first, or?

S. M. Vijayanand: Yes. Well, yes, you can stop by around eight minutes, and you can do it in the next round if we have time.

Mathews Numpeli: Alright. So please let me know when the time is over, Sir. Here, I have two things as decentralization experiences. The first one is my experience beginning from 2001 at the palliative care center. Like all of us who have convened here already know, palliative care began in Calicut in 1996.

Seena K. M: We can't hear you, Mathews

Mathews Numpeli: Now is it okay, Sir?

Seena K. M: You can switch off the video if there are issues with the range.

Mathews Numpeli: There are no issues with the range. Something else. During 2000-01, a network

04 The National Health Mission (NHM) was launched by the Government of India in 2013, encompassing 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/>

05 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-1992c>

06 The Aardram Mission is one of the four missions under the 'Nava Kerala Mission' initiated by the government of Kerala. The main objectives of Mission Aardram are 1) To provide People-friendly Outpatient Services, 2) Re-engineering Primary Healthcare Centers into Family Health Centers, 3) Improving access to comprehensive health services for the marginalised/vulnerable population, and 4) Standardization of services from primary care settings to tertiary settings. See: <https://arogyakeralam.gov.in/2020/04/01/aardram/>

of volunteers named 'Neighborhood Network in Palliative Care'⁰⁷ started in Malappuram⁰⁸. Through them, many clinics became more popular. The clinics that already existed under the leadership of the doctor in charge during that time happened to become more popular. So, people collected money from local residents and demonstrated how to run a palliative care clinic with the cooperation of local residents.

During that same phase, the members of the local administrative bodies⁰⁹ also took part in this volunteering activity. So, the representatives of the local administrative bodies themselves urged that they people should help palliative care clinics in ways that were possible. The nearby Panchayats came forward and said it's a good thing and it should be supported. The first thing they did at that point of time in the process of decentralization, [was that] things like waterbeds, wheelchairs, airbeds, etc. were purchased and handed over to the community palliative care clinics by the local administrative bodies. There was a provision for that in the phase of decentralization. So, with that, they purchased these things for the palliative care clinics. Through them, a process of delivering [necessary items] to the patients used to happen. Later, they started to buy and donate medicines. The Panchayats themselves gave the medicines to the palliative care clinics run by voluntary organizations. So, during this time, palliative care run by the people became more popular.

There was a discussion in Malappuram that even government-run palliative clinics should come up in a similar way. Because the Panchayats provided medicines, many patients were sent there to the palliative care clinic. Hence the patients with pressure, diabetes, etc. also started to go to

palliative care clinics. So, some of us at that time recognized the danger of this situation and advised them that the Panchayats themselves can do the same thing in their own PHCs. Then, some of them were ready to take it up. Three Panchayats nearby took it up. They had many hindrances then—they will need a nurse, medicines, and so many things. Then these palliative clinics told the Panchayats, "We will provide all that. Just run it in our label. We will release a nurse. We can also supply medicines initially. Later, after some time, you can submit a project and work things out." It was with that confidence that four Panchayats in Malappuram ventured into the palliative clinic program.

For that, what all did they do? They convened a meeting there. Organized a group of people. Informed them about starting a project like this. Asked them to generate a list of ailing patients. With that list, they went and consulted them at home. Understood the problems directly. They explored what all can be done together with the Panchayats and PHC. It went on like that. Seeing that it was going well, the rest of the Panchayats recognized this and started to take it up. Later the district Panchayat prepared a project and took it up—in the name of "Arike"¹⁰. Within four years, they did this under the name of a project called "Parireksha"¹¹. And over those four years, throughout the district of Malappuram, a project was submitted to develop this in all Panchayats. In the first year, it was done in 25 Panchayats. In the second year, it was done in 50 Panchayats. It was improved like that.

It was during that time, with Vijayanand Sir's involvement, at Areekode¹², inviting all the local self-government institutions, Sir introduced the subject. A meeting was convened like that. At that time Panchayat presidents from Idukki, Ernakulam,

07 The Neighborhood Network in Palliative Care (NNPC) is a network of community-owned palliative care initiatives in northern Kerala, India. See: [https://www.jpsmjournal.com/article/S0885-3924\(07\)00107-8/fulltext](https://www.jpsmjournal.com/article/S0885-3924(07)00107-8/fulltext)

08 Malappuram is a district located in the central region of the southern Indian state of Kerala.

09 The village panchayat is the local administrative body, consisting of 10-20 seats and carrying out a range of functions, particularly those outlined in the Third Schedule of the Panchayati Raj Act of 1994. See: <https://www.panchayat.gov.in/documents/20126/0/Kerala+Panchayati+Raj+Act+1994+and+Rules.pdf/18190ecc-55b0-0b61-bf1e-f6925eb98145?t=1554879157643>

10 With the government implementing Kerala State Palliative care policy in 2019, 'Arike' is a home-based palliative day care service. <https://www.thehindu.com/news/cities/Kochi/home-palliative-day-care-service-launched/article28872337.ece>

11 'Parireksha' was a comprehensive palliative healthcare program which was started in two or three Panchayats of Malappuram district in 2002. Following its completion in 2006, it was taken up by the Malappuram District Panchayat and to rest of the Panchayats of Malappuram district.

12 Areekode is a town on the banks of the Chaliyar River in Areekode Grama Panchayat in Malappuram district, Kerala, India.

Alappuzha, Kollam¹³, etc. came there and listened. After they listened, they went and submitted projects and implemented the plan. It started at each of these Panchayats. Recognizing that it was really good, more Panchayats signed up for that. Thus, by 2006, around 100 Panchayats came up to that level.

NRHM¹⁴ comes in at that juncture. Considering this as an opportunity, a project was first tabled for Malappuram, Kozhikode¹⁵ and Wayanad¹⁶ districts. By making it mandatory in these three districts, a program was conducted here in 2006-07. Because it was a success, a state-level project was taken up to expand it even more. Then it reached NRHM as a standing project. After all this, after 2006-07, in 2008 it was introduced as policy. By 2012, when almost 95% of Panchayats in Kerala started implementing it, the government declared it as a mandatory project, and it then reached 100% of the Panchayats. It was a really good achievement.

The problem with that: when we go to the grassroot level, with the help of people we should identify patients, recognize their problems, and see what these problems are. We should look at what can be done on the part of the governments, what can be done by voluntary organizations, and what can be done by the volunteers. Thus, we envisioned this as a project that is implemented by everyone. We haven't really been able to make it completely to that level. [There are] issues. Government is doing things their way. People are doing it their way. The voluntary organizations are doing it in their own

way. Though there were attempts to do things in coordination and at some places it has succeeded too, I still feel that the fact that it isn't made into a standardized process is a drawback.

My second experience [that I want to narrate] was when I joined the health service in 2013 at Ayavana¹⁷ PHC as a Medical Officer. With my experiences, to improve the ward health, an effort was taken up with the help of the Panchayat. [This was done] by training the ASHA¹⁸, Anganwadi¹⁹, Kudumbashree²⁰, and Ward Members in each ward²¹, and by discussing things with them, [as] they all have a really good capacity and interest to do a lot of things. But when it comes to the level of Panchayats, it isn't reaching their level of initiatives. When it reaches the Panchayat level, most of it is getting lost. So, let's do things focusing on each ward. In each ward, we set up a group, gave them training, and established a center called "Ward Facilitation Centre" by the Panchayat—like giving the people many services from the ward itself. Otherwise, when it comes to sub-centers and PHCs, it is still under the concentration/mechanism of the government. There is a complaint that the opportunity for participation of people will be less there. Do whatever is possible within the ward. To get the waterbed, wheelchair, and airbed people don't have to come to PHCs. All those things, they can get in each of their wards. Instead of Panchayats, it was handed over to the wards. And they started to distribute it. They take it back when the use is over. They keep it there itself. And they give it to the new patients. Such a process was brought in there.

13 Idukki, Ernakulam, Alappuzha, and Kollam are all districts within Kerala.

14 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>

15 Kozhikode is a coastal city in the south Indian state of Kerala.

16 Wayanad is an Indian district in the north-east of Kerala state with administrative headquarters at the municipality of Kalpetta.

17 Ayavana is a Panchayat in Ernakulam district in the Indian state of Kerala.

18 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>

19 Anganwadi is creche or childcare center, made available across the country, particularly in rural India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. Anganwadi means "courtyard shelter" in Hindi. See: <http://wcd.kerala.gov.in/anganwadis.php>

20 Kudumbashree is a poverty eradication and women empowerment programme implemented by the State Poverty Eradication Mission (SPEM) of the Government of Kerala. See: <https://thekudumbashreestory.info/index.php/what's-kudumbashree>

21 Wards are the smallest subdivisions of the Gram Panchayat—the democratic structure at the grassroot level. From respective panchayats, a ward member (elected representative) will be assigned for each of the wards in the Gram Panchayat area.

Many other programs [were done along] with that. For example, Paracetamol, Albendazole, ORS, bleaching powder, and condoms, etc. are issued from the PHCs to be distributed from the [ward] itself. From there, the ASHA18 worker will take it further. The member is actually the overall leader. The ASHA worker will do the technical things. And the Anganwadi worker¹⁹, Kudumbashree worker²⁰, and volunteers will support it. I had set up a facilitation center in each of the 14 wards there in this manner. We were able to do that well too. But we could not institutionalize it. Last year, we took it up within the NHM project and implemented it at one Panchayat each in all districts.

We cannot say that it's a complete success yet. But it was recognized well by all as a concept. We got tremendous support from the Panchayat for this. Everyone is moving it forward. But our technical support [is needed]. In my experience so far, people are ready to do it. They have done it during the floods and COVID. They are really ready to do it. They can do it in a really good way. There are not many problems. But when they do it, the bureaucrats are still not able to take them into confidence. So, now it is like we can take support from people when we do things. But we are still not ready to fill the gap by working with them when they do things: as a government or government system. Even now when we take up some activities in the health sector: for example, if it is by NHM, we take up some activities, and we seek support and gather maximum support that we can get from the people. On the other hand, realizing what the problems faced by the people are, by understanding what they are doing and finding out what more can be done to it [could be a beneficial approach].

The flexibility and freedom to plan programs for the grassroots in this manner are not available yet. Generally, in this I feel, it still remains at the Panchayat level. It's still under the leadership of the officers. Even taking the feedback from the people... If it reaches the ward level, the people

in the ward, the ward members, Kudumbashree, ASHA, Anganwadi teachers, people in the wards [will have the power]. People are responsible. By giving them responsibility, by giving them power— an institutionalized system where people from the ward decide a majority of their things, and we give whatever additional support that they need when they can't do things. That is our dream, Sir. Thank you.

S. M. Vijayanand: You have set a good trend by stopping within the exact time limit. Next, I call Ramachandran V.V. It was when he was working in NHM that a project was sanctioned by the Central Government for the Panchayats for the first time. What I am saying is that since 2011, all over Kerala more coordination and more focused interest between the Panchayats and the Health Department had come. For this, the award of "Arogyasree"²² really helped. Right from '97 it was there. But this got formalized and top brass got interested in Panchayati Raj. Until then, it was more or less at the institutional level. Ramachandran...

Ramachandran V. V: Thank you, Sir. You can hear me well, right, Sir? I was working in the Rural Development Department. It was Vijayanand Sir himself who was the secretary for the whole time.

To get an initiative, and a continuity for everything, there were two reasons. It was Rajeev Sadanandan Sir, who was the health secretary then, who posted me first in NRHM after I retired. For me, at that point in time, I really did not have an idea about what decentralization is in health. I got an idea after I had a discussion with Biju Prabhakar Sir, who was the NRHM Mission director. So, in fact, I have three godfathers. I got complete support from Rajeev Sir and Biju Sir. I got Vijayanand Sir when I went to Delhi. What should I say, it was like all the favorable factors came together. Vijayanand Sir really took interest and taught me everything about the Central Government. I really felt the effect when I went to Delhi for the NHM Governing body meeting. The

22 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 Ardam Keralam Puraskaram. See <https://www.thehindu.com/news/national/kerala/kollam-local-bodies-bag-top-health-awards/article27401855.ece>)

Comprehensive Health Plan's (CHP)²³ share was hiked from just 2 crores to 20 crores. The second thing is that I received a really good nodal team. Vijayakumar Sir, Dr. Sajith Kumar were there in the capacity of State Nodal Officers¹. Then the other Health Inspectors²⁴. It was a team with great commitment. Then, I had chosen two or three persons from my department; Gopalakrishnan from KILA (Kerala Institute of Local Administration)²⁵. We can't forget all of them. So, we could really make a good team.

Then there are political factors. We cannot ignore it. Adoor Prakash was the [Health] Minister concerned. I can't believe a Minister visiting and reviewing all the fourteen districts along with me. I was witnessing a scene where Health Department officers, Panchayat presidents, Members of Parliament (MPs)²⁶ and Members of the Legislative Assembly²⁷ (MLAs) convened together for a meeting for the first time. A historical moment that gave momentum. The Minister himself was involved in everything directly. A program for seven consecutive days: in the morning and evening. That helped to give it a good kick start for CHP. We all know for some 10 to 15 years; the Health Department was more or less away from the decentralization. I was able to really bring it back on track at once.

Another major thing was the support of DMOs²⁸ and MOs²⁹. I am sure the doctors in the Health Department form the biggest group of most

intelligent people. But, even for them, they did not have much of an idea about decentralized planning. Even then, when classes were organized at KILA, I was really surprised to see how these DMOs really tried to understand its essence as if they were small kids learning new things. So, when the health officers and DMOs took it up, I was able to take it forward well. Most importantly, I noted, like how Vijayanand Sir and Mathews Sir pointed out, Pain and Palliative care is the best example of integration in our decentralization. I got a chance; me and Mathews, to take part in one of those meetings at IMG³⁰ - you may remember it. I was really surprised thinking about all those things that we discussed regarding what all things should we take into consideration to issue a government order. An order jointly vetted by the Health Department and Local Self Government Department (LSGD); I think that was for the first time in the history of our Government. Vijayanand Sir, taking the lead, Mathews initiated everything together. Vijayanand Sir vetted it with utmost interest and pain and palliative care was taken to the maximum possible heights. The number of people who benefited from it is unimaginable. I adopted this approach as an example. We got a real sense of direction from that.

The second thing I wanted to state is that not many people opposed it when decentralization was introduced in the health sector. It's true that we were slightly distant from decentralization for

23 On 15 August 2011, the Prime Minister of India announced that the forthcoming 12th Five-Year Plan will be committed for health. The Plan's approach in the health sector for the next five years was underlined with the objectives of improving public health coverage, improving quality of services, addressing second-generation health problems, and implementing a regulatory mechanism to ensure quality of standards. The order was issued by Ministry of Health and Family Welfare; accordingly, a district health plan of the district was drawn out for every LSGs by a decentralized process and consolidated into a Comprehensive Health Plan. See: https://www.researchgate.net/publication/259288560_Comprehensive_Health_plan_-_Another_Initiative_Of_decentralized_planning_from_Kerala

24 A Health Inspector (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: <https://shsrc.kerala.gov.in/pdf/1182018H&FWD.pdf>

25 Kerala Institute of Local Administration (KILA) is an autonomous institution functioning for the Local governments in Kerala. It was registered under the Travancore-Cochin Literary, Scientific and Charitable Societies Act 1955. See: <https://www.kila.ac.in/about-us/>

26 A Member of Parliament in the Lok Sabha is the representative of the Indian people in the Lok Sabha (the lower house of the Parliament of India).

27 A Member of the Legislative Assembly (MLA) is a representative elected by the voters of an electoral district (constituency) to the legislature of State government in the Indian system of government.

28 The offices of District Medical Officers (DMOs) are "responsible for maintaining and developing the health care system in the District and guiding and supervising the Health and Family Welfare Programmes in the District." See: <https://ribhoi.gov.in/dmho/>

29 "The Medical Officer of Primary Health Centre (PHC) is responsible for implementing all activities grouped under [the] Health and Family Welfare delivery system in [the PHC's] area." See: <http://clinicaestablishments.gov.in/WriteReadData/360.pdf>

30 Institute of Management in Government (IMG) is the apex training institute of the Government of Kerala. It is situated in the heart of the capital city Thiruvananthapuram. See: <http://www.img.kerala.gov.in/#>

the past 10 to 16 years. But when the projects were introduced, Panchayats expressed interest and approached to take it up on their own. I mean, there were these favorable political factors and even social factors. We had official support. When these three things came together; though we didn't pull off the momentum that we had during "Peoples' Planning campaign"³¹ which was nearly impossible, we were able to make the health sector relevant. As part of it, Dr, Sanjeev is here, we did social audits at the end. We conducted pilot social audits at three or four places. and the results were amazing. What a response it had gotten! It was possible for politicians and others to comment about the role of doctors and officials from the health department, etc. It is a big thing that we were able to make a good start.

