

Witness Seminar on Community Action for Health in India

The case of Decentralization and Health reforms in Kerala

Second of Three Witness Seminars

Held online via Zoom on 30th July 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

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

Background and Purpose

Community participation in health in India—key antecedents^a

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^c

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

- 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.
- c. 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.

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 Campaign (PPC) in Kerala, also known as Janakeeya Asoothranam.^{8,9,10}

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

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

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

Twenty-five years after decentralisation reforms began, we placed our emphasis on the journey of decentralized planning for health in Kerala, with particular reference to the post NRHM period. We sought to more deeply understand perspectives on the contexts, actors, approaches, key developments, and implementation of decentralisation in the health sector, along with reflections on what did and did not work.

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

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Witness Biographies

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

CHAIR:

Dr. Sairu Philip

Dr. Sairu Philip is Vice Principal as well as Professor and Head of the Department of Community Medicine at Government T.D. 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 Local Self Governments (LSGs) and introduced curriculum innovative initiatives in Community Medicine.



Mr. Sibi Augustine

Mr. Sibi Augustin is a retired Technical Assistant to the Department of Health, Kerala. He has got years of experience working with the health department and closely with the community health movements as well. He is currently associated with Kerala Institute of Local Administration (KILA) as well with the poverty alleviation program in the state.



Mr. Saij Kishore C.

Mr Saij Kishore C is a retired Health Inspector from the Department of Health, Kerala. He is currently a Resource person at the Kerala Institute of Local Administration (KILA). He was part of the state-level resource group for training various stakeholder as part of "Aardram Mission" in the state. He has been associated with working with LSG institutions for a long time.



WITNESSES:

Mr. Mujeeb Master

Mr. Mujeeb Rahman M. is a former Ward Member of Wandoor Block and Porur Grama Panchayat in Malappuram district. He is a teacher by profession and has also served as a school Headmaster. Mr. Mujeeb initiated and engaged closely in activities to improve immunization coverage and adolescent health through Panchayat level interventions.



Adv. E. Sindhu

Adv. E Sindhu is currently the President of Perumpadappa Block Panchayat in Malappuram district. She served two terms continuously as a Panchayat President. She is also a practicing lawyer.



Mr. Suresh Babu

Mr. Suresh Babu is Health Inspector, Department of Health, Kerala. He is a former District President of Kerala Sasthra Sahithya Parishad (KSSP) and is still actively associated with KSSP.



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: My name is Dr. Sreejini. I am working on this project. I am the moderator for this Witness Seminar, and I am expected to give a welcome address. A humble namaskaram to all who have gathered here. On behalf of The George Institute for Global Health, let me extend a warm welcome to all of you who managed to be present here despite your busy schedules. It was on a short notice that I could invite you before the beginning of the seminar, like only a few days back. I thank all who were able to respond and come here to sincerely participate despite the short notice. Before moving on further, let me tell you what this Seminar is about, and [introduce] its participants.

I welcome Sri Mujeeb master, former Ward Member of Vandoor block, Porur Grama Panchayat, Malappuram. Namaskaram. Advocate Sindhu, Block Panchayat President, Perumbadappa, Malappuram. Namaskaram madam. Sri M. P. Snehajan Sir, former Panchayat President, South Mararikkulam, Alappuzha. Namaskaram Sir. Sri Suresh Babu, he is an activist with Kerala Sasthra Sahitya Parishad. Namaskaram Sir. Sir Sibi Augustine, retired Technical Assistant. Namaskaram, Sir. Similarly, we have two more people here with us who have agreed to participate in our Witness Seminar. Sri Sai Kishore and Sri Soni: one of them is travelling and another person has some health issues, and hence they can't participate in this. But our team will talk to them later. And the Chair for this Seminar is Dr. Sairu Philip. Madam is a professor and the Head of Community Medicine Department, T.D. Medical College, Alappuzha. I don't think I have to say a lot of words about such an energetic personality. It motivates us tremendously that, despite her extremely busy schedule, she attended my phone call and listened patiently and gave us time. Madam, we welcome you to this Seminar.

Why are we all gathered here? We are here for this Witness Seminar. I would like to say a couple of words about its relevance, because all of us

discussed this over the phone. Now, when we are all here on a common platform, [let me talk a little bit about it].

We are intending to conduct a Witness Seminar on the relevance of decentralization of the health sector in Kerala. In this Seminar, we are going to discuss the models of decentralization implemented in Kerala. It is about the contexts in which it was implemented, approaches taken by various people around it, its developments, and—despite the developments—details about its limitations, if any. So, we are conducting this Seminar to know about the details of the process. This is the second Witness Seminar by The George Institute. The first one was done among the policymakers. This second one we are conducting with people like Panchayat Presidents, who work with the people, because we may be able to find more examples here. Some of these examples may be totally new to us, something that we may not find through papers or even a Google search. [We hope to] unearth such examples through these Witness Seminars. That's the purpose of this second Witness Seminar. There is a third phase to this, a third Witness Seminar at the implementers' level.

When I talked to all of you over the phone, I was talking a lot about this Witness Seminar. What is this Witness Seminar? We should know what it is first. Only a handful of studies were conducted in India through Witness Seminars. It's new methodology. We know that there are descriptions that we gather about an event of a historical epoch from the people who had experienced it first-hand. We call it a first-hand account. So, they were part of history or a phase that way. We gain an oral history from them. We are then recording their perspective on things. For example, many things might have happened in our field. But only people like you who have worked on the field may be aware of such things. Or maybe there were only some booklets or pamphlets about it. It doesn't get recognized on a large scale. So, we are conducting this Witness Seminar to do that. So, what are we gaining from this Witness Seminar? A

transcript will be made from this Witness Seminar. This transcript will become a historical record. So, a Witness Seminar is a process [whereby] the oral histories of the people who participate becomes a historical record. This is our study.

Now, I hope all of you have read the consent form. We got the forms signed from all of you. And your participation is voluntary. There is no pressure on that. If you feel like you would like to participate, we need participation from people like you. That has to be completely voluntary. We are recording the whole seminar on Zoom platform. In case someone has a difference of opinion or is unable to accept what another person has to say, we may not reach an agreement. The importance of this Seminar is that everyone will record their opinions the way they are.