The number of projects taken up for the health sector steadily increased every year. From around 5%, around 8 to 9% was set aside for this sector. The good thing is that we were able to get more projects and also maintain the quality of those projects. Like what Vijayanand Sir said, the "Arogya Keralam" award²² was really motivational. I believe that it took off and soared really high. A good tempo was established. It was possible to take it to higher levels qualitatively and strictly engage with the award ceremonies without mixing it with a political interest. I think that is when I felt really content when I could do these things and establish a good rapport between the health department and LSGs through CHP. The model projects selected by the LSGs were broadcasted through Doordarshan³² and that was a milestone. I don't have more things to say here, Sir. The rest of the evidence and documents I had shared when I took part in an earlier seminar. Thank you, Sir.

S. M. Vijayanand: Next, I call Dr Sairu Philip. I think she has been briefed about this Witness Seminar earlier also. Since you were at the top, you can talk about other things too, but I would like you to talk about what you contributed towards decentralization. How could you facilitate decentralization? How were you able to bring in synergy with the tertiary and levels below that?

Sairu Philip: Thank you. Sir. I would like to talk about things in a scattered manner, like how it flows through in my mind.

My first experience with decentralization, I think, was from 1997 onwards. I belong to the Department of Community Medicine. At that time, according to Iqbal Sir, decentralization was a space that Community Medicine departments could engage with. He told us that there was a major role for Community Medicine in giving technical guidance and to the Panchayat or local self-governments in public health. This thought has always stayed in my mind. Mostly I had worked at Alappuzha³³, though I have worked in Manjeri³⁴ and then Kozhikode³⁵ for a while too. Probably it was Vijayakumar Sir³⁶ and Dr. T.M. Thomas Isaac³⁷ Sir who were the main reasons for me to get involved in decentralization process in Alappuzha. So, from my alliance with Panchayats since then I have discerned a dramatic change in focus during the two decades. The focus of Panchayats in the initial ten years (1995-2005) were in like construction of roads, buildings, etc., while in the next 10 years (2006-2016) the focus shifted to other areas like setting up community-based BP clinics, screening of diabetes, palliative care programs, etc.

I was fortunate enough to work with a Panchayat that approached things very innovatively right from

31 People's Plan Campaign, begun in 1996 in Kerala State, was an experiment in decentralization of powers to local governments with focus on local planning. See: <http://thekudumbashreestory.info/index.php/history-and-evolution/the-kudumbashree-idea/the-peoples-plan-movement>

32 Doordarshan is an autonomous public service broadcaster founded by the Government of India, which is one of two divisions of Prasar Bharati. See: <https://prasarbharati.gov.in/doordarshan/>

33 Alappuzha (or Alleppey) is a city on the Laccadive Sea in the southern Indian state of Kerala.

34 Manjeri is a major town and municipality in Malappuram district, Kerala, India. It is the fourth-most populous municipality in the state.

35 Kozhikode is a coastal city in the southern Indian state of Kerala.

36 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.

37 T.M. Thomas Isaac was a member of the legislative assembly of Alappuzha and the State Minister of Finance at the time

2002. Now when I look back, I realize there is a need for a visionary to bring this. It was that space of a visionary that Dr. T.M.Thomas Isaac Sir filled in Alappuzha. At the same time, there was support from a group of people in the Panchayat who thought along similar lines. When I first got involved with decentralization led by Vijayakumar Sir, the goal was to make a real change at Mararikkulam³⁸. What all can be done to make a visible change in the health of people at Mararikkulam? Though the program started in an enthusiastic pace in eight Panchayats under Mararikkulam constituency, unfortunately in 2003, Isaac Sir could not continue it for certain reasons. But, for us, it was like a major entry space. Out of the eight, three Panchayats who volunteered, finally it started and continued in one Panchayat. That was Muhamma³⁹ Panchayat. From then on, they started calling the Community Medicine Department for every public related technical advice in Muhamma Panchayat.

The Panchayat president of Muhamma Grama Panchayat Sri C.K. Bhaskaran⁴⁰ was a real visionary. I mean, he would initiate a program if it would be of benefit to his people. At that time, I was in a very junior [position]; Assistant Professor in Community Medicine. After associating with a few programs, he developed a trust in me. Even today, I really don't know how that happened. At that time, it was like a dream for us to get the Panchayats to implement innovative public health projects based on our ideas.

We did a number of innovative public health projects in that Panchayat from 2003 onwards. Like establishing outreach Blood Pressure (BP) clinics, community-based morbidity management clinics for filarial lymphedema patients, providing nutrition to persons on treatment for tuberculosis, etc. All these projects were done with the help of Panchayat Plan Fund⁴¹ and implemented with the help of Community Health Centers (CHC)⁴²

Muhamma health team and the community. The fruition of these projects and its successes gave us energy and enthusiasm to go there again and again informally in the years to come though the original formal project had ceased long time back. The Panchayat team would take technical consultancy for innovative public health program from us. Thus, we could do a number of projects at primary, secondary and tertiary levels related to public health in this area. Many of these seeing the outcome were emulated by other Panchayats.

In 2006, I got transferred to North Kerala where community-based palliative care was carried out with enthusiasm in an activism mode. The palliative care activists asked a question to me: "Why can't we replicate this North Kerala model of palliative care in Alappuzha considering the existing community networks available there?"

I got transferred back in 2007 to Alappuzha and once while addressing a large group of volunteers in a Panchayat led program in Muhamma I shared the palliative care models of North Kerala and addressed the same question to the audience. The Panchayat president of Muhamma Sri C.K.Bhaskaran Sir suddenly remembered the number of bedridden patients we had captured through the comprehensive health survey and he promised in front of the audience that he will take up the cause. He kept his word; he inspired his Panchayat committee and Muhamma was the first Panchayat in South Kerala to initiate a Panchayat-led, community-based palliative care program in August 2007. They put aside Rs. 1.5 lakhs from the plan fund to do [palliative care]. The palliative care volunteers from North Kerala facilitated the implementation process. The people discerned the benefit of home care to bedridden in influencing their quality of life and the Panchayat became a trend setter for other Panchayats with regard to community-based palliative care program.

38 Mararikkulam is a village in India, in the district of Alappuzha, Kerala state.

39 Muhamma is a census town in Cherthala Taluk in Alappuzha district in the Indian state of Kerala.

40 Sri C. K. Bhaskaran, who passed away in July 2014, had been the President of Muhama Panchayat for 12 years. He had played a very important role in initiating the Panchayat-based palliative care in Alappuzha.

41 Plan Funds are disbursed to local self governments based on an annual Development Plan that can occur for centrally sponsored, i.e. national schemes, state specific schemes, as well as local development funds. These are earmarked funds See: https://www.celsgd.kerala.gov.in/celsgd/gen/schemes_guidelines.php

42 The Community Health Centre (CHC), the third tier of the network of rural health care institutions, was required to act primarily as a referral centre (for the neighbouring PHCs, usually four in number) for the patients requiring specialized health care services.

When I look back at the factors that contributed to the success of these public health programmes, a major factor is the leadership of Panchayat President who wanted to do good things for his people and his courage to do proactively programs which did not have initial visibility but had long term impact. To mention one of his qualities; he never paid attention to political affiliation while including a person as his team member. I am saying this because I worked with that Panchayat for 15 years and it was in the 15th year that I got to know that people who worked closely along with the Panchayat President did not belong to his party. He had this unmatched ability to identify the potential of each person and he utilised the person's strengths for the common good. So once the election is over, all members—irrespective of the party [to which they] belonged—could contribute and work as a team. That was Sir's quality. He was not a highly educated person. Yet, once he identified the quality or strength of a person, he was an expert to make use of it for the Grama Panchayat⁴³.

To be honest, I still don't understand how I became part of Muhamma. It was around 30 kilometers away from where I work. It was not part of our Rural Health Training Center (RHTC) area, nor Urban Health Training Center (UHTC)⁴⁴ area. It is not my hometown. I belong to a different district. Other than the passion for public health and an interest and desire to do things, there was nothing official that connected me to that Panchayat. The Panchayat president realized my strengths and made use of my skills and capabilities for the people through projects. I had the privilege of being part of many projects that had an impact. That is what I see as a win-win situation there.

I can tell you here that the visionary intervention by Isaac Sir was another factor which helped the initiation of many public health initiatives in this area. He would instruct each Panchayat to take up

innovative activities in a specific area and develop it as a model; if it is public health in one Panchayat, it would be something else in another; say agriculture. So, if we have an MLA who is working with a vision, a Panchayat president with inspiring leadership quality and a team of dedicated ward members, what can I say! The health centre team under the stewardship of local self-government ensuring community participation; that's the magic recipe for success of public health initiatives in this area. Now when we talk about the health center, Muhamma CHC, all of them, the doctors and the health workers had shared a really good rapport with the Panchayat. The CHC team did not have any ego issues with the Medical College team working there with the Panchayat. That too counts. Often, we may not get that space to engage in an area not under our official control because we are from the Medical College. I consider it fortunate to have been able to engage and be involved in such a win-win situation here without facing any ego clashes. I see it as a great privilege for us to experience the power of decentralization. Subsequently, we were invited to neighbourhood Panchayats for technical advice, and we got opportunity to be part of the team for innovative projects in other Panchayats in the years to follow (gender friendly projects, etc.).

In 2016, when Kerala state had initiated the "Aardram" project and set Sustainable Development Goals (SDGs) related to that, it was informed that Panchayats too set their own SDGs. Aardram project endeavoured to make infrastructural changes and quality improvement of Health care institutions. Thus, tertiary, secondary, and primary health sectors were going to get a face change. So, we were thinking we should prepare the community to utilise the services available and accessible to them and prime them to protect their health through primary and secondary prevention. This needs community participation. Aryad⁴⁵ Block Panchayat, again under the leadership of Isaac Sir, was a fitting place to

43 The Panchayati Raj is a decentralized form of government. It includes the Gram(a) Panchayat at the village level, Block Panchayat (a cluster of villages), and the District Panchayat. See: <https://minorityaffairs.gov.in/sites/default/files/Government%20Mechanism.pdf>

44 Rural Health Training Centre (RHTC) and Urban Health Training Centre (UHTC) are two community medicine practicing areas for teaching and training of medical undergraduates and postgraduates in Community Medicine. See: http://iapsm.org/pdf/Operational_guidelines%20for%20UHTC_RHTC_Final_March_18.pdf

45 Aryad is one of the Panchayats in Alappuzha district in the Kerala state of southern India.

demonstrate it. Thus, under the guidance of Isaac Sir, 'Ardramee Aryad' program⁴⁶ was implemented in all of the 80 wards under this Block Panchayat. We selected one volunteer per 25 houses. Thus, around 1300-1400 volunteers were there in 80 wards. To train such a big group, what can I say; it was really an ambitious task. Community Medicine from the Medical College led the training component. A big team of thirty to forty doctors would be involved, and two or three doctors would be there in each of the 80 wards to teach the 25 to 30 volunteers in each ward. We would train volunteers to take BP [blood pressure], use glucometer, measure Body Mass Index, counsel lifestyle changes, etc. The win-win situation for me here was that my house surgeons and PGs [postgraduates] were part of this process. We would be there for at least five days in each of the five Panchayats. This experiential learning in the community was important for medical students to get to know the natural environment from which their patients came.

To execute all these things, there should be proper coordination between Grama Panchayat, Block Panchayat, and the health centers. If I have some more time, I will tell you something else too.

Initially, there was a kind of insecurity. ASHA18 workers felt that the community volunteers would overtake them. Later, they realized that these volunteers were those who could help them in their work more efficiently. And the people at the health services felt that we were infringing on their area of work. Slowly, by three years, everyone came together in one platform. The program was sabotaged so much in between because two floods which affected this area: Kuttanad floods and the subsequent floods⁴⁷. And the program came to a standstill. We lost all the survey forms that we collected. So many glitches happened like that. Even then, we reaped the benefits when COVID hit us in 2020; by then health services, Medical College, community volunteers, LSGs, Grama Panchayat, and Block Panchayat were all aligned in

one platform. So, we were able to put it to good use during COVID.

I mean, we went to all the 80 wards once again three times. We could talk to them regarding COVID prevention, reverse quarantine, etc. We started even ward-level quarantine support centers and a control room at the block level. It was in this area where the first cluster of COVID-19 was formed in the district. The good thing is that the LSG intervened while the health services were taking a big load there. The volunteers wore [personal protective equipment] kits and visited each of the houses and enquired if there was anyone with symptoms or a social need, etc. Thus, with the help of the Panchayat and community involvement, the critical social determinants of health were addressed during pandemic times.

The next advantage was that we had focussed initially on Non-Communicable Diseases (NCD) prevention and, by this time under 'Ardramee Aryad' program outreach, NCD clinics had been established. So, those people who got screened for NCD at the ward level could come to outreach clinics conducted by MOs. Additional funds for NCD medicines for use in outreach clinics were provided from 'Ardramee Aryad' Project. I guess during the COVID lockdown time, only NCD clinics functioning were these outreach NCD clinics functioning in Aryad Block. All the other clinics, even those in the Medical Colleges, weren't distributing medicines. So, because they couldn't get medicines from the Medical College, people from the nearby municipality area also came and got medicines from here. They couldn't go to Medical College or GH. So, we exhausted our calculated stock. There was a big ruckus there; because towards the fag end no medicines were available. That's the other side. But one thing I can confidently say again is that it was the only area where the NCD clinics functioned, and people received treatment even during the COVID lockdown. I am talking about the time when there was a complete lockdown. It

46 The 'Ardramee Aryad' project is a reverse quarantine project to protect individuals over 70 years and those with underlying conditions in 80 wards of Aryad, Mannancherry, Maraikulam South and Muhamma grama Panchayats under the Aryad block Panchayat. See: <https://timesofindia.indiatimes.com/city/kochi/reverse-quarantine-in-alp-to-cover-40k-families/articleshow/76346837.cms>

47 Since 2018, Kuttanad, a region spanning Alappuzha, Kottayam and Pathanamthitta districts of Kerala, has been witnessing frequent floods with high devastation capability. Even when other parts of Kerala are not experiencing any kind of waterlogging, flooding is happening in Kuttanad.

was actually a positive thing that later came out as a negative (when there were no medicines available at “Aardramee Aryad”). It was published in all the newspapers, etc. We started to give medicines to everyone without enquiring where they came from. That’s why there was a shortage of medicines.

I think there should be a binding force when many Panchayats work together. It was Isaac Sir as an MLA who was that binding force here. He worked very passionately as a change agent and monitored and supervised activities over time, which contributed to success of programs. Because every five years, elected people in Panchayats may change with elections. Unless there is a common vision, it is really difficult to maintain the thread of continuity. I think, to bring about a sustained change, it’s necessary to have a change agent—a visionary, people, and an LSG team working together.

I might have missed out on many things in between. I am at my workplace now. So, if anything is missed out, if Sir asks, I can add more.

S. M. Vijayanand: Dr. Sairu, I think you should write this as a case study. I will help you edit it, with the help of KILA. Because there are a lot of lessons, very important lessons for the Panchayats in the future.

Sairu Philip: Sure Sir.

S. M. Vijayanand: Next, I will invite Dr Sahir Shah. Punalur is a model hospital. You can talk about how that happened and how the municipality facilitated, etc.

Sreejini J: Vijayanand Sir, Dr Sahir Shah had some emergency and had to leave.

S. M. Vijayanand: Oh, is it? Then I will call Dr. Sanjeev.

Sanjeev S: Can you hear me, Sir?

S. M. Vijayanand: Yes. I can.

Sanjeev S: Namaskaram to Vijayanand Sir and to all others. Dear friends, I am Dr. Sanjeev. My experience is derived from working in the Primary Health Centers in Thiruvananthapuram, Thrissur, and Alappuzha regions. Beginning from a pre–Peoples’ Planning stage, through Peoples’ Planning and the emergence of NHM and its activities, it has now reached the “Aardram” project. Now I am a Medical Officer working on the activities of NHM.

It is through the activities of Kerala Sasthra Sahithya Parishad [KSSP]⁴⁸ that this particular vision of the development was devised. Under their leadership, there was a development rally and discussion with people which helped identifying the gap that how much people are staying away from the development activities of that place. The realization and experience of how much we could gain from involving people and their elected representatives towards the development of our land mostly came out of Kerala Sasthra Sahithya Parishad and its activities. I am someone who had worked in the health sector even before the decentralization and Peoples’ Planning. We were going through a phase that witnessed the extent to which people moved away from government systems. From a government system that was relied on by a meagre 10, 20 or 30 % of people, my experience was of a transition into an endeavour that brought about the maximum participation of people in the development of the health sector, with the advent of Peoples’ Planning campaign.

I worked in Kallikadu⁴⁹ Grama Panchayat the most. It is a village Panchayat in Thiruvananthapuram district. I was a Medical Officer there for almost 12 years. When I reached there as part of Peoples’ Planning, the situation there was like, what should I say, fish out of water. There was a lot of power. [We had] received a huge fund. But what to do with it? From a clueless situation, I can tell you about how it was possible to develop a proper sense of direction by establishing an efficient dialogue with people. The most important idea regarding this NHM and

48 Kerala Sasthra Sahithya Parishad (KSSP) is a People’s Science Movement of Kerala, India. Founded in 1962, it started its works at the science society interface, with about 40 members as an organisation of science writers in Malayalam. Over the past five decades it has grown into a mass movement with a membership over 50,000, distributed in more than 1,200 units spread all over Kerala. See: <https://kssp.in>

49 Kallikkadu is a village in Thiruvananthapuram District in the southern Indian state of Kerala. The village is one of the 11 census villages in the Neyyattinkara taluka of Thiruvananthapuram district.

planning was to look at the possibilities and blocks to bring together health workers, people, and the elected representatives around one table. Once that was achieved, when everyone was brought together around one table, we were able to focus on and bring transformations in our development issues; I mean to say particularly in the health sector. That is one part of what I would like to talk about here.

With the advent of NHM, we received more human resources and gained more freedom in spending the funds. The main thing is that there should be discussions towards a vision and focus on comprehensive development in its overall perspective; not just about anything specific. Ward Health Sanitation Samithi⁵⁰ was an apt forum for that. Kallikkadu Grama Panchayat really efficiently made use of this Ward Health Sanitation Samithi. The state model Ward Health Sanitation Samithi under the leadership of Ramachandran Sir was conceived based on the experience gained from here. In each of the Health Ward Sanitation Samithi we made change in the structure by creating a group that included elected representatives and distinguished people in it. And a group called Arogya Sena⁵¹ was formed. As a result of their efforts, a high range region like Kallikkadu controlled chikungunya and dengue. There was no one who was not affected by dengue or chikungunya earlier. From having 25, 30 or 40 documented cases of Dengue, it was brought down to one or two. Even Leptospirosis [Elippani in Malayalam] was also brought down to around one case. It was this peoples' intervention that safely guarded the Panchayat for three years.

We aimed at the integration of labour opportunities; the integration of NREGA [Thozhilurappu in Malayalam]⁵², Kudumbashree workers²⁰, Anganwadi workers¹⁹, ASHA workers, health workers, and elected representatives. Jaundice was rampant in one Vattapullu colony. So, when we convened a meeting and conducted a study with the people there, we got to know it was an issue related to drinking water. To resolve that, a village committee was formed, and they raised this issue in the Grama Sabha meeting. As a result, realizing the possibilities for integration, utilizing the Rajiv Gandhi Drinking Water Scheme⁵³, an overhead water tank was sanctioned. Thus, once the drinking water issue was resolved in that high range area, not a single jaundice case was reported. This change, in my experience, was a result of peoples' participation. That's what I wanted to say first.

Second, in the case of mosquito-borne viral diseases like dengue fever, a ward member should know which ward it is prevalent in, what is the density of the population, etc. When there was a situation to contain it within the ward level with the help of the Ward Health Sanitation Committee, they were able to identify the reasons for the increase in the number of diseases and implement specific micro-level activities as a response. We could also form a group with elected representatives and the other important people in that area.

And in the case of lifestyle diseases, [there are] similar success stories of going to the wards with a BP apparatus and glucometer, and conducting micro-level screening camps and making an impact by bringing in modification in their lifestyle, etc. I am

50 One of the key elements of the National Rural Health Mission is the Village Health, Sanitation and Nutrition committee (VHSNC). The committee has been formed to take collective actions on issues related to health and its social determinants at the village level. They are particularly envisaged as being central to 'local level community action' under NRHM, which would develop to support the process of Decentralised Health Planning. VHSNCs at the ward level also exist across the country, and are called Ward Health and Sanitation Committees or Samithis. See: <http://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=149&lid=225>

51 The 'Arogya Sena' (Health Army) was founded on 12 March 1995 at Bedse, a tiny village from Tal. Maval, Dist. Pune, Maharashtra State, along with a handful of people. Since then, it has expanded to a team of doctors and volunteers, training people in Disaster Management and Medical Relief Work. See: <https://arogyasena.in>

52 The National Rural Employment Guarantee Act (NREGA), 2005, i.e., Mahatma Gandhi Employment Guarantee Act 2005 (Thozhilurappu Padhathi), is an Indian labor law and social security measure that aims to guarantee the 'right to work' and enhance livelihood security in rural areas by providing at least 100 days of wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work. See: nrega.nic.in

53 The Accelerated Rural Water Supply Programme (ARWSP) was introduced in 1972-73 by the Government of India to assist the states and Union Territories to accelerate the pace of coverage of drinking water supply. The programme was given a missionary approach with the launch of the Technology Mission of Drinking Water and Related Water Management, also called the National Drinking Water Mission (NDWM), in 1986. The NDWM was renamed as the Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991. See: https://niti.gov.in/planningcommission.gov.in/docs/reports/peoreport/peoevalu/peo_rgndwm.pdf

not going into the details because of a lack of time. Similarly, health-related activities, activities linked to NREGA in the agricultural sector, etc.—integrating the efforts of departments of agriculture and health workers made it possible to utilize barren lands for promoting paddy and banana cultivation.

Anyway, compared to earlier usage of 20-30%, now around 80-84% of people are utilizing the health services these days in our Panchayat through due consideration given to the people's need. This fact is clear from a social auditing that was conducted by an independent agency. I think Ramachandran Sir can certify about this social auditing as it is the report given by the people during the social audit conducted by CMD⁵⁴. The fact that it is transformed to a situation where currently 80% of the people are depending on the Government sector is the result of an efficient engagement of NHM and Peoples' Planning. The same is the case with infrastructural development. Only if it's developed will people visit that institution. For that, it is not enough to depend only on plan funds.

I could prove what is achievable when there was an active engagement of people when I was in Thrissur. When we convened a sub-center Samithi meeting and told them about their needs, that sub-center was electrified within one week and it got transformed to a "Wellness Care Centre" that is needed for women. It was a result of peoples' engagement. That's specifically why we were able to implement a pilot project on universal health care at Kallikkadu. The experiences gained from here formed the basis for framing the guidelines for today's family health centers...

S. M. Vijayanand: We can't hear you

Sreejini J: Sanjeev Sir, It's not audible.

S. M. Vijayanand: Dr. Sanjeev, we can't hear you.

Sreejini J: It's not audible, Sir

Seena K. M: You could turn off the video. If it is issues related to range, turn off the video. Turn on only audio and try?

S. M. Vijayanand: I think he is unable to hear anything that we are trying to tell him.

Ramachandran V. V: Sanjeev is still talking I guess, right?

Sreejini J: Sanjeev Sir? I will try to call him on his phone.

S. M. Vijayanand: Yes, please do that and we will see.

Ramachandran V. V: Can we get someone else until the audio issue gets resolved?

Sreejini J: Sir, can we continue with someone else? We can resume this later. I will let you know.

S. M. Vijayanand: Has Dr Jayakrishnan joined? Jayakrishnan Thayyil?

Jayakrishnan T. Thayyil: Yes Sir. I am here.

S. M. Vijayanand: You can do a ten-minute intervention.

Jayakrishnan T. Thayyil: I hope I am audible. Good evening. I just got back from Medical College. I have not prepared much. I got to know about things only now. Yet, I will try to explain from my vague memory.

S. M. Vijayanand: Basically, about decentralization.

Jayakrishnan T. Thayyil: Yes. I am planning to do that. In fact, when decentralization was introduced in 1996, I was working in the Community Medicine Department, Medical College, Pariyaram⁵⁵. During those days, I was very passionate about democracy, participatory decentralization, etc. The thing was that, during my student life, I was involved with a student movement linked to the "Peoples' Health

54 The Centre for Management Development (CMD) is a leading self-supporting autonomous institution which provides Research, Consulting & Training support to development agencies, the corporate sector and the Government, both at the national as well as state levels. See: <https://www.cmdkerala.net/>

55 Pariyaram is a Grama Panchayat consisting of two villages: viz. Pariyaram census town and Kuttiyeri village.

Program⁵⁶ Another thing that stimulated me most was my association with “Kerala Sasthra Sahithya Parishad.” I was with KSSP. They were working in the Kannur region⁵⁷. So, I had been involved with them initially when they had started working in the Panchayat. It was initially in the Kadannappalli⁵⁸-Panapuzha Panchayat near Pariyaram Medical College. I had been working on the basics; the Grama Sabha, training, (how to prepare a project, etc.). Interestingly enough, we used to go work in a normal school auditorium, sit on wooden desks, and work. A number of voluntary workers had joined us: retired teachers, many retired people. We got plenty of voluntary inputs. Though some of them were involved in politics, I would say people participated in this in an apolitical manner. Everyone participated in its formations.

The first project that I can remember in Ninth [Five-Year] Plan was a health status report for Kadanappalli-Panapuzha panchayat. We went door to door and produced a health survey on basic health issues from A-Z. We had come up with a status report based on a life cycle approach around that time. Other than these activities, I was also part of an advisory committee for the Kannur district planning and had given inputs for the Thalipparambu block too. During those times I used to go to all the blocks and Panchayats and even for Grama Sabha meetings. I remember I had given plenty of inputs towards health to make necessary corrections, etc.

And then by 2004 I had come to Thrissur Medical College. I started getting more involved with

KILA29 and interacted with people like Balan Mash, Ramakanthan Sir, etc. Since then, for a long time, ‘til 2012 I could work with KILA. For LSG training, guidelines preparations, module preparations etc.—a lot of things like that. These experiences from KILA have enriched me at many levels, gender attitude and many other things in Kerala. And I got to know many of the officers from various departments like the ST Department, Social Welfare Department, etc. I got a chance to learn a lot regarding planning. I was associated with district planning in Thrissur as an expert and had given many corrections during that time. I was actively involved in the 9th and 10th plan too. It took a lot of time and effort to come up with the guidelines regarding how to prepare plans for the health sector. I remember, for the 10th plan, I myself went there and even sat there for several nights.

After that, some development happened at KILA: many Panchayats associated with UNICEF, with Dr. Peter John, for an initiative on how to make Panchayats child friendly. I had worked from A to Z on that project. I visited many Panchayats in Kerala. I remember that I interacted and gave guidance to many people in the capacity of a trainer and a consultant.

There was a state-level technical advisory council during the Ninth or 10th plan⁵⁹. I worked as a convenor for health in that. And even chairman. I was the State Technical Advisory Group⁶⁰ member for the districts from Thrissur onwards. Hence all the projects, even district Panchayat’s projects, went through my hands and I remember I have engaged

56 Jan Swasthya Abhiyan (JSA) is India’s regional network of the global People’s Health Movement (PHM). See <https://phmindia.org/about-us/> for JSA information and <https://phmovement.org/> for global PHM information

57 Kannur is a coastal city in the south Indian state of Kerala.

58 Kadannappalli is a census town in Kannur district of Kerala state, India.

59 The witness was not certain whether the state-level technical advisory council existed during the Ninth or during the 10th Five-Year Plan. Our team additionally was unable to specify the plan being referenced after some research, although it is more likely, given the nature of the comments made, that the technical advisory council in question preceded the 10th Five Year Plan. India’s Ninth Five-Year Plan was implemented between 1997 and 2002. It focused on “rapid economic growth and the quality of life of the mass of the people”, aligning itself with pro-poor policies and the elimination of inequities. Its objectives included rural and agricultural development, food security, primary health care, environmentally sustainable development, and more. See: <https://niti.gov.in/planningcommission.gov.in/docs/plans/planrel/fiveyr/9th/vol1/v1c1-2.htm> India’s 10th Five-Year Plan differed from previous plans, placing greater emphasis on the State’s role in planning and development. Involvement of Panchayat Raj institutes, decentralised planning, focussing on social development (literacy, healthcare, monitoring, implementation, strengthening of the agricultural sector to drive the state economy, reforms to enhance economic development, etc.) outlined in the Plan bore resemblance to the Kerala Development Model. See: <https://niti.gov.in/planningcommission.gov.in/docs/plans/planrel/fiveyr/10th/10defaultchap.htm>

60 State Technical Advisory members, also known as Key Resource Persons (KRPs), were and continue to be responsible for spearheading training programmes and the People’s Plan Campaign. See: https://niti.gov.in/planningcommission.gov.in/docs/reports/peoreport/peoevalu/peo_kerla.pdf

with them well. I was able to give my inputs in all of that.

That's how I remember the fish farming project in Kasaragod⁶¹. I remember distributing guppy fish in an initiative against mosquito-borne diseases in Pilicode⁶². Similarly, installing and finding budgets for mosquito screens in the hospital, and even on the windows as a part of Kasaragod district Panchayat's initiative. I remember, Kudumbashree workers in Kozhikode, Thrissur⁶³ and Thiruvananthapuram⁶⁴ did not have personal protective equipment while they were engaged with waste management. I remember giving them awareness and making it into a project for them.

Another thing was in 2006 in association with CapDeck⁶⁵ to explore how we can connect academic institutions with Panchayats and, with their inputs, explore more opportunities to come up with more projects. There was an initiative for training people, helping them identify problems and projects, and implementing them. In connection to that, I was the one who gave training for many Panchayats in Thrissur. I had given training for the panchayat in Thrissur and Palakkad through community medicine department (of Thrissur Medical College) for project preparation. I had gone several times to Akathethara⁶⁶ Panchayat near Palakkad⁶⁷ town. I went there personally and convened several Grama Sabhas and identified their health problems, 10-15 of them were identified and then ranked them, prepared a write up first and converted it into a project and implemented it. I think it was in 2006-07. I vaguely remember the name of the Panchayat president was Sadanand

or Sadasivan. They received an award for the best Panchayat. How an academic institution can link LSGs and give inputs and make good projects, etc. I remember the training given for preparing projects, etc.

Those days when I was working in Thrissur and has working relations with KILA I got to interact with a lot of people. I remember meeting Chandrababu in connection with the District Sanitation Mission. I have done projectization at many levels; many projects and training blocks, Panchayats, with the education department, etc. I am unable to remember many of those individual projects though. And like what Sairu Philip madam was saying, as part of that case study I have come and stayed in Muhamma. Similarly, I got a chance to meet Mr. Jagajeevan, who was associated with "Grameena Patana Kendram"⁶⁸. Association with KILA gave me several chances to visit many model Panchayats while contributing in the capacity of a trainer and consultant.

When Ramanand (Vijayanand) Sir was the Panchayat secretary, I went there several times as a participant. And I had been preparing materials for the standing committee⁶⁹. I was preparing training materials for LSG members on behalf of KILA five months back. My personal opinion is that, since 2010, the peoples' participation in planning has been really declining; by the time 11th plan got over in 2010 with the introduction of computers. And since then, things had become like complete packages. Earlier when we wrote up a project, there was a clear background to it, who are the beneficiaries, what is exactly happening, how

61 Kasaragod (formerly Kassarode in English) is a municipal town and administrative headquarters of Kasaragod, the northern most district in the state of Kerala, India.