Now, I will brief you about the protocols we follow after the Witness Seminar. After the seminar, we will be storing the video and audio files on The George Institute platform. The transcripts we bring out of this won't be anonymous. It will be in the name of who said what. That is another important aspect of the Witness Seminar. All the participants have a chance to review after the first transcript is ready. That means you have a chance to correct, add or omit whatever you have said during these ten or fifteen minutes. You can also support your arguments along with a document if you think that's required after we send you the transcripts. But it would be helpful if that can be done within a week after we send you the transcript. And we will only go for the final report after consulting with you for one more time. So, this is how we follow up with the Witness Seminar. I am not taking any more time. Over to you madam, over to the Chair.

Sairu Philip: Let me first thank Devaki, Gloria, Sreejini, Hari Sankar and Manu from The George Institute for making me the Chair of such an

important Witness Seminar. Along with that, a special welcome to each of the participants here who have travelled along with and witnessed the chronicles of decentralization of power: Sir Mujeeb Master, Adv. Sindhu Madam, Block Panchayat President Perumpadappu, Snehajan Sir, a former Grama Panchayat President who later become Block Panchayat Vice President, Sibi Augustine Sir. A special welcome to all of you from my side. Like it was explained earlier, it has been around 25 years since Kerala has introduced decentralization of power. In your capacity as a fellow traveller, this Seminar is an attempt to capture the folios of that history, the way you have seen and experienced it, like how we capture it in a camera. It is like a live Witness Seminar. There are no limits for it. You can say whatever you feel like—Sreejini mentioned that earlier. So, first, let me ask you if you could tell us about the ideas that took decentralization forward, and if you could think of some examples. Also, I think it would be a good idea if you could share your experiences about decentralization in the health sector. Anyone can speak. All of us can speak. Snehajan Sir, Mujeeb Master.

Mujeeb Master: The Chair for this session, dear Sairu Philip Madam; Sreejini, who welcomed us; Devaki Nambiar, Principal Investigator; the other members like Gloria, who contacted us multiple times on behalf of The George Institute; other dignitaries from various fields who are gathered here to share their ideas in this Witness Seminar.

From the questionnaire¹, we could understand many things regarding the possibilities and limitations of decentralization of power in the context of health. We know decentralization of power is an idea that developed in parallel with the national freedom movement². It is pointed out in different ways in the thoughts of Gandhi and Tagore³. The potential and possibilities of decentralization

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- 1 A set of questions was shared with all Witnesses as part of their orientation to and preparation for the Seminar. The specific questions asked are included in our Methods Annexure, provided at <https://www.georgeinstitute.org/witness-seminar-reports>
 - 2 The national freedom movement was a series of historic events with the aim of ending British rule in India. It lasted from 1857 to 1947. See: <https://www.pacificatrocities.org/book-timeline-of-indias-independence-and-democracy-from-1857-to-1947.html>
 - 3 Mohandas Karamchand Gandhi and Rabindranath Tagore were major figures in India's freedom struggle. Both favoured of decentralization of power. Seeing India as largely a rural nation, they saw each village community as eventually reducing its dependence on the state by pursuing a path of self-reliance, or swaraj. See: <https://www.thestatesman.com/opinion/rabindranath-tagore-man-who-walked-alone-1502786407.html>

of power are mentioned in the Administrative Reforms Commission⁴ reports of the first elected government in 1957. But the implementation didn't take place at that time. Some serious discussions on decentralization of power came up to the fore during the EMS⁵ [Namboodiripad] government of 1967 as well. I have read in his autobiography where EMS says, "When I suggested that power should be distributed at the ground level, nobody except the Minister for Panchayats⁶ supported me."

After that, it was during 1986-1987, at the time of the Leftist government⁷, where a concrete phase of decentralization emerged. It was the district councils⁸ that stood as the epitome of decentralization of power in Kerala. The names of those district councils itself were district sarkars [governments]. The most serious debates of that time were on the placement of the District Collector⁹ as Secretary under the district council president. Many people, including Indian Administrative Service (IAS) officers¹⁰, campaigned against it, but later, it is history [because] it became part of the administrative system led by the United Democratic Front (UDF) Government and so on.

We can trace the roots of decentralization of power from the time of the freedom movement. With the implementation of the Panchayati Raj Act¹¹, decentralization was legally implemented in India from 1993-1994. But we all know that it was put into a proper form and worked out as People's Planning Movement¹² with the government in 1996 and the subsequent ninth plan.

There is a question asked here on why decentralization and from where the idea was formed. From what many of us have understood, we could see that it was the governments led by the Left that promoted decentralization the most. I have read in the program of parties like the Communist Party of India (Marxist) [CPI(M)]¹³ about what the governments should be like after democratic revolutions. They say that in a government formed after a democratic revolution—government followed the revolution— there should be democratic spaces or platforms from the lower to the upper strata under the government. People like EMS took forward the process of decentralization of power in the background of such a conceptual world, I think. We have a question here itself. Which