62 Pilicode is a village in Kasaragod district in the state of Kerala, India.

63 Thrissur is the headquarters of Thrissur district, in the center of the Indian state of Kerala.

64 Thiruvananthapuram, formerly Trivandrum, is a city and the capital of Kerala state, southwestern India.

65 The Capacity Development for Decentralization in Kerala (CapDeck) was initiated in 1999. The goal of the project was to strengthen and support the Kerala's efforts in capacity building for democratic decentralization and devolution of powers to local bodies. See: https://doc.who.int/record/259150/files/11-SDC_in_India2009.pdf

66 Akathethara is a residential area in Palakkad city in the state of Kerala, India

67 Palakkad, also known as Palghat, is a city and municipality in the state of Kerala in India.

68 Grameena Patana Kendram is a non-governmental organization (NGO) working in Kerala established around the time of the People's Planning Campaign, to provide technical input and consultancy support for the implementation and monitoring of People's Planning initiatives work, as well as support for human resource development and rural technology use. See: <http://grameena.org/>

69 Each level of the Panchayat (Grama, Block, District) contains three Standing Committees: Finance, Development, and Welfare. Each Standing Committee plays a unique role at its respective Panchayat level. See: https://cag.gov.in/uploads/download_audit_report/2009/Kerala_TL_Local_Self_Government_Institutions_2009-10_APPENDICES.pdf

is it monitored, etc. That's my personal opinion and many others have also shared it. Since things got computerized in 2012 after 12th plan⁷⁰, the participatory character was lost. When you code things to A and B, I feel the participatory nature of planning is lost at the development stages itself. To overcome that, under NHM, in 2012, with the support of a special fund, there was a plan to come up with a Comprehensive Health Plan. I guess a preliminary meeting was convened at Alappuzha or so. It was me who prepared the material for that. I have prepared modules on the Comprehensive Health Plan and gone for many state-level training in Malappuram and Wayanad, etc. I remember we had given training modules on conceptualization and projectization, not limiting it to just modern medicine, but for Ayurveda and Homeopathy doctors as well under the Comprehensive Health Plan. These are the things I have to tell you here.

And one thing I suggest is that there is a doubt about the decline of peoples' participation; which is the essence of decentralization; in the Grama Sabhas. The empowerment of Grama Panchayat and decentralized planning is the major reason why Kerala could deal with COVID. And women empowerment in Kerala has happened the most through decentralization. That's why we are able to stay strong with the planning and implementation at the local level. It's also because of decentralization that we are able to bring about empowerment against centralized planning. I would like to say that the best idea is to increase the participation of people in the system and involve everyone without politicizing things.

S. M. Vijayanand: Thank you, doctor. Talking about the last point you mentioned, I am someone who experienced the "computerization can kill participation" problem. But nobody listens to me. They just enter the data in a very mechanical way. No one realizes that. No one cares about it either. I

have tried my best. I am still doing it. Have not been very successful too

Jayakrishnan T. Thayyil: They might have thought of many other "freak" and innovative things if you look at all the projects. Here only readymade things get clicked. That's a drawback.

S. M. Vijayanand: Thanks. Now, Dr. Divya? Especially focusing on capacity building, but of course, you can focus on anything.

Divya V. S: Namaskaram Sir. Namaskaram to all the members. I am Dr. Divya. I am the officer in charge for capacity building, NHM. Basically, I am an oncologist. After MBBS, I studied radiation oncology. So, to start with, I never imagined that a doctor would have to do the role of a manager when I was studying. But most of the things that we do is that role. Especially when we go to PHCs. I joined the health department in 2009 as an assistant surgeon. It was at Malayinkeezhu⁷¹. In terms of Peoples' Planning, it was only palliative care at that point in time. That time there was a group of Medical Officers: those who are active even today belong to that same group, I think. I did not have a clear idea about the peculiarity of the Constitution Amendment—why does this Panchayat Raj have additional powers, what does it mean to give more chances for people to participate, etc.?

We used to just think that there are a number of Government orders, and we are bound to follow them as Government officers. So, I never thought someone who works as a Medical Officer at a PHC is someone who is [or] should be efficient with managing these human resources that have come from various sectors, managing changes in job routine, etc. So, my initial phase as a Medical Officer went on like the ancient proverb that says, "the elephant never knows its strength." But I joined Palode⁷² after my PG. In between that, I had worked as a casualty Medical Officer in a taluk hospital.

70 The 12th Five-Year plan for health services in India covering 2012-2017[1] was formulated based on the recommendation of a High-Level Experts Group (HLEG) on Universal Health Coverage, and other stakeholder consultations. The long-term objective of this Plan was to establish a system of Universal Health Coverage (UHC) in the country.

71 Malayinkeezhu is a suburb of Trivandrum, the capital of the Indian state of Kerala.

72 Palode is a town in Thiruvananthapuram district in the Indian state of Kerala.

Life is comparatively easier at the Taluk hospital⁷³. You will never have to use your brain at all. One will have to just go there on time and do the work as a casualty Medical Officer. There was no need to think about Peoples' Planning or any planning. In many places, even the superintendents also won't have to think about anything like that. It never will have to go beyond crisis management. Even though at some places things are going on well in terms of planning for the future, even now at most places the chief officials of big institutions mostly wouldn't come down to the level of planning. That's what I understood based on my experience as a casualty doctor in the taluk hospital.

After that, I worked as a Medical Officer at Palode after PG. It was there that I understood the real power of People's Planning. Even then I understood it as I was implementing something that someone else devised and planned. The gap that I think happens here is that, because it's planned by someone else, the ownership element will be missing when it's implemented. But that ownership was maintained because of the strong Panchayat will; under the ownership of the Block Panchayat.

The Block Panchayat really made me comfortable. Because they realized that a specialist had joined, they were exploring what all could be done with the help of a specialist. They planned and sanctioned an amount that they could, and they decided to conduct a cancer detection camp immediately. The Block Panchayat started to think about what could be done immediately that could sustain my interest in it. Moreover, it is the biggest Block Panchayat in Kerala; Vamanapuram block⁷⁴. They were also quite keen on the expenditure; that they should come up as the first one in the expenditure. They kept thinking about how to efficiently utilize and

spend all the available funds. Hence, there was an amicable intervention on their part to implement even those projects that were not submitted by me.

Additionally, they would keep asking if I needed some funds. The only thing about that was that they had formed some projects that they themselves thought wouldn't be implemented for sure. So, they were thinking about whether there were any possibilities for those funds to be spent in the hospital. Fortunately, I was a resource person for Aardram as well. Hence, I was a regular participant in the group of people who were really enlightening me about the power of Panchayat Raj. So, I had submitted a project (to block panchayat) called "day-to-day plans" which compiled all the logistic expenses incurred at the office and avoided charging them from the Hospital Management Committees (HMCs)⁷⁵. It was a project like "trim the foot to fit the shoe." In that way, I am really glad because I was able to increase the income of the hospital like the head of a private hospital.

Another thing that I found very difficult was that planning was impossible. Some months Rs. 5000 would come in the plan fund. That might be for palliative care or the care of the elderly. That Rs. 5000 can be used to procure something, only if I had something similar to that in the bucket list. Some projects may be to celebrate a particular day of importance and that might be sanctioned only a day before. So, we can't really make it part of a broader process of planning and prepare in advance for it. So, whatever was available will have to be grabbed right away and get done with—that was the practical way. During those days, I could only do KASH accreditation⁷⁶ for that institute.

One thing was that at the time I was able to be part of the district's plan preparations. I was lucky

73 Taluk Hospitals are below the district and above the block level hospitals (CHCs). The objective of setting up Taluk Hospitals is to provide comprehensive secondary health care (specialist and referral services) to the community through the sub-district Hospital. See: <http://nhm.gov.in/images/pdf/monitoring/crm/2nd-crm/kerala-1-35-madhy-pradesh-36-69-2nd-crm-report.pdf>

74 Vamanapuram is a Block in Thiruvananthapuram District of Kerala State, India. Vamanapuram Block Head Quarters is Vamanapuram town. It belongs to South Kerala Division. See: <https://www.onefive-nine.com/india/villag/Thiruvananthapuram/Vamanapuram>

75 Hospital Management Committees are regular standing committees prescribed by regulatory agencies and deemed necessary by hospital administration in formulating policies and coordinating and monitoring hospital-wide activities that are considered critical in the delivery of quality health care services. See: <https://vikaspedia.in/health/nrhm/national-health-mission/initiatives-for-community-participation-under-nhm/rogi-kalyan-samiti-rks>

76 Kerala Accreditation Standards for Hospitals (KASH) is an accreditation program established by Kerala's government at the state level, aiming to improve and maintain the quality of health care services. Patient rights, satisfaction, and trust are central to the program's objectives. See: <https://arogyakeralam.gov.in/2020/04/23/kash/>

enough to be part of a project to get cancer detection camps done for all the districts. D'Cruz Sir was the additional DMO and in charge of DMO at that time. D'Cruz Sir was very keen on identifying candidates with such potential and utilizing them well. So, when we received some money to be spent for the project in the plan fund; around Rs. 1 lakh, we decided to do cancer detection in the Block Panchayats. We were asked to implement it in eight Panchayats. While that was being done, Sir made another announcement there that a team from the district can be deployed in case any Panchayats would like to do such cancer detection camps. We were able to do 129 camps in that year as a result: in all the tribal settlements in Kuttichal⁷⁷, and all the Panchayats in the coastal area. Many Panchayats repeatedly did those projects several times. A culture developed around it. Now it has all stopped. I used to cherish that activity.

There used to be two or three camps in a month in a Grama Panchayat. For that, in addition to me, there will be a gynaecologist, a dental surgeon and a pathologist. We used to take the sample and make the report at the district hospital lab. We will identify and directly contact only those who tested positive. In all the literature and everywhere else, the usual trend percentage of identification used to be less than 1%. But in our camps, we used to get up to even 3% detections. This was an activity that made me really happy. At the same time, since we never had an order, routine, or a system to follow it up, not many things could be followed up upon.

Now if I look at what is happening in CHC Palode, it is heart-breaking. Most things would have vanished. It is so sad to realize that even IP utilization, etc. are very low especially at a place where we used to generate a lot of income. There is no system to sustain things and the Panchayats will keep changing every five years too. But I think I would like to state my opinion here that I believe our department can actually bring in some routines and order to it.

After this, I took charge as a Nodal Officer¹ of training. I came on deputation after I worked as a specialist. By then, I had gotten a chance to

take part in around 600 training programs for a combined team of Panchayats and health workers conducted with help of KILA²⁹. I was a part of a big group, including Sanjeev Sir, that used to give those training sessions. We gained a lot of insights from those training sessions. Unlike what we tend to think, it is not a rosy picture of Kerala. Peoples' Planning³¹ has not reached every nook and corner of Kerala. Not all of our Medical Officers are that empowered to know in detail about decentralisation or think about its seriousness. Like Sir said earlier, the convergence activity happened based on the empowerment and attitude of that Medical Officer. The crux of Peoples' Planning lies in that convergence. From a pool of a thousand resources, not everyone may have the capacity to streamline it into a goal. More than everything, that is a managerial capacity. To build that managerial capacity, as a Medical Officer²⁸ I never got any training from anywhere. I never received any directions from anywhere. I doubt if the other Medical Officers get the same. We all have to do it proactively. For that, there should at least be a system of monitoring should be part of the system.

When I was a Medical Officer, I never got a feeling that the Department expected a continuity of such work. I wish there was such a system. There is no lack of resources in Kerala. It's a lack of sustenance. It lacks continuity in resource utilization. I feel that is something that can be improved. I have attended many training sessions by various divisions in our health department and really experienced the benefits of training done with KILA if they are to be disseminated at the primary care level.

In the case of dissemination, I have personally experienced the fact that things will really get better if you increase the involvement of elected representatives. I strongly believe that dissemination has an important role to play from the point of view of capacity building. And hand holding also has a big role to play. A centralized hand holding will not work. We have to empower the people in supervisory roles and educate them on how to effectively communicate, monitor, and train their junior staff. I believe KILA is a significant channel of

⁷⁷ Kuttichal (formerly known as Mannookara) is a village in Thiruvananthapuram district in the state of Kerala, India.

dissemination. One of the reasons why the trainings given by health department stay in higher levels itself is because there is no channel that can do a cascading of whatever we input to them at a higher level to the grassroots. There is a gap in the role of an activist or an elected representative who can act as a catalyst. This is what I have to say. I haven't contributed much from the perspective of capacity building, though. But thank you, Sir.

S. M. Vijayanand: Thank you. Now I think only Seena is left, I guess. Am I right?

Sreejini J: Dr, Preethi is there.

S. M. Vijayanand: Okay. Let's get to Seena and then Preethi.

Seena K. M: Namaskaram to all of you. I will first talk about the channel through which I got associated with the Peoples' Planning or decentralization program and then talk about NHM.

When I was a student, Vishalakshi Teacher of the District Panchayat and Duttan Master⁷⁸ of The Center of Science and Technology for Rural Development (COSTFORD)⁷⁹ were the ones who taught me about Peoples' Planning. It was with them that I started working on projects during weekends in my student days. I can remember the involvement of Dathan Master really well. I had travelled in and around the Panchayats in Thalikkulam area with him and took so much effort to understand what has to be done there. Because the lead that Thrissur had taken at that time for decentralization was quite important. Whatever we had done in forming Self-Help Groups⁸⁰ there at that point of time has really helped me in my career later.

After that, I got a chance to be involved with the Planning Board collaborating with Sakhi⁸¹ and CapDeck in 2004. I mean, I got to work for around two to three years in gender planning, budgeting, auditing, and preparing manuals for the Government for a study on gender status in various municipalities and corporations. I got to know especially about the things that are implemented for women under Peoples' Planning at that time. Thus, I got involved with NHM and its activities from the beginning itself.

I joined NHM in 2006 December. Though activities of NHM began in 2006, like all of us know here, it was during the plan preparations in 2007 that we got to know that we have to give a project implementation plan to the Government of India every year. That plan must be in accordance with a consolidation report from all the fourteen districts. So, for that during 2007, 2008, 2009; there was an effort from the part of NHM. I had been part of that process. But I don't think that kind of an effort reflected well in these plans' preparation and the projects.

In one district, there was a ward-level survey conducted, and I think such an initiative was implemented for the first time in Alappuzha and Malappuram districts. If we had prepared and prioritized a project implementation plan based on the feedback from those places, I am sure the budget for the first year would not have stayed within Rs. 200 or 250 crores. So, I really doubt if the feedbacks from those districts have really reached into the plan that should reach the central Government, though the process has taken place.

It was during that time that the NHM began to do some programs in decentralization. That process had gone on for the first three years until 2010. After

78 Sri. T.R. Chandra Dutt (b. 1944), also referred to as Duttan Master, is one of the original founders of COSTFORD and has been serving as a director since the organization was started in 1985. See: <http://costford.org/founder.php>

79 The Centre of Science and Technology for Rural Development (COSTFORD) is a non-profit organization in Kerala founded in 1985 by C. Achutha Menon, Kerala's former Chief Minister; K.N. Raj, Economist and former Chairman of the Centre for Development Studies (CDS); Laurie Baker, Master Architect; and T.R. Chandra Dutt, Social Activist. The organisation focuses on rural development, particularly developing and providing climate appropriate, affordable housing. See: <http://costford.org>

80 A Self-Help Group is a self-governed, peer-controlled information group of people with similar socio-economic background having a desire to collectively advocate for a common purpose See: <https://www.ncbi.nlm.nih.gov/books/NBK310972/>

81 Sakhi is a non-governmental, not-for-profit organization based in Thiruvananthapuram, Kerala, India. Sakhi develops gender justice practices and programmes. Since 1996, Sakhi has worked with several partners, donors, networks, and other national organizations on gender equality. See: <http://sakhikerala.org>

that, as usual, the plan preparations happened in a combined meeting between DMOs, DPMs and RCH officers of the respective districts, taking into account the priorities of their own districts.

Dr. Mathews has detailed the activities of NHM during the planning process, Palliative care program. According to me, NHM's contribution is mainly human resources. While Panchayats took the responsibility of community nurses, manpower at the secondary and tertiary levels, doctors, physiotherapists, etc. were supported by NHM. That kind of HR management has to be really appreciated. The activities at the primary level or the day-to-day activities, like palliative care, were facilitated by the involvement of LSGs through the Panchayats' funds for the projects.