- 4 The Administrative Reforms Commission (ARC) is appointed by the Government of India for giving recommendations for reviewing the public administration system of India.
- 5 E.M.S. Namboodiripad was the former Chief Minister of Kerala during 1957-59 and 1967-69.
- 6 Panchayat is an institution of local self-government in India given constitutional status through the 73rd Constitutional Amendment of 1992 to devolve decentralized power at the local level. See <https://www.india.gov.in/my-government/constitution-india/amendments/constitution-india-seventy-third-amendment-act-1992>
- 7 After E.M.S. Namboodiripad (a member of the Communist Party of India) was elected as Kerala's Chief Minister in 1957, he chaired the Administrative Reforms Committee. He was the first to introduce (via recommendation) a decentralized administrative structure in the state. However, the process of implementing his recommendations was delayed due to changes in power. The Ministry of 1987-91, led by the Communist Party of India (Marxist), took further concrete action towards decentralization. See: <https://frontline.thehindu.com/other/article30218672.ece>
- 8 The District Council, also known as the Zila Panchayat or Mandal Parishad or District Panchayat, is the third tier of the Panchayati Raj system and functions at the district levels in all states. A Zila Parishad is an elected body. Members of the State Legislature and the members of the Parliament of India are members of the Zila Parishad. The Zila parishad is the topmost tier of the panchayat raj system and acts as the link between the state government and the village-level Gram Panchayat. See: <https://www.panchayat.gov.in/hi/web/ministry-of-panchayati-raj-2>
- 9 District Collector is the executive head of the District Administration with responsibilities in the sphere of revenue, civil administration, development, Panchayat and local bodies, etc.
- 10 Indian Administrative Service (IAS) officers work at the national level within India to enforce the law, collect and administer revenue, and shape policies, among others. See: <https://cseplus.nic.in/Home/DisplayPDF?streamId=PCsUnEplvZihdzEe8FEMf/ozdm2Z1SV9EtWCRovKRC3lakWb5Az6zBHUA5aOBE/F63T7xmhv7oprudau8lxE7qwEbpF7FdZRY38CgzX0Ow3cxPusYL1aWOaLZjLhzSg>
- 11 The Panchayat Raj system has been in place in India for many generations, being instantiated in Panchayati Raj Acts going as far back as 1947. Panchayati Raj refers to the establishment of a three-tier Panchayati Raj system: Gram Panchayat at the village level, Panchayat Samiti at the block level, and Zila Parishad at the district level. See: <https://www.panchayat.gov.in/web/ministry-of-panchayati-raj-2/state-panchayati-raj-acts/rules/regulations>
- 12 Decentralized planning in Kerala was started under the People's Plan Campaign (PPC) in 1996. Under this campaign the Government took the process of decentralized planning as the entry point to drive all reforms at the local government level. See <https://plan.lsgkerala.gov.in/planning.aspx> and <https://thekudumbashreestory.info/index.php/history-and-evolution/the-kudumbashree-idea/the-peoples-plan-movement>.
- 13 The Communist Party of India (Marxist) (abbreviated CPI(M) or CPM) is a communist political party in India. It is one of the national parties of the country. The party emerged from a split from the Communist Party of India (CPI) in 1964. The CPI(M) was formed in Calcutta from 31 October to 7 November 1964.

all movements led to this? Who pulled it down further, etc.? As we all know, the People's Plan movement was implemented in 1996. We also know about the background of the subsequent alternative governments in Kerala. That Government transformed it into a development project. In that, one of the major allegations against the Peoples' Plan movement was that it was a program for certain people from the lower levels of governance to loot the treasury, and that's the reason why funds are allotted to the bottom. But we have all moved on from there. We realize the depth of the programme when we look at it from the perspective of the Health Department. It is often said that Kerala had fertile soil, and seeds of these ideas germinated out of the progressive movements and contributions of our renaissance thinkers. There are multiple factors to be credited for that, such as literacy, literacy of women particularly, etc. When we discuss the health sector, we should discuss very seriously the land reforms¹⁴ in Kerala. The relationship between land and health is an important question.

People build a house when they get land for that. They start to think of health and education when they have a house of their own. Thoughts on education will develop as a part of that. We all know that education complements health well. When we say health, we don't just indicate a doctor, medicine, or a hospital, right? There are many more factors to that. We all understand it as an umbrella term. To work out all those factors, literacy and women's literacy particularly are very important. The fact that those factors were favorable in Kerala really accentuated the growth of decentralization and Peoples' Planning, etc. Ever since its inception, I was involved with this process of decentralization of power as a teacher through the Literacy Mission¹⁵ of 1987. I was in my plus-two at that time. It was

Pre-Degree then. I was in my Pre-Degree first year. Since electricity was not widespread those days, we used to take lanterns and go take classes. It was not just the letters that we used to teach them. Concepts like personal hygiene and cleanliness of the environment, etc. were part of the curriculum. Thus, the health education programmes conducted in Kerala have really helped to improve the health sector in the state. Kerala has a merit; that of low infant mortality rate, higher longevity and many such indicators. We were successful to develop a Kerala model in the health sector.

When we explore what led us to all this, we cannot ignore the role of missionary activities back in time. During my Lower Primary (LP) school days, Christian missionaries used to come in a white jeep to the school, wearing hats, as part of their missionary activities for the smallpox vaccination program¹⁶. We didn't see such nurses around these days. They used to give smallpox vaccinations in the school. We continued it further. And we used to have this concept of a family doctor. It was one of those concepts that had aided the health sector to an extent for a long time. But then things changed. We paid a huge price for all the advancements we made in the health sector later. Morbidity increased in Kerala even while we crossed many other milestones in the health sector. We turned into a community of people prone to new diseases and second-generational diseases. It is in the context of such debates on why such things are happening that we should explore the relevance of decentralization of power. Because we should understand why we are retreating. Our family doctor concept weakened. The tendency of privatization of health were visible by the 70-80s and was full blown by the 90s. Our Government Hospitals seemed to be namesake institutions. The private medical industry began to thrive when our

14 Due to the ancient land relations and taxation and regulation under the British Raj, at the time of Independence, India inherited a semi-feudal agrarian system, with ownership of land concentrated in the hands of a few individual landlords. Since Independence, there have been voluntary and state-initiated/mediated land reforms in several states. The most successful examples of land reforms are in the states of West Bengal and Kerala. The Land Reforms Ordinance was a law in the state of Kerala. See: <https://www.thehindu.com/todays-paper/tp-national/tp-kerala/Land-Reforms-Act-no-longer-relevant-says-Industries-Secretary/article15168682.ece>

15 The Total Literacy Programme (TLP) was launched in the late 80s in the Ernakulam district and Kottayam Municipality of Kerala as a drive against mass illiteracy, and to achieve total literacy through people's participation, which later expanded to cover the entire state. See <https://kerala.gov.in/total-literacy> and <http://literacymissionkerala.org/>.

16 Following the passage of the resolution to eradicate the disease by the World Health Assembly (WHA) in 1958, India started the National Smallpox Eradication Programme (NSEP) in 1962, with the target of vaccinating the entire population by 1965.

public health systems became inaccessible and unfriendly to people. I feel that's exactly when we forfeited an important concept of medical/health justice for all of us as a community. I think the idea of decentralization of health, along with the participation of the public, became more relevant when we started exploring the situation of and the possibilities of improving the accessibility of our health services to the marginalized. We know about how the central government projects work. NRHM¹⁷ is mentioned here. The problem with NRHM is that, as a project conceived and designed at the Center, there are limitations in the way in which it is implemented at the bottom. The element and possibilities of participation of people in the health sector is very limited here. For example, the Sarva Shiksha Abhiyan (SSA)¹⁸. We know that it's an education project. We have worked with it. One plan in that project was to provide school sign boards. What does it mean? Many schools in North India don't have sign boards. We may not be able to distinguish the schools there from toddy shops or any other shops. Hence, when there was a plan to provide sign boards in those schools, schools in Kerala also had to follow it and get sign boards again. So, decentralization was attempting to overcome these limitations [of] when planning happens from the top. Take the example of my Panchayat, when we were working on a development document in 1996 as part of a seminar on development, we realized that there was not even a single project on drinking water scheme, neither by the Water Authority nor by the Public Works Department (PWD) in my Panchayat. We know that hygiene and health are very much interlinked; similar is the case of the drinking water. Ours is a small, rural Panchayat. Despite that, it was

after 1996 that many drinking water supply projects, minor and major, were formed and implemented.

From this, we can understand that the availability of clean water as part of a drinking water supply project really made an impact on the elimination of several waterborne diseases, and also brought in good results for the public in the health sector. Another issue is that of toilets. When I was a Ward Member, most of the demands of people made to the Panchayat were related to toilets. The fact that they were to come up with sanitation projects that helped people to build 400 or 500 toilets with the help of Peoples' Plan is one of the major achievements in the health sector in that sense. Now you can see, right? Do you know that the newspapers in North India accord for the second Modi wave, the election of the second Modi Government, to their successful projects that built toilets? That means, what we implemented 30 years back here in Kerala is replicated now in North India today.

I was trying to tell you that most of the credit for all the advancements we made in the health sector should go to decentralization of power and Peoples' Plan movement¹². We can see that under the 8th plan, there is an allocation of 150 crores towards the health sector. In comparison with the 8th five-year plan, by the 9th plan¹⁹, it becomes 600-700 crores along with the participation of the public. Such participation is very crucial, whether it is in the case of health, education, or development sectors. The ownership feeling about public institutions by the common people and a thought that it was their responsibility to better it in a way helped to end a sort of alienation and it brought about a feeling that it was theirs with the help of decentralization of power. In the case of infrastructure development, it

17 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. Since 2013, it has been integrated under the overarching National Health Mission (NHM) 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>.

18 Sarva Shiksha Abhiyan (Education for All Movement) or SSA is an Indian Government programme aimed at the universalization of Elementary education per the 86th Amendment to the Constitution of India, making free and compulsory education to children between the ages of six and 14 a fundamental right (Article 21A).

19 India's Eighth Five-Year Plan identified community participation as crucial to development. Further, it acknowledged that the Government should facilitate such participation via institutional infrastructural advancements, especially in rural regions. However, not all government tiers were involved in this strategy. The Ninth Plan was intended to advance community participation through developing participatory institutions and supporting strategies related to self-reliance. See: <https://niti.gov.in/planningcommission.gov.in/docs/plans/planrel/fiveyr/9th/vol1/v1c1-2.htm>

helped to come up with the best quality hospitals, PHCs, or even sub-centers (or whether it's the case of Medical Hospitals or general hospitals, above that level). That's also one reason why we could contain COVID-19 the way we did²⁰. That's the strength of our health sector. We must say that that strength was developed through decentralization of power and Peoples' Plan Movement. We will be able to see the real depth if we compare both phases: before and after Peoples' Planning. What happened in Kerala during those 40-45 years? What happened during 10-25 years after Peoples' Planning was implemented? We need to take into account the serious interventions made in the education and health sectors. However, we have to accept that there are many limitations that still exist in our health sector.

For example, if there is a requirement for a doctor, it would come from the government level. It is still not possible to appoint a doctor in consultation with the public, someone who can engage with the people and someone who can stand with the people, except in the case of appointment of doctors in the evening Out-Patient (OP) departments. I will share an experience from our Panchayat. When I was the chairperson of the Panchayat Welfare committee last time, we facilitated a BUDS center²¹ for people with different abilities²². Similarly, a multipurpose yoga and fitness center for women. It was part of a broad project for intervention in the women's health sector. Since all this was built in the PHC compound, there was an audit objection against the doctor worth some Rs. 60 lakhs alleging that there was no permission sought from the Department. What does this mean? Even with the decentralization of power and we say that power is with the Panchayat, etc., who owns the land? It is

owned by the department and people with power in it. The ownership over land is very crucial. Did the Panchayat ever receive such powers? Same is the case with appointments. These are still some of the issues that the Panchayat presidents face while taking up such initiatives.

However, one thing we can undoubtedly state: it was the Left movements that led the Peoples' Plan movement and decentralization. Even though many people from both the right and Left wings have supported and co-operated with it, it was the Left who took it forward. That's precisely because the central idea of the Left movement itself is aligned with the concept of decentralization. As per the Sen Committee²³ report, 40% of the funds and powers were allocated to the bottom level. I still accept the fact that it is still not enough, and we have not been able to reach that level of a local government. I will conclude my words here. We need to take the decentralization process even further. And the other states definitely have a lesson to learn on this from Kerala. With the help of literacy and participation levels of people of Kerala, we could really form a better education policy and spread the Kerala model and our efficient health institutions to other regions as well. I express my gratitude to everyone who is part of The George Institute for giving me a chance to participate in this Seminar. I conclude my words here.

Sairu Philip: Thank you, Mujeeb Master, for taking us beautifully through those days. You can always add if you think you missed out on contributing something to us. Who would like to go next? Sindhu Madam?