Another main linkage with the LSG was the ASHA¹⁸ program that we started in 2007. When we began ASHA program in 2007—everyone knows—we started it by rejecting the need for a second ANM. It was quite a contested matter. But the Government took that decision at that time. These days I used to think, if we had taken a second ANM, there would have been benefits definitely. But when we were hit by COVID, because of this huge human resource on field—it seems there were 5000 JPHNs and 27,000 ASHAs—we were able to manage this epidemic. ASHAs' activities are fully linked to the Panchayats. In today's scenario, I guess in 2009, Kerala is the first state where ASHA workers address all the issues related to non-communicable diseases, palliative care, and mental health, etc. while ASHA program started exclusively focussing on RCH program.

It's just probably been only two or three years, maybe since 2018 or 2019 or so, that other states have started engaging with ASHA workers for these activities. When we go for reviews, they would always ask us how we in Kerala were able to implement such a program. We had taken it to such levels. And like we already know, it's during COVID that the concept of ASHA became more visible. What do I say! Today, even a small kid knows about

ASHA workers, thanks to COVID. The major thing is that the LSGs, the people had accepted them and it's worth mentioning that they started working together with RRTs⁸². The convergence in RRTs was really effective. Though it has dimmed a little bit right now, it's unfair to not to give a special mention to it.

The Comprehensive Health Plan was another innovative activity that was mentioned by Ramachandran Sir. I see him as a major promoter of that movement. And then the award is another significant thing. Now "Arogya Keralam Puraskaram" award is renamed as "Aardrakeralam."²² Though last year there was a delay in things because of COVID, we had been able to do some activities that incorporated many things related to COVID. The other thing was a social audit, that was also mentioned by Sir.

Another thing that we did innovatively was something that we did in relation to the plan fund by NHM titled "Bhumika." A very important thing that we noticed when we did a status survey of women is a lack of space in the health department to address the issues of women who faced violence; even though we have a number of arenas to address women's issues. I think it is in that context, when Dr. Mridula Eepen was a member of the planning board, there was a decision to start such a program in 2009, in consultation with the then Health Secretaries. This is still ongoing as an innovative program backed by the Health Department and NHM. Many of them still say that the number of cases at Bhumika is less. But we think that if we are able to help at least ten women who are subjected to violence at Bhumika, it is a miraculous activity. These are the Panchayat-related activities.

In 2007, we implemented some district-specific programs. One was the construction of "Valaaymapura" [small, temporary living spaces for women considered impure for various reasons such as menstruation] for Adivasi⁸³ adolescent girls and

82 Public health rapid response teams (RRTs) are one mechanism of a larger emergency response strategy that can be utilized in a COVID-19 outbreak to ensure a fast and effective response.

83 "Adivasi" (Hindi: "Original Inhabitants"; official name (in India): "Scheduled Tribes") refers to any of various ethnic groups considered to be the original inhabitants of the Indian subcontinent. See: <https://minorityrights.org/minorities/adivasis-2/>

women in Adimali⁸⁴ and Kanthalloor⁸⁵. We learnt that about three of them are reported to be still in use out of the eight constructed. This was again a result of a program in convergence between Idukki district⁸⁶ Panchayat and Mahila Samakya⁸⁷. These are the main activities that we do in association with NHM or local centralized planning.

S. M. Vijayanand: Thank you Seena. Now we can go back to Dr. Sanjeev. We lost contact with him earlier. We were waiting. Dr. Sanjeev, how did it help the Kallikadu experiment to become an FHC? That's where we lost talking.

Sanjeev S: Sir, can you hear me?

S. M. Vijayanand: Yes, we can.

Sanjeev S: So, I was suggesting that Peoples' Planning and NHM had facilitated the LSGs to engage with the health activities locally. The effort at Kallikkadu was not limited to the Kallikkadu area. We worked together with the Medical Officer and elected representatives in a nearby Panchayats of Kuttichal and Veeranakavu. We implemented a Comprehensive Health Plan with the support of NHM and Peoples' Planning. When I say NHM's support, there is human resource. It was easier to spend the funds for the activities carried out together with public health workers, ASHA workers, and volunteers. We were able to extend it to the nearby three Panchayats. The presidents of those three Panchayats were honoured by the Government, and we were successful in creating a model like that. That's what we can learn when we look at the results of such a participatory approach with people.

During the Mass Drug Administration (MDA) for lymphatic filariasis elimination program activities, we were able to make an 80% consumption rate in our panchayat because of this association and peoples' participation. This survey was not carried out by us. It was done externally. Similarly, the case of communicable diseases program or even non-

communicable diseases control program.

Another noteworthy program is our mental health program. It's really side-lined these days. Through a survey conducted by us, we were able to identify around 300 mental health issues. We screened 75 people from that and 40 of them came to the Primary Health Centre [PHC] along with the other patients and got medicines from there. Thus, we were able to prevent suicides or avoid situations of lack of supply of medicines for mental health patients.

Similarly, we were able to empower the sub-centers with the help of NHM and Peoples' Planning. As a result, we were able to introduce a lot of public health initiatives that had to be managed at a micro level, at the level of ward and sub-center. If I go into all that it would take a lot of time.

One problem that I found there was that Peoples' Planning did not make use of Medical Officers or public health departments well in its initial phases. There was a lack of awareness among elected representatives about it. It was conceived as a program to merely develop some infrastructure. This had caused a major setback in the initial phases in public health.

The importance of public health was addressed at least to an extent with the coming of Chikungunya and some other communicable diseases. It opened up the possibility of convergence between various departments to face these crises. I am glad to say that, when the Universal Healthcare project was implemented, it was better addressed and the idea to convert the activities to Family Health Centers was facilitated based on these experiences.

With the introduction of Aardram, the gap between medical officers and elected representatives was addressed. The training was helpful to understand that health planning and implementation of the projects should ideally be done after joint consultations of health department and LSG. The details of the project should be discussed. The

84 Adimali is a town in the Idukki district of Kerala, India.

85 Kanthalloor is a village in Devikulam taluk of Idukki district in the southern Indian state of Kerala.

86 Idukki district is a densely forested, mountainous region in the southern Indian state of Kerala.

87 The Mahila Samakhya programme was launched in 1988 in pursuance of the goals of the New Education Policy (1986) and the Programme of Action as a concrete programme for the education and empowerment of women in rural areas, particularly of women from socially and economically marginalized groups.

Aardram training also gave a proper idea on how to prepare health status reports. I was fortunate enough to work actively as a faculty from the beginning 'til very recently. One gap I noticed there is that, at the beginning of a five-year plan or in the beginning of a new term of Government, a Medical Officer may be moved from their position in the general transfer. There is no system in place to give training to maintain a continuity of work along with the newly posted medical officer. Similarly, public health is not utilized properly whether at the family welfare/sub-center levels. What I have to say in this regard is that there should be some changes brought about to facilitate a more efficient method to make use of public health in a better way.

The takeaway is the bond provided by Aardram between the Panchayat, people, and health workers and other departments, and convergence between them; the significance of RRTs, ward-level health committees. The advantage was visible during the fight against COVID and floods. During the flood, I was in a panchayat in Thrissur where the impact was the worst. When these methods were adopted, it was possible to prevent the outbreak of communicable diseases there. I am winding up by saying that by making use of the possibilities of our Peoples' Planning and NHM, by giving continuous awareness, we will be able to facilitate a much more efficient engagement with public health.

S. M. Vijayanand: Dr. Preethi?

Preethi P T: Good evening, Sir. Namaskaram to all of you. I am Dr. Preethi. I work at the PHC in Purakkad; which is now converted into a Family Health Centre. I listened to what the important people of NHM and Peoples' Planning had to say. My area of work was mostly Purakkad.

We are talking about this at a time when our work is being analyzed during the outbreak of a lot of communicable diseases like chikungunya; especially COVID now, and floods too. I feel we did a number of activities relating to NHM and Peoples' Planning and explored most of its potential for palliative

care project in Purakkad⁸⁸ Panchayat. Like we said earlier, for something that was started at a primary level, we are now able to facilitate and reach even secondary care services to the people really well, with the involvement of LSGs. Moreover, by 2007 when NHM began its activities, the ward-level nutritional committee had started to devote more importance to household-level activities. Now, we have more possibilities to submit field-level projects than before. There is a major involvement of LSGDs too in that.

One of the important programs was a project for NCDs. In Purakkad, most of the people had NCD-related diseases. More involvement was made possible through these projects. And the change of face of all the PHCs was also facilitated by NHM. In the Aardram program, we implement a number of projects through Family Health Centers and health and wellness centers. This infrastructure is a major factor. The old PHCs have changed a lot in their appearance.

We had a major involvement of volunteers; people who are not health workers through RRTs. Its RRTs and many other groups take up activities at the ground level. That's why we were able to contain COVID to a good extent.

Though there were a lot of ASHA workers, we got a lot of help from these volunteers as well. This idea of E-Health also was implemented through NHMs. We gained a lot of benefits through that in the PHCs. Like what Sanjeev Sir said, identifying patients with mental health issues, identifying palliative care patients, and running palliative care were all made possible in my PHC area with the help of a survey supported by NHM. Similarly, we were also able to support them and give them treatments at the PHCs with the help of health volunteers.

The contribution of ASHA workers was really important. We were able to do a lot of "Quality (Assurance)"⁸⁹ programs at Purakkad with the involvement of NHM. We were also able to deliver quality services and record these services in a well.

88 Purakkad is a village in Alappuzha district in the southern Indian state of Kerala.

89 The National Quality Assurance Standards (NQAS), thus far established for District Hospitals, Community Health Centers, and PHCs, were developed to improve the quality of health facilities via the creation of national standards. High-performing facilities are awarded Quality Certification and financial incentives. See: <https://arogyakeralam.gov.in/2020/04/01/nqas/>

Many times, we forget to record our services at the health centers. That's also possible now.

Now when we talk about the projects, I think the palliative health project is the most successful of them in Kerala, even in my PHC area. The second is NCD programs. For that, with the involvement of people, we formed peoples' groups in each ward—small groups with the help of LSG, members, ASHAs, health volunteers, etc.—to promote NCD programs and train them to give promotive and preventive programs, do exercises etc. We have come up with projects for that, at the level of PHCs with the help of LSGs. These are the things that I wanted to speak about briefly.

S. M. Vijayanand: Thank you, doctor. I think we have covered all the witnesses; right, Sreejini?

Sreejini J: Yes, Sir. Now, if you have anything to comment on the things that the others have said, we might remember many things when we hear others, right? So, if you have any comments like that. Because we have time.

Jayakrishnan T. Thayyil: We can add as well, right?

S. M. Vijayanand: Yes.

Jayakrishnan T. Thayyil: Regarding LSGs. When we talk about decentralization; it was in Kerala, for the first time in the world even, a quality institution of palliative care was developed. It was the neighborhood initiative of Malappuram with the lead of the Panchayat, I think in 2003. That's why we could become a model for the world.

And then Kudumbashree and the functioning of BUDS school⁹⁰. And when I did a survey, I got to know that around 12% of ASHA workers are themselves ward members. During the last planning stages, there was that much involvement.

Then the case of girl-friendly toilets. The idea and implementation of girl-friendly toilets in each school and institution were through the Panchayats.

Another thing that I wanted to add, as Dr. Divya said, is about the interface between doctors and LSG members. I think because health is most close to peoples' lives, that is where LSGs can do the best. But for the MBBS⁹¹ courses taught in Kerala, decentralized planning, Peoples' Planning, etc. are out of the syllabus. So, whenever someone passes out of this course, they are unable to mingle with the Panchayat members because it's outside of the syllabus, and outside the learning too. When I realized this, in 2019, I had a talk with Joy Elamon and explored why can't we do a two-day training on decentralization during house surgency in Kerala in each college. We had prepared the modules and thought of starting from Kozhikode and then extending it further. We planned to start it in January 2020, but we have not been able to do it. That's the sad part. Actually, at least during the house surgency period, there should be a small training to understand how the LSGD plan process happens, what are the interactions between LSG members and health [workers] are, etc. and explore the possibilities to do that, at least in Kerala. It will be helpful for them in the future to understand that when they go out.

And personally speaking; we have 50% of women members in Kerala. In 2015 during the last election in October, I had written a gender health status paper and published it in Mathrubhumi weekly⁹², around five to eight print pages. Similarly, even before it was introduced through Aardram, I had written a paper on the very idea of FHCs. Mathrubhumi had put it in the editorial part. I had also done a paper on what all can be done by the Panchayats for people in old age. I stop here with this.

Sairu Philip: Even I wanted to tell you about the aspect that Dr. Jayakrishnan had mentioned. I learnt most about public health, through this life in each Panchayat. So, one thing that we don't understand is that, as doctors, our skills are limited.

90 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 at Venganoor Panchayat. See <https://www.kudumbashree.org/pages/85>

91 Bachelor of Medicine, Bachelor of Surgery, also called MBBS, is the primary medical degree awarded by medical schools in India. The curriculum was initially developed in the colonial period and continues to be followed.

92 Mathrubhumi weekly is a supplement in Malayalam newspaper that is published in Kerala, India. See: <https://www.mathrubhumi.com>

For example, one major issue that I faced in Aryad⁹³ was the availability of pharmacists. When it was directed that medicines had to be distributed only through the pharmacists at the outreach centers, it was the Panchayats that solved the issue. They said we will hire two pharmacists and we can send two pharmacists to all the outreach centers in turns. They hired pharmacists like that. So, what I always see is that Panchayats can easily solve issues that we may struggle with.

Second, regarding the students, the biggest benefit I had in my experience was that I took them to the field and let them have interactions. Because whatever theory we teach, we need to see that happening in front of our eyes. They are teaching the students and they will learn it when they see the changes happening at various levels, I feel. We should have it, at least in community medicine in Kerala; in our field practice centers. We always teach them curative skills but [what about] this management, soft skills, interpersonal relations, conflict resolution? We let them come out with a feeling that doctors are the most important people. It's not so. I think it's high time that we give soft skill training in the Medical College itself.

And Dr. Jayakrishnan Sir, I had also told this to Joy Elamon Sir. In KILA, an online module to understand Peoples' Planning. An online module that's suitable for medical students. Some small online modules that highlight the process of Peoples' Planning, the decentralization process, and the role that a Medical Officer can play in order to make local changes. Short videos. So, with that, we can tell our students that "you should complete it." We may make it mandatory too. For the completion of community medicine, during house surgency, this module or a small course. But it should not be so cumbersome. Something with only what they should know. If KILA brings it out, we can make KUHAS⁹⁴ also do it. Everyone who passes out from Kerala should know the potential of decentralization.

Correct me if I am wrong, the success here is 40% financial devolution. We have funds to do at lower

levels. That's the opportunity looked forward to by people from the other states. So, students should know about that opportunity and understand that Medical Officer's position in a Grama Panchayat is like that of the position of the health secretary or DHS at the state level, like we all say that person who brings in change. So, we have the opportunity to give that feedback. Things have changed because of COVID but still, let us surely work together for that.

Ramachandran V. V: Sir, one point that Dr. Sairu Philip and Dr. Jayakrishnan said. I have observed this syllabus when I had visited Medical College with Vijayakumar Sir. I observed this gap—that there is nothing in the syllabus about LSGD. I thought it would not look good if I pointed it out. But it's notable that all of them have pointed it out. Their syllabus should be revised. Maybe the students of Dr. Jayakrishnan or Dr. Sairu Philip may learn it well, but not many of them will let them learn from the field. It may not happen even for an MD in community medicine. So, it would be better that it's taken care of.

And the next thing is what Dr. Divya mentioned. We can't question their expertise in their field, but it will be really good if they are given exposure for the managerial side. We really had a conversation regarding this in Kozhikode, but it was not fruitful. If they are trained more that way, they will be able to deal with things better. Most of the time they realize that they are good at it only when they do it. I have observed that a lot. When they do it in their capacity, I used to get 100% from them. I suggest it would be better.

S. M. Vijayanand: Mathews?

Mathews Numpeli: I have one or two things to add. There are many good things about Peoples' Planning that I am not going to talk about now. I am thinking of a couple of added points.

Giving people medicine is one of the main processes in the PHC. The general principle is,

93 Aryad is one of the Panchayats in Alappuzha district in the Kerala state of southern India.

94 Kerala University of Health Sciences (KUHAS) is a state university located in Thrissur, Kerala, India. It was established by the Kerala University of Health Sciences Act 2010. See: <http://kuhs.ac.in>

we get medicines from the Government, or the Panchayat buys additional medicines and gives but even then, there is no provision to receive support from the general population. A voluntary organization can buy and give; people can buy and give. What is the general policy? If there is medicine in the PHC, everyone will get it; if it's not there, no one will get it. So major discontinuity happens.

Even in the Ashraya project, to help 100 families who are really struggling. There are even mental health patients who need medicine. We still could not implement this through Peoples' Planning. So, there is something missing in consolidating everything and implementing it at the PHC level. There is an issue like that in receiving peoples' support because things go bureaucratically.

We had formed a palliative care management [committee]. We call it PMC. In addition to everything, there will be Panchayat5, PHC, Kudumbashree member20, Anganwadi19 teacher, representatives of volunteers, etc. in the managing committee. After some time, there were conflicts among them. Because the community representatives would say "Why you could not do this" and PHC people would say, "We can't do that", and so because of that we took it off. There was a situation like this. With the community's representatives, things were not easy. Because the officers are not able to do many things. And they couldn't answer the people logically as to why it was not possible. So, we went ahead without community's representatives and worked with Panchayat members, Kudumbashree members, Anganwadi; now, only a government mechanism is reviewing its projects.

Ideally, the whole project should be reviewed by the Panchayat, the hospitals, etc. We can't reach that level most often. So, we review only the projects that are submitted. The ward health review, the Panchayat health review, etc. should come as the LSG mechanism. PHC will review its activities but there is no body or institutional mechanism to

review LSG. That's a gap. We are pointing it out, but nothing is happening.

And this process too. If we have to construct a house, we select five poor people for that. Panchayat sanctions Rs. 4 lakhs. The people there are ready to contribute, voluntary organizations are ready to contribute and make it Rs. 8 lakhs. But there is no mechanism to consolidate and construct a house in the Panchayat. Panchayat says we will give you Rs. 4 lakhs and if it's possible, you can do it. We can support that way if it's possible, but it is not possible to receive support from the good will of others. The voluntary organizations, churches, religious organizations all are ready, and they all construct houses for them. But it's not possible for Panchayats to receive their help. We saw it when COVID and flood occurred. Everyone supported it but there is no mechanism in Peoples' Planning to consolidate it productively and give confidence to the people that we can do it. It's not the problem with the people. It's the problem of not planning the institution, I guess. Thank you.

S. M. Vijayanand: Mathews, if I may clarify, there is nothing that stops the Panchayat from receiving donations from someone. There is a provision in the Panchayat Raj Act, in kind or cash. It is that they don't do it. Actually, the Sen Committee⁹⁵ amended it and included it in 1999. But there is a problem in the example. If the Government gives Rs. 4 lakhs and there are 30 houses in the Panchayat, it's okay that everyone gets Rs. 5 lakhs. But if one person gets Rs. 7 [lakhs] and another one gets Rs. 5 [lakhs], then that's a problem in that sense. But there are no issues for them to take donations.

Mathews Numpeli: But for some practical reasons, when it comes down to the ground, this is not possible to implement. There are no issues we can say. But when the officer implements in reality, there is no mechanism to support him including in the audits. We have many sorts of audits. In that, even for NHM, we face those issues at district level.

95 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 constituted in 1996 and chaired by Dr. Satyabrata Sen. The Committee made recommendations on how fund flows should be managed, above and beyond the provisions of the Kerala Panchayati Raj Act of 1994. See Isaac, T. M. T., & Franke, R. W. (2002). Local Democracy and Development: The Kerala People's Campaign for Decentralized Planning. Rowman & Littlefield

It's typical of our government mechanism itself. At the lower level, people are courageous to do it by themselves. The Government officer may even do it well with an NGO from outside. But inside the Government, he is not able to do it. Such a major fault is there on the ground. I think it has to be corrected and only then there will be confidence at the lower levels.

Divya V. S: Actually Sir, there are two things. As a government officer in a PHC, we can receive money and give a receipt to the HMC and HMC can do things at their level. Even palliative committees can receive money and do it. But the attitude to do these things will differ. Depending on that one has to decide on what all orders should be attached for this to complete the file, or should we do it without completing any files, should we do it after the Panchayat's decision etc. They should decide which is the easiest way to carry out this activity. That is directly linked to one's managerial capacity. That's the managerial capacity like what Sir said.

I noted what Jayakrishnan Sir said. I have an experience [to share]. For one and a half years when I was a Medical Officer at Palode, we used to get two or three house surgeons to stay there and learn things. So, they used to be a part of all the activities of the PHC. They would be a part of managing that PHC. Until they leave, after taking part in Panchayat committees, and visiting different sites as our representative or Medical Officers, I was able to give them a hand holding. They used to take up a managerial role and experience how to do conflict resolutions etc. So, I tried to teach them things like the particular pattern of that PHC, its strengths and weaknesses, this is where the revenue comes from, other than salary there are various other funds and it's possible to run it like this, etc. If the students are sent to PHCs every year, unlike one or two months during house surgency, they will get more than two months' time. Moreover, they will help as a member of that Family Health Centre. In my opinion, thus, they will get used to how public health works in the field. Thank you, Sir.

S. M. Vijayanand: Are there any more comments?

Mathews Numpeli: Sir. Just one thing. In the context of what was said earlier, there is enough support for institutional development by the Government. But for the beneficiaries, to receive it directly, to consolidate public support and spend, the mechanism is very difficult, Sir.

S. M. Vijayanand: But there is a legal provision. I will tell you the reason why they don't do it. In Kerala, if one beneficiary is given that, everyone else will ask for it. So, it may not be possible like that. That much voluntary donations may not be available. That's why they don't try it practically in many places. For many poor and widows etc. these Rs. 4 lakhs may not be enough. Some people in Panchayats are doing it. I noted it directly at Mezhuveli Panchayat. For SC housing. They facilitated this a lot.

Mathews Numpeli: Sir, if we receive funds from outside, let's say Rs. 4 lakhs and another person [donates] Rs. 2 lakhs and together it is Rs. 6 lakhs. Then we need to do many other processes for that. Tender it, we should give it to the committee, etc. All these have to be included. In the case of palliative care, we created an account in the name of the palliative care management committee and it received the money. But we are not able to make it useful. I mean for an individual beneficiary to get a contribution from people; we still need to make a mechanism for that. It's happening elsewhere during COVID and flood.

S. M. Vijayanand: Though this is not for the benefit of The George Institute, I will write this as an item in the Finance Commission. I am writing the report now. I will include how to receive individual donations and ask the finance [committee] and will definitely write it down. If there are no more comments, let us conclude. I won't take much time.

The George Institute, we are extremely lucky. If you can analyze it properly, you can write a treatise on what works under decentralization. It was very beneficial for me. I have been benefited by it more than anybody else in today's meeting.

So many things came up here. For example, this palliative care from below; a model developed by the people, and committed doctors adopted

it through Panchayat and then the state. That's a reverse flow. It's an unintended positive effect of Panchayat Raj. And like what Ramachandran said, these key stakeholders. Sairu said that beautifully. A magical recipe, a leadership. It can be local leadership. People like Dr. Isaac may not be possible everywhere. Maybe one in Kerala. But within Panchayat presidents there are many good people. It is a lesson for strengthening decentralization, why Panchayat presidents have to be good. Many of them have very tense relationships with professionals. Some of them believe the power of Panchayat is to get some commission or to get a bed in the HMC out of turn, etc. So, for them, it's a major lesson.

Similarly, the award to motivate Panchayats is a very important thing. And what has come out, that's a rarity, is the situation analysis. So, the situation analysis done at Kallikkadu and Kanjikuzhi⁹⁶ should be the beginning of health planning. Even though it was done in the initial phases of Peoples' Planning. Now people have forgotten. The important point is that we think it becomes a project if we upload it to a computer. The decision of 2012 has not been changed after nine years. An expert in vetting; that was a principle of Peoples' Planning. Getting non-governmental professionals into the mainstream to vet projects, to give ideas and including formal technical sanction. Taking this off was the biggest setback for Kerala. The Panchayats were okay with that.

Another very important thing that came up is reverse learning. medical students, even doctors, can learn from the field. So, this is a win-win situation. What the doctor said is a very important thing.

Another interesting piece of data I got today; I should verify it, the number of ASHA18 workers who got elected as Grama Panchayat presidents. I think NHM or somebody like SHRC should do a study. Seena, please note it. It can be studied easily. If we get it done, it's a model for Kerala. How to internalize it. They continue to be ASHA workers. That's interesting.

Seena K. M: Sir, during this panachayat election 746 people got elected. Out of the 746, 113 of them are Presidents, health standing committees and different standing committees.

S. M. Vijayanand: That is a very important thing. Another important thing is "doctors as managers." So, when I was thinking about it, so foolish of me, I volunteered to help with a manual for PHCs. Now it got cut. For 18 months no work got done because of COVID. One of the aspects there is about mandatory things. One should do this, do that, there should be this act, there should be projects etc. The second aspect is doctors as managers; the second volume of the manual. I am not sure if I could write it. I would like to do it. But even if I couldn't, now I know who can write it. So, I can get inputs from all of you.

Divya V. S: Sir, I was also a part of it.

S. M. Vijayanand: Yes, yes.

Divya V. S: But I still remember the first conference of Aardram6 in 2016. In your speech, you were asking if it is written down anywhere about what a Medical Officer should do if one bulb is not working.

S. M. Vijayanand: Yes. I know that. In our first manual, thus will come. The second manual is the managerial aspect; conflict management, interface with the elected leaders, ego issues, etc. And NHMs' importance has come out very well. I don't have to repeat all the points—how it deepened, how a synergy with the local Governments had come about, etc. So, in my opinion, it has been a very good thing. I am sure The George Institute will use it to spread the ideas in a larger way. I just wanted to ask. Devaki is also there. Will you stop with just giving a Witness Seminar to the public or will you try to cull out something big and come out with a paper?

96 Kanjikuzhi is a census town in Kottayam district in the Indian state of Kerala. It is a suburb of Kottayam town.

Devaki Nambiar: So, Sir, thank you for this very important question. And thank you, everyone. I am sorry, I am supposed to be a Malayali but my Malayalam is terrible.

S. M. Vijayanand: That doesn't matter. But you understand Malayalam?

Devaki Nambiar: I understand Malayalam. I have taken lots of notes. This has just been like you said, such a treasure trove of information. So, we are doing these transcripts of what you all have said in Malayalam and also in English.

Yes, we absolutely have to do at least two additional things. One is to actively construct a timeline. So, you know, you all have been giving your perspectives. Some are sweeping across all the areas, some are geographically located, some are focused on certain cadres or groups of people. We have to somehow create a composite that is a timeline but then show all of those perspectives. So, we would definitely be doing that.

Then there are a lot of themes that you all have brought out, and one of them actually aligns very much with something WHO is talking about, which is called the idea of a learning health system, and you all just in this meeting have described some of these. What Vijayanand Sir and some of you all said—there is this idea of learning through information. So, the idea of a situational analysis and just using data and that kind of a thing.

Then there is this idea of learning through deliberation. I think many of the examples that you all have said is the interaction, even the switching of roles through interaction, through deliberation-learning.

The third is learning how to learn, right? And I think Kerala has, and in fact, most of the WHO is actually informed by case studies that were done in Kerala. That's partly because there are enough Indians in the WHO who know where to look for examples. But, in addition to that, I think, the decentralization process specifically has many models of this idea of learning how to learn, how do you create some of those cycles. In some cases, we have not fully succeeded, but the fact that we even talk about

that in this state as compared to some other states is an aspect of that. So, I think using that frame of a learning health system to talk about the decentralization experience, its successes and failures, is another area we will explore.

We are hoping that some of our young scholars and emerging scholars will look at this, and maybe they will start chasing you all for further interviews, but they will have their first treasure trove of data from different perspectives. So Sairu Ma'am has chaired one session, you have chaired one, Mr. Ramankutty has chaired another. So, we really have three Witness Seminars documenting different aspects of it. And you have all endured two hours on Zoom, so I am very grateful that you did this. Thanks to COVID we had to do it this way. But we fully expect to do that, and we want to give these transcripts back to you all as well. For example, you were saying Sir, some of you all should write this down and put it out. Maybe if we give you the transcripts, you can use it as a base to do that. That's also the intention for us to do this. So, this is not our knowledge. This is actually yours and it is Kerala's knowledge. So, we would be very excited. Sreejini has coordinated the whole thing so that we will create these transcripts, share them with you, you will be able to edit, refine or do whatever you want to do, and we will finalize and that is for you also to keep in case you want to use it for your own thinking or writing or your work. So, we would be thrilled if that also happens.

S. M. Vijayanand: That is a good thought. Using this is not a valid sample in that sense. Just opinions of some kind of very small Delphi technique. You get so many stakeholders. So, this is what is emerging from the Witness Seminar. That would come as a very good thing. But they will keep it as just an ordinary sample. So, from some kind of a Delphi expert, this is what is emerging and this needs to be validated through research. So, this is an intermediate thing, acknowledging that would be very useful. As a person familiar with decentralization who has observed it continuously for 15 years on a day-to-day basis and later for another six years, I find that what has come out will fit into a neat picture. That, I think you should try.

Devaki Nambiar: We could do it. We have done it before.

S. M. Vijayanand: With all kinds of disclaimers saying we did it. So that there is a kind of validity in what they are saying. And it's all falling into a place. Okay. Thanks.

Devaki Nambiar: Yes Sir, we will look into that, we will get back to you. Thank you, everyone else.

S. M. Vijayanand: Thank you, all the panellists. Put together, this will come out as a major document. It should. So, thanks once again. Thanks for the opportunity. I got a lot of points even for my current work as the Chairman of the Finance Commission. Okay. Bye. Thanks.

Proceeding ends.

Individual (follow-up) Interviews

Interview with Mr. Suresh K

11th September 2021 | Held via Zoom

Individuals Present: Mr. Suresh K, Sreejini J., Gloria Benny

Sreejini J: Hello Sir, Good Afternoon Sir.

Suresh K: I am audible right?

Sreejini J: Yes. You are audible.

Suresh K: Okay. Tell me what exactly you want to know.

Sreejini J: Actually, we, from The George Institute, like I mentioned earlier, are conducting a Witness Seminar. It's a new methodology, where we consider you as a witness of that period because, Sir, you were a part of this NHM4, the movement and all that happened. So, we consider you as a witness in the whole process. We are actually looking into the decentralization in Kerala as well as community participation with special emphasis on post-NHM period or NRHM14 period—post-2005 period. We just wanted to know what really happened on the ground and we consider you an important witness and that is the whole idea behind the Witness Seminar. We did the Witness Seminar at three levels. First, among the policymakers. Then, among the field staff (that means the Panchayat presidents and those who were working at the field level—the HI [Health Inspector]²⁴, and the Panchayat presidents of various Panchayats in Kerala). The third Witness Seminar, which you were a part of, was the Witness Seminar among the implementers which spoke about what actually happened. We want to record all of this, and this will actually become a transcript. So, after a long period of time, if somebody wants to check what really happened, this can be used as reference material. We are preparing an archive kind of thing. So, we will be doing an archival kind of

recording and documentation. We did this among the implementers. 10 people were invited, and all presented, except you and Dr. Sahir Shah. He also could not attend the meeting. Actually, he was also there in the meeting, but due to some unforeseen circumstances. he had to leave the meeting. We thought that since you are an important official of the NHM, and [because] you may be knowing a whole lot of things which others don't know, [it was important to talk to you] to get the NHM point of view. Because when we spoke to other people, the NHM point of view did not come through clearly. From an NHM official, we will get the NHM point of view. So, this will be recorded. We are actually planning to add this part along with the earlier Witness Seminar proceedings. So, this is Gloria. She is a colleague of mine. And Harisankar—he is also a colleague—will be joining shortly. So, we can start, Sir.