E. Sindhu: Okay, Madam. Dear Sairu Madam,

20 The core element of Kerala's response to the pandemic was an active involvement of the Local Governments nesting in a larger social mobilisation, which was reported as exemplary during the first wave of the pandemic in India. See Sadanandan, R. (2020). Kerala's response to COVID-19. *Indian Journal of Public Health*, 64 (Supplement), S99–S101. https://doi.org/10.4103/ijph.IJPH_459_20. Also, see <https://www.who.int/india/news/feature-stories/detail/responding-to-covid-19—learnings-from-kerala>

21 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>

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

23 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. See Isaac, T. M. T., & Franke, R. W. (2002). *Local Democracy and Development: The Kerala People's Campaign for Decentralized Planning*. Rowman & Littlefield

Namaskaram to all my dear friends, and all the people like Gloria who are conducting this Seminar. Namaskaram to all of you. 'Til now, I was lost in the world where Mujeeb Master took all of us. Mujeeb Master discussed the chronicles of Peoples' Planning and decentralization of power. I would not want to touch up on that. We know Gandhiji's concept²⁴ of decentralization of power. Though we had implemented it with the help of 73rd and 74th constitutional amendments, we were not that successful in reaching it to the bottom level completely. Peoples' Planning movement was introduced in 1996 as a response to this limitation—to make that concept a reality. Mujeeb Master introduced the concept of Peoples' Planning very effectively here. During 1997-2000, though I was a student, I was part of Peoples' Planning Movement. And that was a movement which has moulded me from my student days even 'til today. I got the opportunity to be part of this movement when I was a law student. For me, it was indeed a major experience to gain a significant perspective on life and society.

After that, I had to move away from all that because of my profession. By 2010, I entered this field as an elected representative, quite unexpectedly. I became an elected representative, and I got a chance to work as the President of a Grama Panchayat consecutively between 2012 'til 2019. Now I am here as the President of my Block Panchayat. So, I would like to say that it is really difficult to talk about our experiences about decentralization and Peoples' Planning within this frame. I guess here in this Seminar we are here to talk about the health sector. Hence, I would focus on that aspect. I would be sharing my experiences regarding the health sector. I think I will start from where Mujeeb Master stopped. It is just that I am starting with what he ended with. The LSG institutions intervened initially to improve its infrastructure. Most of the cases are like that. Earlier, we used to depend on one government

hospital; now, things have gone beyond that for common people. The LSGs have played a major role in doing so. Changes have happened in our institutions. Decentralization played a major role in bringing people closer to the institutions by engaging and improving its infrastructure. That means our hospitals come under the power of the Panchayats. If we look at how much they have intervened with the plan formulae, we can say it was always a success. But we definitely have had a rich experience in the case of our LSGs. When we read some Facebook posts in the context of 25 years of decentralization, we can see the interventions we did in the health sector.

It is that effective engagements were possible where people with good ideas and efficiency came to power. Like how Mujeeb Master indicated, we had a phase of immunization and compulsory vaccination program. LSGs had played a vital role in all that. We know Dr. Sairu Madam had been part of the leadership for that. The LSGs who were keen and willing used their plan funds and have made really important engagements. Some executive committees who were more efficient were even able to come up with new projects on immunization as well. In my experience, most often the guidelines were not in favor of us. There was a phase when the implementing officers limited their activities within those guidelines. Like mentioned earlier, there is a tendency to do the projects focusing on the audit objections, even today. But when we got officers who could read between the lines, and Medical Officers and health workers who worked side by side, we were able to plan such projects. When I shared my experience, we initiated a project called "Athijeevanam²⁵". It is our Comprehensive Health Program.

It was reported that the number of cancer patients in our area was very high, and a survey was conducted on that. We initiated this project to understand the reality and to know what we can do to prevent it. We conducted a comprehensive

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

25 A local panchayat-level health program, focused on cancer detection. A nearby Block Panchayat (Neeleshwaram in Malappuram) had a similar project in association with Malabar Cancer Centre for the early detection and prevention of cancer, named Athijeevanam. See: https://athijeevanam.org/en_US/nileshwar-block-panchayat/

survey. For around two to three months, around 1000 people, including volunteers, were actively involved with that. We did that under the leadership of the Malabar Cancer Care Research Center. We were able to identify several lifestyle diseases and many other things with the help of this survey. We followed it up with a detection camp. The important thing about this was that the primary aim of this activity was not just identifying cancer patients and giving them treatments. It was also to spread awareness in our society and help them know about how it happens, how to detect it early, how to start early treatments, etc. The entire team of executive committee, volunteers, and the health workers shared the same idea. Our survey was also like - anyone who took part in the survey will be able to know what the symptoms were, how to identify the symptoms, etc. We thought it was most effective among women. Women were empowered to talk openly about the diseases that they usually find uncomfortable, like breast cancer and cervical cancer, etc. This project continues successfully in our Panchayat even today. Many women benefited from this project. We do tests like Mammogram, etc. We do have financial constraints, but still—we have people who come to the camps. When people in our area happen to feel such symptoms and issues, they are willing and empowered to come to the doctor and take treatments for it. I was just sharing one of our experiences here.

Another important thing is that we devised all our activities not just around the doctor and hospital. We planned it towards converting our immediate surroundings to a healthy one, in such a way that it started from farming and ended at the level of hospitals. Waste management was the main factor affecting our food and environment. Diseases break out from unhealthy surroundings. Now, we have facilities that even include a plastic recycling unit. We were able to implement all that without any issues. We were able to link all our projects to healthcare. Our motto was "Healthy Marancheri" ['Aarogyam ulloru Marancheri' in

Malayalam]. So, whatever projects we took up, we were able to connect it ultimately to the health sector. That was my experience. There were interventions in farming, waste management, and the environment. We explored how we can ensure safe drinking water and quality air to breathe when we first started thinking about Healthy Marancheri. Because that was a must if we wanted to make Marancheri healthy. Like what Mujeeb Master said, if we are talking about a highly morbid Kerala, it is not practically possible for a single Panchayat or a region to survive that. So, we were planning our projects to help our area and community towards that goal, step by step. Our environmental activities were designed like that. Water conservation activities were also planned like that. Decentralization and the Peoples' Planning Movement opened up a big opportunity for LSGs. In my experience, such an opportunity can be used in the best way in the health sector. Apart from that, rather than looking at health activities merely surrounding the doctors and hospitals, we addressed issues of the elderly, women, children and challenges faced by differently-abled²² people. In the case of physically challenged babies, we start thinking about physiotherapy only when it is time for schooling or maybe after five years of age. That is where LSGs can play a role. With decentralization, we got an opportunity to see and engage directly with such situations. I believe that is the biggest success story of decentralization. There were a lot of limitations when things were decided from the top. But when decisions were taken from the bottom, we were able to enumerate the number of differently-abled children, understand what were their challenges, what are their health issues, what of all those issues can we intervene and give a solution [for], etc. Thus, we were able to prioritize and allocate sufficient funds required for that.