Actually, I want to know... With Kerala, we all know that decentralization happened with the People's Movement in 1996 and a whole lot of devolution of funds, and all such things happened in Kerala. But with NHM, when we spoke to many [people], we got a perspective that the NHM didn't do that much, with the NHM coming in 2005. We wanted to know how decentralization, and with the NHM there were a whole lot of funds devolution and a whole lot of support, especially with the infrastructure part, NHM has held up the health infrastructure. So, we want to know what actually happened. Like you know, with decentralization, whether there was a kind of coalition between the two, because NHM is actually from the center and decentralization was more on a local or a state level. So, what actually happened, whether the interaction was good, or were there any limitations or hinges. That is what we want to know.

Suresh K: First let me introduce myself. I am Suresh. Basically, from the AG [Accountant General] office. I am on deputation. I came on deputation first, way

back in 2000 when the RCH program⁹⁷ was going on: Reproductive and Child Health (First phase). That was going on. After that, I was there for five years, and then I went back to my parent department. I was called back by the then Health Secretary, Dr. Viswas Mehta, who later retired as Chief Secretary. And I had my second stint which started in 2006, and I worked until 2011 November. Then I went back again to my department. Then back in 2016, NHM... At that time, it was NRHM, then it turned to NHM. Then, NHM had put out advertisements and I had applied, and I was selected again, and I came back to NHM. I am working as the administrative and human resource manager. That is my background. Now, first of all, let me tell you: you can just interrupt me at any point of time when you feel that I am digressing a lot, at any point of time you can tell me, because I am just sharing several things from my experience. If it is not relevant, you can just interrupt and tell me that.

When we talk about LSGs, their involvement actually started back in 2000. Sorry, '98, I should say. In '98, there was a program titled DRHP (District Reproductive Health Program)⁹⁸. That was implemented in Malappuram district. The Program was basically conducted in coordination with the local bodies. I was not there when the program was started, but I was there at the far end of the program. The program ended in November 2000, and I had joined only at that time. And I was asked to just do all the accounts, complete the program, and ensure the balance and everything is handed over to the Government of India. So, I had gone to Malappuram at that time, the last week of that month. And incidentally, the funding process... because during those days this concept of the health department implementing a project by LSGs was a new concept or maybe it was very rare, but

I was not familiar with that. But in Malappuram, I remember, around 35 or 40 odd Panchayats were given funds for various activities in the health sector, mainly in the Health Centre and in the neighbouring areas. That was a small-scale activity. Nowadays actually we can easily correlate communicable and non-communicable diseases. But it was not as explicit during those days. In that project they had funds to construct toilets, provide water source and drinking water, etc. Though these are known to be determinants of health, those days no one was able to see this larger picture. Because it was only evolving then. So, there were funds for all that. Many Panchayats did very active work and some Panchayats did not. Then, I had personal interactions with them for nearly a week. There were confusions regarding how to return the unused funds or how to immediately complete the work: some Panchayats completed the work in different ways, but some didn't. Some of them didn't even understand the system and why they were given these funds. But somehow that program ended. And we had to give a detailed report on what exactly happened in the program. So, at that time, our Project Director, Dr. Arjun (Additional Director, Family Welfare) discussed this with the district level officials. He convinced them that this process of devolving funds through LSGs and then implementing various activities can be successful provided they have a good idea what exactly they have to do. The Panchayats should have a very good idea what exactly they have to do. That was point number one.

Point number two: Funds should not be released fully, initially. It should be released part by part. Because there are chances of misutilization if you give it in full. So, he had forwarded that suggestion. Simultaneously, I think it was in 2000-2003 that

97 The Reproductive and Child Health (RCH) Programme was launched throughout India on 15 October 1997. This programme aimed at achieving a status in which women will be able to regulate their fertility, and women will be able to go through their pregnancy and childbirth safely. See: https://www.nhp.gov.in/reproductive-maternal-newborn-child-and-adolescent-health_pg

98 The District Reproductive Health program (DRHP) was separate from the RCH program and started as a pilot program in the Malappuram district in 1998. The program also included a health determinants component. The program ended in 2000.

Integrated Population Development (IPD)⁹⁹ program of UNFPA¹⁰⁰ was implemented in Malappuram, Wayanad and Kasaragod, [in] these three districts. There was a similar approach through LSGs even at the State Level. After that I was involved with UNFP IPD during the closure phase, and similar issues and points were raised at that time. The Government of India was actually very much interested, as LSGs were given a lot of powers in our state. They were very much involved and interested to know how much of an active involvement of LSGs works out in the health sector. So, I was saying that the IPD experience was somewhat similar. Then the RCH program was implemented. It was way back in '98. And our State started it fully in 2000. When it started, LSG involvement was mostly in one area: civil works. That means constructing a labor room and operation theatre in Community Health Centers, modification or renovation of existing labor and operation theatre. In that context, they find a person from among themselves, and that person will be the convenor for the civil works, and they will do that particular work. It was a time when such a beneficiary system was started.

So, many such works were implemented like that. There were a number of Panchayats that did really good work because of the constant interaction with them. There were many Panchayats that lacked it and had faced several issues as well. Still, there was a close involvement with them. We used to regularly visit—I, rather, used to regularly visit Panchayats, even though civil works were happening in the Community Health Centers. It was like if the Panchayat gave permission, it would work out, but in case if some procedural delays happen in the Panchayats, it will be bogged down. There were strict instructions that this should not happen. I used to meet around 100-125 Panchayats four to five times a year. During those meetings, when I used to meet them and discuss the possibilities,

they used to lap it up and do the work efficiently. And they did even better later. This was by 2003-2004. After all these, there was a seminar organized by the Government of India. You may be familiar with RKS, right? Rogi Kalyan Samiti¹⁰¹. Our HMC. The Government of India was very interested when they knew that we did all the RCH activities through HMCs. They were enquiring about how it has been done. And we did a seminar presentation on how the process is being done by the HMC, how it is a body consisting of Panchayat president and several other representatives from the Panchayat as well the official representatives, local leaders, etc. They got really interested in listening to this. They already had some knowledge about this, but they were more interested in finding out the details of it which we shared with them. And then came NRHM in 2006. There was a lot of involvement by the state and the health department with the LSGs. They were happy as well to explore this. I remember an IAS officer told me at Trivandrum that a new project is coming up: "We will be planning to replicate many of these activities in the new project throughout the country". I never knew what exactly that project was at that time, because RCH was started by '98 and supposed to end by 2003, but they kept on extending it year by year.

So, this happened in 2005. They said in 2006, "There will be drastic changes in the health sector, and more Panchayats and more LSGs will be involved in many other activities. You people are doing excellent work, and we will be replicating many of the activities that you people are doing." I did not have a clue about it then. I had realized that there was a process of implementing health activities at least at a small scale, by submitting projects to the Panchayats. I was not involved in that though. I was only involved with NRHM and RCH. We launched NRHM in 2006. Then, after a small delay, we started implementing it. Everything

99 The Integrated Population Development (IPD) Project was an externally aided project in collaboration between the government of Maharashtra and UNFPA that ran in several districts of the state from 1998-2002. The objectives of the of the project were to improve access to essential package of quality reproductive health services in project areas in identified groups; to contribute to creating an enabling environment for gender equity and equality, women's empowerment and realisation of reproductive rights; and to strengthen the capacities related to reproductive and child health including family planning program, project management in project areas. See: <https://hetv.org/india/mh/healthstatus/population-development.htm>

100 UNFPA is the United Nations sexual and reproductive health agency. See: <https://www.unfpa.org>

101 Rogi Kalyan Samiti (Patient Welfare Committee; also known as Hospital Management Committee) is a simple yet effective management structure. This committee, a registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital.

was set up in Trivandrum—I mean Kerala. Districts Program Support Units¹⁰² were established in the districts in 2007. So, in the state, it was established in 2006 August-September, and in the districts by 2007 March. So, during August 2006, we started. They had conducted a few seminar meetings at the level of Government of India on what exactly they would like to have, how they visualize NRHM, how it should pan out, how it is panning out throughout the country, and also how activities should be done in the state. There was a lot of freedom. From the start itself, they said that though they will give funding, we have to plan the program, implement it, and find the requirements, etc. Because RCH program had a tight framework. They had a framework that strictly specified this funding is for this activity, etc. This became broad now. Their book itself was titled as Broad Framework¹⁰³. We had to find out what all we can do in that broad framework. We were asked to find out at what levels we should have the involvement of the LSGs and Panchayats, and we should come up with an annual action plan. All the states should do that. This annual action plan was in fact our first bottom-up approach. This was the first time that we were implementing it.

They said the original plan of NRHM itself is a bottom-up approach. It should come from the field. It should be planned at the Block level LSGs, then it should come to the sub-centre, and then to the PHC. From there again to the Block, then district, and then to the state. A consolidation plan should be prepared at the state level and be given to the Government of India. As part of it, first we will have detailed interactions with the Panchayats. And then we selected Wayanad district as the first district for this interaction. Now, even when we were doing all these, we were not really clear what exactly, and what all things were possible under NRHM. They said very broadly that they will give funds and they will give freedom. They told us about the activities very broadly. But still we were unaware about what all is possible under this.

So, we went to Wayanad as a team. What we did was, we called all the Panchayat presidents. [We] convened a meeting with Panchayat presidents, Panchayat standing committee chairman⁶⁸, health standing committee⁶⁸ chairman and presidents, etc. I still remember that we conducted a meeting on November 1st, 2006. They introduced the broad framework by the Government of India. And we asked them about their needs since we were also blank, though we had some basic ideas. To be frank, we did not have an idea about what to do.

I hope I am not boring or going off track. So, we asked what their needs were. We got some interesting responses. One of the Panchayat [Presidents], who is incidentally [president of] one of the smallest Panchayats in our state, stood up and said that he needs a medical college in his Panchayat. That means the expectations were sky high. We know exactly how much space, how much funds, etc. are required for a medical college. Those days this was beyond dreams for Wayanad, even today it is not a reality though the process is on. So, the president of a Panchayat which didn't have altogether even the 300-400 acres land required for a medical college, still wanted it. Primarily because they had so many problems. Wayanad especially had a lot of health problems. Access was a major problem during those days. So, many demands came up one by one. In short, that was an enlightening meeting for us. Because, in most cases, unfortunately we thrust our ideas on to the Panchayats. On the contrary, there are a lot of advantages when people in the field realize their expectations, demands and requirements. It is not really useful when we pump in funds, it is useful only when we give them permission for what they really need. Otherwise, it is absolutely useless. We would be utilizing this fund without any use. So, when we spoke to them from that perspective, we got to know that they have several types of requirements ranging from equipment, human resources, drugs, IEC, infrastructure, etc.

102 The District Programme Support/Management Units are an institutional mechanism within the NHM that are linked to a District Health Knowledge Centre (DHKC) and its partners for the requisite technical assistance. <https://nhm.gov.in/index4.php?lang=1&level=0&linkid=456&lid=685>

103 This refers to a guideline called the Broad Framework, intended for preparation of District Health Action Plans under NRHM. See: https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/dist_health_action_plan.pdf

Demands were huge but we were able to come up with a framework. That was a good method. So, based on that, we came up with a broad framework. And we were able to prepare a budget for that. To come up with a budget, after we prepared the framework, we devised possible activities in response to that and found out budgetary allocation for that and arrived at a total budget. Unfortunately, we did not have information regarding the other districts. We were instructed by the Government of India to submit the project within one month and we were hard pressed for that. We went to the field in the first week of November and we were expected to come up with the report by the end of the month. Based on the interactions with the Panchayat members and their requirements we prepared programs and activities for that. By looking at the requirement-funding aspect, we prepared a budget at the district level. Somehow, we planned a pan-Kerala budget corresponding to that and sent it to the Government of India. They made some modifications and later we started implementing it throughout the state. During implementation, one of the activities which the Panchayats were very happily accepting was the untied fund for Ward Sanitation Committees (now it is called as Village Sanitation Committee). And then the other one was the fund for the health institutions and annual maintenance grant for the health institutions. Believe it or not, there were Panchayats who utilized that fund in a proper way. I should say within hardly four or five months, they demanded more money. So, throughout the country they introduced a criterion: this much for each PHC, this much for Community Health Centers, etc. They came up with such criteria. So, we could give only that much. But their acceptance rate was really high. Even though there are many other fund sources, most of them come as tied funds.

If it is a tied fund, there will be a number of riders and conditions. We removed all those conditions and made it an untied fund and came up with some guidelines regarding what all can be done. That ran into four to five pages. Everything was put up as bullet points. So, they were able to touch on several areas that probably included lightbulbs, toilet cleaning, etc. Those small things people often

forget and don't put money on. We usually miss out on that. For example, in the rubber industry, things like cleaning up the waterlogs, etc. Naturally, we need human resources to do that.

Human resources actually are not permitted in this untied fund. Just human resources. Human resources, major construction and major equipment procurement is not approved. Because there was not enough money for that. Fund was allocated as Rs. 50,000, Rs. 1,00,000...up to Rs. 5,00,000. But for an activity like this, they were able to get someone to come and clean hospital premises and such small tasks. And later they got so many ideas. They kept a water purifier for safe drinking water, TV, chairs for the public to sit, curtains for the doctor and token number system, etc. All these things, each Panchayat discussed it with their local Medical Officer and explored the requirements and sent us the photos after implementation. Then, we discussed it with the other districts. Many of them felt really good about those ideas. Basically, everything belonged to them. I mean, the ideas came from the grassroot level itself. So, when their HMC meeting happened, they used to let us know the requirements based on the discussions that happened there and we used to tell them how to do it because there can be audit issues later when someone takes a decision arbitrarily. So, we told them specifically to jot down their requirements in a paper. When the meeting was convened someone could read it out. All the members can agree to that. Because basically this is the requirement for the health sector. Then it can be minutes in a proper way, procurement can be affected, and payment can be given.

They will not be comfortable with all the bureaucratic complications and procedures. In a simple manner, we can write down things like this: like we decided to buy this particular thing, maybe TV. We decided to use [this to buy] new chairs, etc. All these things, they can write it down in a sentence and be counter-signed by the president and medical officers. That is our minutes. We will take a copy. They can give a purchase order while making the payment. Along with the payment, keep a copy of the same as well. That we had instructed

them to do. When they started doing it like this, it became easy for them. Maybe they did it earlier as well [but] I don't know about it. In the health sector, in Wayanad, things were done properly: especially their public health activities. At every traffic junction, they kept IEC messages and boards, etc. I had plenty of photos. It might be there even now—I am not sure though. This sent out a strong message to the public. And regular meetings were convened by the Ward Sanitation Committee. When things like this happened, LSGs were very cooperative as well. And then we started providing some human resources as well through NHM. In the context of human resources, everyone will want more doctors and more staff nurses. So, we kept some guidelines for that. One doctor for 200 OP [patients] is not practical. They will have to see everyone within one or even half minute each. So naturally, the quality of medication and quality of the doctors' treatment will decline. The Panchayat presidents were actually able to understand that. They thought it would be better if they got more people. They used to present it in the meetings. They used to communicate it to the Honorable Minister. When we talk about our minister, we must say she was really wonderful, and she used to travel throughout the state. Sreemathi teacher. That, we have to state it here. At that time there will not be any institutions that she had not visited. I am pretty sure about that. When someone used to talk to her about some institutions, she used to respond with the color of the gate, or if it was in that turning of the road, etc. She used to remember everything like that. So, when they used to communicate to the Minister regarding the requirements from the field, their reflections, etc., she used to present it. Either in these meetings or when she used to call or even when she used to return after a tour or so, she used to tell us to give this resource to this particular institution, that they urgently require a doctor. She used to do things like that. So, it was easy for us because Madam won't just listen to random things and tell us. She used to inquire about that and find out whether that requirement is really there. Her request will come only after that. Like I said earlier, everyone had their

own requirements like new buildings, new medical colleges, etc. But we did not receive such funds from the Centre. Funding was very limited in that sense.

So, in the case of civil works, we cannot practically come up with new buildings in each hospital in a matter of a day. It is not practically possible. We had to do some planning there. We had to find out where and what exactly was required in each place and provide them based on priority in the first year, second year, and so on. There were many considerations: their existing buildings, availability of space, their requirement in terms of patient load, etc. Thus, we had to decide on many things based on so many aspects. And we were lucky that many of the Panchayats' Presidents who used to come with their requirements and requests, when we told them about all these aspects and considerations, they would get convinced. They would still insist that their request should be somehow considered next year at least. These are all good examples of how the LSGs used to lap the projects up in a big way in terms of this funding and utilization. This process went on well for around three to four years. And we are very happy to say that we were able to provide many things: infrastructure, human resource, drugs to an extent, equipment, etc. Firstly, there were multiple reasons for it. There were requirements from different places. Second, we were able to identify exactly where the requirements were. That was the benefit of the LSGs. And the honorable minister was very active. All those worked out as advantages. All the procedural processes got transformed.