We have reached Aardram Mission²⁶ now, and Mujeeb Master earlier indicated the idea of family doctors. As part of Aardram Mission, our health institutions are becoming Family Health Centers

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

now. This is a great opportunity for LSGs now. Some examples like Noolpuzha²⁷, Punalur²⁸, and Chaliyar²⁹ demonstrate to us about the possibilities, and what can be done to create such models with decentralization and Peoples' Planning in Kerala in my opinion. Similarly, many people are asking what are the areas in the health sector where decentralization has been effective and where it has been a failure. Similar to what Master had earlier said, some stubbornness still exists here. Some [Medical] Officers³⁰ are able to move beyond it, but not everyone is capable of doing it. So, we should be able to make a system that enables everyone to do things. When we plan some projects there are several hindrances faced by us. Sometimes, the guidelines are a block. But sometimes at the local level, some other officers are able to see beyond the ones who design these guidelines. That's how we are able to come up with newer projects. During the last Government, we formed a committee just for such innovative projects. We were able to move to that level. But even before that, some doctors who were socially sensitive were able to play a major role in that. We were successful there. Whether it's Noolpuzha or Punalur or Chaliyar, we should never forget that there were Medical Officers who worked shoulder to shoulder with the Panchayat presidents. In the health sector, it is not the executive committee that forms the system. We have Suresh Babu here. These are the success stories of their efforts to put this system together as well.

Like I said earlier, we are still facing some challenges. I am not sure to what extent Madam will agree with me on this. There are some organizational blocks and issues here even today. Even then, the moment we realize that we are all together and part of the community and that we believe in our ability to create such models, we all will be able to set aside all those issues. Decentralization has handed over

to us such a revolutionary and coherent system. I agree that there are drawbacks, but as someone who got a chance to participate right from the beginning, I would still say the positives are more than the drawbacks. This opportunity where we are all sitting talking about things like this itself is an outcome of decentralization of power. Our experiences tell us that, even though there are many political parties, and we alternate governments each time, I don't think that the political parties can stay away from good things. If we come up with a development project that is a real requirement for a region, in my experience—and this is my personal opinion—, everyone will support and stay with us beyond politics. For example, when we were a minority, I mean our council was with nine members and the opposition had 10 members. When I was the President, the executive council had stood with me for all the progressive decisions that I took for the benefit of the Panchayat. Not even a single decision had to be taken based on the majority. We were able to discuss it as the decision of the governing council. I was a Panchayat president who was fortunate to receive an award constituted by the Government of India, for the best Panchayat in Kerala, for the past four years consecutively. We were able to do that because we presented development projects that the people really wanted. Political differences are a matter only during the elections. There will not be any other factors otherwise. So, we should be able to take the others into confidence in that sense. Our Peoples' Planning Movement gives us that kind of an opportunity. Our working groups, development seminars, planning committees, Grama Sabhas³¹, etc. are common platforms for that. If we effectively utilize that common platform irrespective of political differences, in my experience we will be... we will be successful.

I am not extending [this] further. I think it has been

27 Noolpuzha is a Village Panchayat in the three-tier panchayat system in Wayanad district

28 Punalur is a Taluk in the revenue district of Kollam

29 Chaliyar is a Village Panchayat in Malappuram district

30 "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://clinicalestablishments.gov.in/WriteReadData/360.pdf>

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

quite long already. There are questions about the inherent characteristics of Kerala, and the lessons that Kerala can put forward to other regions in terms of decentralization. Kerala is indeed a model in this case. Many such models are being brought about in Kerala; not just the health, but in terms of the education sector, etc. We started talking about Yoga Day only recently. All our projects were focused on the health sector. The major challenge that we face today I guess is the lifestyle disorders. To address these lifestyle disorders, we need to democratize the NCD [Non-Communicable Disease] clinics³² even more. I think we go for treatment only when they are properly diagnosed; maybe that is because we have access to medicines and facilities. The LSGs should focus now towards how to ensure a life condition that's free from diseases. Such interventions should come from the governing councils towards that goal in Kerala now on. We have a lot of facilities, but we should be able to reach a level where no patients will have to use them.

About the question on what role this Movement has played in tackling the present-day diseases like COVID. Without a doubt, we can see that it was the LSGs' strength that enabled us in our defence against COVID along with the Health Department. Sometimes even more than the Health Department. I mean, it was when a system that was very close to the people interacted with them directly; working with the government, we were able to tackle it. In that sense, I am sure that Peoples' Planning and democratic decentralization was indeed a success in Kerala. I will stop after sharing one of my concerns. In the wake of 25 years of decentralization, we should really introspect whether we really are able to reach the level that was envisaged. I am putting forward my concerns

here in this forum regarding a centralization process that is happening. I have always personally felt that there were tendencies to take back the powers once bestowed on us, whether it is in the case of Aardram Mission²⁶, Haritha Keralam Mission³³, LIFE³⁴, or even public education campaigns. It may not be a conscious effort. But still I sincerely felt that there was some bureaucratic centralization. I am expressing it here in this forum very genuinely. We should also be aware of such things. We should be able to make these LSGs as local Governments. We should definitely work with the State Governments and their projects to bring about structural changes in our society. At the same time, there is doubt if there are some centralizing tendencies over the LSGs and their powers. Along with allocating funds to the local levels, there should be plans from the top and funds for those projects (e.g., Complementary Nutrition, SSA).