I think it was in 2008 where we were able to run procurements from the Medical Service Corporation¹⁰⁴ in a really transparent way. It is very important to do the procurements in a time-bound and transparent way. We have to look at it from the other side as well. When it takes several months after payment for a company to deliver something, no one would be interested to do that again. So, such processes were changed. The government removed all those hurdles and started a corporation. After that, we were able to

104 Kerala Medical Services Corporation (KMSCL) is a fully owned Government Company for providing services to the various health care institutions under the department of Family Welfare as per Section 617 of Companies Act, 1956.

do the procurement and effect the payment on a timely basis. When payments were made in time, naturally the cost of drugs, etc. came down. I still remember, in 2008-09, when the first procurement came up from the Medical Services Corporation, the tender was invited for around 500 items of drugs. In that, the cost of 80 or 70 items increased, but the cost decreased for around 250 items when compared to the previous year. That was the result of transparency. Since there were no vested interests and it was transparent, from top to bottom everyone was interested in promoting the system and ensuring that the system is there for the benefit of the public. We were able to run it well because we took a special interest in it. LSG involvement over the period of three years had really increased.

Social auditing was introduced in between. Ramachandran Sir had mentioned about the social auditing that day. The Arogya Keralam award²² was introduced after such involvement from the LSGs. The involvement increased even more when the best Panchayat was identified and appreciated. We had introduced more programs that time like palliative models, etc. It was made compulsory that 5% of their budget should be compulsorily allocated to palliative care. Along with that, they used to take much interest and actively participate in the new health projects as well, whenever they were introduced. By the time Arogya Keralam award²² was instituted, the annual budget contribution went up to Rs. 600 [crores] from Rs. 200-400 crores. Last year, it even further went up to Rs. 960 crores. Panchayats' contribution is above Rs. 950 crores in the health sector, which is really huge. No other state would have that much contribution for health. I strongly believe that this success was made possible because of their involvement over the period of years.

Now the Fifteenth Finance Commission¹⁰⁵ has given a report. Based on that, around Rs. 2900 crores are being given to Kerala for health activities alone. It is exclusively allocated to be spent only for the activities under the health sector. And more importantly, it will be only through LSGs. There is a dedicated paragraph highlighted in the 15th Finance

Commission about LSG's involvement in Kerala. I don't know whether you have seen or not. The report is available on the internet. If I am not wrong, I guess it is chapter seven where there is a specific paragraph about LSG's involvement in Kerala. It is based on that paragraph that their insistence came on spending most of the funds from the 15th Finance Commission through the LSGs. The first set has begun now. The state level is headed by the Honorable Chief Secretary, and it is the District Collector who chairs at the district level. All the committees would be meeting in the coming weeks. As this is the first year, we will be receiving 559 crores allotted for now. We are asked to give a project in a very short period. So, we are planning to give it with the limited facilities and time. They have clearly instructed that next year onwards it should be a proper grassroot-level proposal and you have to go to the Panchayat, discuss with them, find out their requirements and then based on that you have to compile that and prepare a project and give it to us by this January.

By January, the Government of India has instructed us to give a project for the next four years based on the consultations with the Panchayats, including Block level, Grama Panchayats, Districts, Municipalities, and Corporations. The process is going on now. I just shared whatever I could remember based on the work I could do. If you have any other specific questions, if I know, I will definitely be able to respond.

Sreejini J: Sir, you have covered almost everything from our questionnaire from '98 'til date. We were more interested to know about the fund flow, and how the relationship between LSG and NHM was. In your experience, are there any notable events of interaction between LSG and NHM? Any example about a Panchayat where something extraordinary happened?

Suresh K: I don't think anything extraordinary happened in that sense in the Panchayats. There were some involvements. For example, I think it was in Malappuram itself: there was an activity that happened without the knowledge of the Panchayat

¹⁰⁵ The Fifteenth Finance Commission is an Indian Finance Commission constituted in November 2017 and is to give recommendations for devolution of taxes and other fiscal matters for five fiscal years, commencing 1 April 2020.

president. That was a civil work. It happened when there was a different president. So, when I went to him to inquire about this and report that there is something lacking about this particular work, he said he never knew about that. He contacted the Secretary. The Secretary said it was an earlier project. And the new President is only [now] getting to know about it. The President understood the situation and went to that institution along with me. He further enquired about it and found out the present status. There were a couple of hindrances. The contractor was not interested. He called that contractor personally and told him about the importance of the project and that this is the requirement of his Panchayat, etc. Though he was from a different Panchayat, this is a public need for all the people and that he should somehow finish it. He spent around two to three hours just for the civil work of that institution.

This happened just because I went there. He realized about this issue only after I went and spoke to him. And he was particular that any chance to build a hospital for the people and his Panchayat should not go in vain. That was the reason behind his involvement. He used to follow it up properly after that and ask me frequently if there were any new projects that they can implement, etc. Many Presidents used to do that. We used to give them activities initially, but it became repetitive in time. They started getting annual maintenance grants and untied funds. And they were very keen to come up with something new. Something that happens for the first time in their Panchayat, and they should lead the way and be a pioneer. So, they used to enquire about the possibilities for that. For example, for implementing theaters as part of the National Program for Blindness Control¹⁰⁶, it was not very common to get the sanction and other procedures. In fact, there was no need to go to Delhi to get a sanction for anything, because there won't be any issues in Delhi¹⁰⁷ if we send a proper proposal with

the requirements.

But I wanted to tell you about their involvement. They were ready to go up to any extent to work on it and ensure that they got the project, so that it can be implemented in their particular Panchayat and that will be beneficial for the public. The involvement of the Panchayats was at that level. There was a meeting conducted for the Panchayat presidents at Mascot Hotel (Thiruvananthapuram). During that meeting, a Panchayat President asked the minister about a requirement for human resources. So, he stood up and said that he had submitted so many things and made a long representation with details of how many people were there in his Panchayat, how many males and how many females, how many OP and IP facilities, and a six-month average, etc. It was a very detailed presentation and document. He demanded that somehow, we need two doctors. The Minister was present in that meeting. She said we can't arbitrarily sanction anything like that. Then he pulled out the document from his file and gave it to the Minister immediately. That document itself was a pressing document. After going through that, the Minister said they are definitely eligible to get their demands. And that we are bound to give it. That means the Presidents got to know how to function in order to get things done and started to work along those lines. That is something wonderful.

There is a Regional Training Centre at Kottarakkara¹⁰⁸. I forgot the name of the institute. It is a few kilometers from Kottarakkara. I used to go there to take classes. I think it was in 2010 or so. People get really interested when we give them some photos of what they can do, rather than present only some documents during the class. I told you right, that in Wayanad and Malappuram they implemented the projects well. So, I collected a lot of photos from there. I used to tell what all to do with the maintenance funds or some other funds by showing the photos. If the guidelines session

106 National Programme for Control of Blindness and Visual Impairment (NPCB&VI) was launched in the year 1976 as a 100% centrally sponsored scheme (now 60:40 in all states and 90:10 in NE States) with the goal of reducing the prevalence of blindness to 0.3% by 2020.

107 Delhi, officially the National Capital Territory (NCT) of Delhi, is a city and a union territory of India containing New Delhi, the capital of India.

108 Kottarakkara, also transliterated as Kottarakara, is a town and municipality in the Kollam district of the Kerala, India.

was for one and a half hours, I would tell them about the guidelines for half an hour, I would show these photos to them for half an hour and the last half hour would be interaction—for example, a fish hatchery. When we used to give them guidelines, they would get an idea that such a project was possible with that funding. That was a major activity in mosquito control. When they get to know that fish hatchery was possible under that program, many people will be happy. They will go to a fish hatchery, and we used to give fish to the public for free to do that project. So, when pictures were used, more and more people used to get interested and ask for details through emails and copies of those photos as well. That gives a positive vibe for us when we work with them like this.

Sreejini J: Sir, when we discussed with some others, many of them say that NHM's involvement is a top-down approach. I mean, they suggest that they don't understand what is happening at the ground. But when I talk to you, we get a sense of how these NHM officials have worked at the ground level to understand the problems of the people. Especially with the current COVID situation, the way NHM supports manpower and for Aardram—there is NUHM manpower, with doctors, staff nurse and lab technicians, etc. All the doctors at NUHM are on contract. So, we definitely get support in that context. Now, we are facing a situation where our system itself is down because of COVID and flood: it has been affected continuously. In between all these, there has been a mismatch. Even though we say there is decentralization, somewhere we see a lack of involvement and it is going in two different directions. So, in the future, what are the possibilities to interlink it? Because these are two strong forces and, if it's combined together, it would definitely give effective results.

Suresh K: Let me respond to the first point itself (top-down approach and bottom-up approach). Initially, we functioned with a bottom-up approach. Unfortunately, if you ask me now, I will have to say that it is definitely a top-down approach. Why? There is a specific reason for that. I mean, the Government of India comes up with new projects each time. And then they will tell us to implement it with the state. Once we start a project, we cannot stop it after two or three years and move on to another project. Maybe it may work out in other states, but it is not practical in our state, because when people find out about a new project that is beneficial for them, they will definitely expect the Government to run that in the future as well. During 2007-08 activities, it was actually like a briefcase given to us by the Government of India telling us to utilize that as per the requirement. Whereas now, they give each of the things in that briefcase and they will ask us to specifically utilize for particular projects. That is the process now. We cannot blame anyone for that, not even the Government of India. Because, we have that many requirements in health now. And moreover, there are so many mandatory activities—Janani Suraksha Yojana (JSY)¹⁰⁹, that is a mandatory thing, JSSK is mandatory, NIKSHAY¹¹⁰ is under RNTCP¹¹¹, which is also mandatory. So, there are so many mandatory activities now. There is a kitty in NHM for mandatory activities. We find funds for the mandatory activities from that. Hence, it may not be practical to set aside these mandatory activities and go for other projects. We definitely have to do these activities.

Secondly, there are many things. There is infrastructure development. We reached many infrastructural projects at different levels. Especially for Aardram when we are going for a patient-friendly approach, we are bound to spend some funds for infrastructure. So, the second point: procurement of equipment, etc. should be levelled

109 Janani Suraksha Yojana (JSY) is a National Rural Health Mission (NRHM)- based intervention promoting safe motherhood. To achieve this, it promotes institutional delivery among lower income pregnant women. See: https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg

110 NIKSHAY is a web-based portal which consolidates national data on a set of key, standardised indicators related to tuberculosis diagnosis and treatment. It is publicly available See: www.nikshay.gov.in

111 The Revised National TB Control Programme (RNTCP), based on the internationally recommended Directly Observed Treatment Short-course (DOTS) strategy, was launched in 1997 and expanded across the country in a phased manner with support from World Bank and other development partners. See: <https://tbcindia.gov.in/WriteReadData/IndiaTBReport2022/TBAnnulReport2022.pdf>

up when we increase spending on infrastructure. There should be human resources along those lines as well. We have taken an approach many times that we will do new projects only when we can have more human resources. But we cannot be that strict on that always, because there may be certain situations when there is a particular need in an institution: for example, dialysis. Unfortunately, there are many people in our state who are in dire need of it. We have been advocating that a working model for dialysis should be identified by themselves. I mean, to get a fixed amount from a patient when they come for dialysis. And with that amount, this should be worked out. But unfortunately, it may not be possible for everyone in our state. We have to think about that aspect too. There are many people who are BPL¹¹² who are unable to give. Then there is no point in insisting on paying Rs. 400 for the bill. That is not a stand that a government can take. So, many higher officials and ministers, in that aspect, say that there should be a working model for that but at times you have to dilute it for the benefit of people. The ex-minister Shailaja Madam used to tell me that we should take a stand, but sometimes, we should dilute it for the public. So, when we have all these as major activities, the human resources, believe it or not, take up 1/6 th of the budget. 1/6th of the budget means Rs. 300 crores or maybe above at least Rs. 250 crores as per the current requirements. I am not talking about the COVID brigade staff. I have not included the staff for COVID at all—this is outside that. Nearly 12,000 people are working under NHM. With the Department it is around 45,000. NHM alone is 12,000. That is a huge number. So, 1/4th of the staff requirement is additionally provided through NHM. In many cases, there will be requirements for that. Similarly, there is a requirement for equipment. Now, as part of Aardram⁶, we are introducing a patient-friendly hospital initiative. That will require a lot of human resources, infrastructure, and drugs as well. And for mental health: we have gone a long way with the NCD clinics. Still, we are always the NCD capital of the country, so many NCD cases

are prevalent. Thus, when we have all these issues, there are budgetary limitations from NHM and the government departments.

So, we are forced to meet even the additional requirements from this. And all these processes, we are compelled to include it through NHM. Because of all these reasons, from the beginning, every year we have to prepare a project implementation plan which has to be given to the Government of India. So, mandatory activities will come up in the first place. There are many such things that we cannot forgo when it comes to project implementation plans. As a result, the remaining budget will be limited. And with that when we have some untied funds, the overall kitty will get covered. So, we have no other choice but to say that it is a top to bottom approach now unfortunately. The extent of freedom for the Panchayats have declined. But Aardram has been really useful for many Panchayats. NHM has supported that in a great way.

Then, what was your second point? I missed out on that. Sorry, there was one more point in that question.

Sreejini J: Sir, we have covered almost everything. When it comes to human resources, we know there has been a mismatch. It is going in parallel tracks. We will know in the future if there will be a positive change in that. We know we are going through a lot of glitches. Many people are of the opinion that in the context of decentralization, the involvement of LSGs and Panchayats with the NHM is going in two different directions. There is rationale for NHM in this regarding why that happens. From the Panchayats' point of view, they are not getting funds. They will have a feeling that they are not able to use their rights. So, when we look at the future, will there be an involvement of both together? Because many of the projects are with the involvement of both the parties. But something is missing somewhere.

Suresh K: I would like to say something specific here. The Government of India keeps adding

112 "BPL" is "Below Poverty Line". It is an economic benchmark related to threshold income fixed by the Government of India, linked to its poverty estimation exercises which have been underway since the 1960s. It is intended to help identify the financially weaker people and households in immediate need of government aid. See: https://rural.nic.in/sites/default/files/WorkingPaper_Poverty_DoRD_Sept_2020.pdf

programs like I mentioned earlier. Now the latest update is that we have 36 national programs running through NHM. So, there are some basic requirements for all these programs. The involvement of the Panchayats for the rest of the programs is very limited. Still, for me the biggest advantage is in the current Fifteenth Finance Commission¹⁰⁴ grant. Like I said earlier, Rs. 2500 crore is the allocation for our state out of which Rs. 559 crores will come in the first year. The Government of India suggested to give it to the Panchayats, work out a broad framework based on their requirements and submit. This will be evaluated by the district committee and then the state committee headed by the Chief Secretary, then the national committee. Though the approval has to reach up to that level, there are many things that the Panchayats can do. So, we feel that though there are some shortcomings from the part of NHM and its approach, this is a chance for the Panchayats to come back. They can implement more health projects. They will be able to plan based on their local requirements and implement even more now, I hope.

The funding through the plan funds for the Panchayat is going steady. This 15th Finance Commission grant will be above that. In that case, I think the Panchayats can get back on track with this support. It will be beneficial for all those Panchayats who are eager to lap it up: it is like the proverb "Crying baby gets the milk". Though they say Rs. 559 crores, if they indicate the requirements, they are ready to give even Rs. 1000 [crores] and Rs. 1500 crores for the Panchayats based on the projects they come up with. If they plan the projects judiciously, I am sure it will get the approval from the district, state, and national committees.

Sreejini J: Thank you Sir, we have covered almost everything. This aspect was much needed for us. We got a lot more clarity on the NHM aspect now, which we had not got until now. We got the perspectives of the Panchayats, the implementers and policy makers when we spoke to a few others. But this was actually very informative as you updated us on what happened on the field from '98 to the present.

Proceeding ends.



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