The funds allocated for the LSGs are being spent on such projects. So, when there are such mandatory utilizations, there will be limitations on creating and implementing independent projects.

The LSGs are capable of planning projects taking into account local resources. And I would like to reiterate that we will be successful in doing that.

Sairu Philip: Thank you Adv. Sindhu Madam. Wish you all the best. Now, Snehajan Sir.

Suresh Babu: Mujeeb Master and Sindhu Madam, who spoke earlier, described things from their experiences. I will stop from where Sindhu Madam stopped. In the context of 25 years of the Peoples' Planning Movement, if we look back, I feel a high tide of memories related to activities and experiences in front of me. Hence, these experiences should be decisive in deciding a sense

32 Within India, the burden of Non-Communicable Diseases (NCDs), such as cancer and diabetes, continues to increase. In 2010, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched to support the strengthening of "infrastructure, human resource development, health promotion, early diagnosis, management and referral." Under the NPCDCS, at the District and Community Health Centre levels, NCD clinics "provide services for early diagnosis, treatment and follow-up for common NCDs." See: <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1048&lid=604>

33 Haritha Keralam is an umbrella mission under the Pachathuruthu (green spot scheme) implemented by Kerala state government to integrate the components of Waste Management, Organic Farming, Water Resources Management. See: <http://haritham.kerala.gov.in/homepage/>

34 LIFE Mission is a massive housing campaign initiated by the Kerala state government to build houses for families without land or housing. The program has an emphasis on financial empowerment, and rehabilitation to landless and homeless individuals. See: www.lifemission.lsgkerala.gov.in

of direction forward when we celebrate 25 years of Peoples' Planning. This seminar organized by The George Institute is extremely relevant in that sense.

There have been some attempts at decentralization in Karnataka and Bengal even before it was implemented in Kerala. But none of them were successful, I believe.

The birth of Peoples' Planning can be attributed to the foresight of the Left Government of 1957 in Kerala. Under the umbrella of Land Reforms, we can see the steps towards that in its engagements with the four pillars of Public Education, Public Health, Public Distribution, and Public Transport.

Several other policy programs were implemented by the subsequent Left Governments that got into power in Kerala. The Complete Literacy Movement of 1990 was born as a continuation to that. The Government was able to make significant popular movements through the Literacy Movement. The continuity and development of such popular movements led to the Peoples' Planning Movement.

The earlier development interventions at the local level in five Panchayats, including Kalliasseri³⁵, under the title of Participatory Panchayat Level Development Planning (PLDP)³⁶ and subsequent resource mapping, etc. gave the courage to effectively implement Peoples' Planning.

As part of PLDP interventions, we can understand that, at the crux of local development lies a distribution plan based on the availability of local resources and realization of local challenges.

Since the resource mapping/primary data collection that was essential for local planning was not carried out efficiently, the data was randomly collected. Though it was not scientifically implemented in our areas, that is how we began.

By the time we started with the 13th plan in 2017, we had prepared status reports from all the sectors. We collected relevant primary and secondary data from each region, and we made interventions based on that. In the health sector, the Government was able to prepare a health status report and give training and support to all the LSGs to prioritize and tackle all the issues based on that report as part of Aardram Mission.

There were major interventions in the health sector as part of Peoples' Planning. I am a Parishad³⁷ activist and I work as a Health Inspector³⁸ along with that. I also work with KILA³⁹ and Aardram Mission as well. With the help of public interventions and Aardram Mission and subsequent interventions, it is a matter of pride that, today, many local activists and workers, including elected representatives, are able to comprehend many issues that were considered to be really complicated previously.

What Mujeeb Master and Sindhu Madam explained here with their experiences, like the mammogram, etc., are clear examples for that. And whatever leaders aimed to target, like the lack of availability of clean drinking water, sanitation issues, sickness, etc., we are marching towards that and that can be said as an overall outcome of 25 years of Peoples' Planning intervention in the health sector.

When we highlight the Family Health Centers

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

36 The Sustainable Participatory Panchayat Level Development Planning (PLDP) project began in May 1996. The major objectives were to evolve a set of models for participatory and sustainable development planning in the principal eco-zones of Kerala and to develop local expertise for the preparation of development schemes and plans. See: <http://www.cds.ac.in/krcpds/pldp.htm>

37 Kerala Sasthra Sahithya Parishad (KSSP): Founded in 1962, KSSP was ideated as a progressive people's science movement consisting of science writers and teachers with an interest in science from a social perspective. See <https://kssp.in/>.

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

39 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/>

and their services envisaged by Aardram Mission, we should remember that such a shift was made possible as a result of two decades of peoples' intervention. We need to improve many things in terms of infrastructure of Family Health Centers. And we also need to improve their services as well even further. Such interventions are required in the case of sub-centers also.

We need to focus on empowering the Health Centers at the local level and also on making their services more effective. I understand that at the beginning of Peoples' Planning, 32% of people used to depend on our public health facilities. When I say public health facilities, it includes even Primary Health Centers as well. Now, when it is turning 25 years, it has increased to 46% as per the latest study report about "Keralam engane chindhikkunnu, keralam engane jeevikkunnu" (How Kerala Lives, How Kerala Thinks) by Parishadh³⁴. I guess it must have increased to 50% during the COVID times. That is a major transformation. I mean, the increase in the number of people depending on public health services shows the good quality of their services. That is definitely an outcome of the engagements done by Peoples' Planning. Other than that, we know that the movement was successful in bringing in the concept of Comprehensive Health Care throughout Kerala. It is very important that the LSGs be able to implement preventive, promotive rehabilitative, and palliative concepts with people's participation. We have a number of examples in front of us in the area of palliative care. Muhamma Panchayat is a good example. Palliative intervention

campaign in Malappuram is titled as "Parireksha"⁴⁰. Similarly, we have a number of remarkable examples for Comprehensive Health Programs.

Sometimes we also can see some experiences at the local level where we were unable to include many NHM⁴¹ projects under the Peoples' Planning projects. I believe the NHM projects that follow centralized planning and implementation are in contradiction with the concepts and projects of Peoples' Planning that incorporate local resources and address local challenges. ASHA⁴² is now implemented under NHM and we should really appreciate that. The fact that the RRTs⁴³, Health Brigade⁴⁴, Green Army⁴⁵, etc. worked shoulder to shoulder with ASHAs is a really important aspect. For the next phase of action of Peoples' Planning, activities towards those goals have to be envisaged. I believe that the second phase of Aardram has already formulated a project in this regard.

Another thing is that, in Kerala, fuel for LSGs in its COVID prevention activities was derived from the strengths achieved through Peoples' Planning Movement and Aardram Mission. It is remarkable that we were really able to incorporate and coordinate all that we assimilated through these 25 years very effectively into all the activities of a Panchayat. We should not fail to understand that this is also the strength of Peoples' Planning. This is where we actually get convinced about what exactly an LSG is.

There are a couple of things that I would like to point out as criticisms. We still have a system of dual

40 Parireksha was a comprehensive palliative healthcare program which was started in two or three panchayats of Malappuram district in 2002; it was completed in 2006. Following this, it was taken up by the Malappuram District Panchayath and to rest of the panchayats of Malappuram district.

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

42 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>

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

44 The Covid Brigade is a group of health care workers and volunteers working to control and reduce the spread of COVID-19 within Kerala. Specifically, they function as human resources within Covid First Line Treatment Centers (CFLTCs), hospitals, care centres, etc. See: <https://covid19jagratha.kerala.nic.in/home/covidBrigade>

45 Green Army is an initiative of Thiruvananthapuram, the capital city of Kerala, India. The initiative's mentors provide school children with educational resources on sustainable living practices such as segregated waste management. Mentors additionally support schools in implementing their own "green" initiatives. See: <https://tmc.lsgkerala.gov.in/sites/default/files/2019/Green%20Army.pdf>

control on the institutions that we handed over. That, in fact, creates hindrances to the activities of LSGs. For example, the chairperson of the Standing Committee⁴⁶ of Health or President can attend the sectoral conference convened through the Health Centers to plan its future activities. But that doesn't get institutionalized. It is not like the President or Chairperson of the Standing Committee is doing an evaluation as part of the daily activities. This evaluation is not like punishing or anything of that sort. It is working together or facilitating or motivating. The issue is that there is no space for this. And under some "unavoidable circumstances," some restrictions should be placed on some officers as well. The emphasis is on the word under some "unavoidable circumstances," I am keeping it in inverted commas as there are chances to misuse it. There are two issues. Power over the institutions should be handed over to the Panchayats. It should be the Health Inspector of the Panchayat. It is Department Health Inspector even now. It should be Panchayat Health workers and Panchayat doctors. That kind of control. The institution gets better when it gets transformed in all levels. We should be able to transform our people into good effective leaders like Sidhu Madam and Mujeeb Master. That is something I would like to point out in terms of a prospective direction.

I remember two friends had come from Hong Kong to learn about our experiences in 2000. I was with them for 10-15 days as a guide. They were very surprised. 21 years back, they were spending around 12 hours on the computer, like how we do now. I remember they presented the cooperative activities and the keenness to record all this as an experience note at the World Social Forum, which I also attended in Bombay. Many rich countries in the world are observing what we do here with so much expectation. We need to recollect and read some of our undocumented models.

We need to address the issue that many times we lose the continuity of the activities with the transfer of an Executive Officer. We are weak in documenting things. We could see this when investigating many other things. The experiences of Sidhu Madam should not cease to exist after her term. The experiences of Jayashree Teacher in Karimba Panchayat⁴⁷ will disappear after her term, or it will stay for a maximum of two or three years. A lot of publications have come up. I remember many innovative and systematic interventions had happened. The project with an intention of raising the haemoglobin levels in pregnant women. It was not just a project. It was a comprehensive program. Farming, hatchery, women's collectives for that, etc. I am only trying to say that I am really sad that such things were not documented properly. That is the reason why Isaac Sir is collecting experience notes with hashtags. However, we should improve and rectify the mistakes and take it forward.

Aardram Mission was a virtual mission. In fact, there was no coordinator for that. The activities were envisaged under the Grama Panchayat Presidents and Panchayat Health Standing Committee at the Primary Health Centers. There were no centralized interventions in Aardram. [Only] some guidelines. If you want to renovate the building, we will give 15 lakhs supplementary funding. If you have such and such needs, you could attract more people. Wherever mistakes have happened, they have to be rectified. Aardram Plus is coming up. We have to rectify the mistakes and go ahead strong and thus I conclude my words here in the first phase. My greetings

Sairu Philip: Thank you Suresh Sir. I would like to ask you about something: the potential of NHM. I mean, the complementary potential of NHM for Peoples' Planning. Have you noticed it any time? Or during COVID times?

Suresh Babu: I think the others can add that on during the discussion.

46 In every Panchayat, standing committees are constituted to perform various functions across specific areas. The Standing Committees of the Panchayats may perform other powers and functions of the Panchayat as may be entrusted to it by the Panchayat in addition to the powers and duties conferred on it by rules made in this behalf. See https://cag.gov.in/uploads/download_audit_report/2009/Kerala_TL_Local_Self_Government_Institutions_2009-10_APPENDICES.pdf for various Standing Committees at the level of LSGs in Kerala.

47 Karimba is a panchayat in the district of Palakkad in the southern Indian state of Kerala

Sairu Philip: Okay. That can be done. Thank you. Snehajan Sir. You have enough experience to talk for hours. In terms of innovative projects. Snehajan Sir? Particularly in the case of "Aardram Ee Aaryadu," gender-sensitive Panchayat. Sir, can you hear us? Okay, then let's move on to Sibi Sir. Suresh Sir talked about before NHM or before and after Peoples' Planning... Could you please talk to us about the differences or the possibilities?

Sibi Augustine: Namaskaram to everyone. Respected Sairu Madam, my dear fellows. This was an exciting reminder. We felt it came from straight out of their hearts when we listened to the leaders of the people. Like Suresh Said, the fact that our leaders are able to get deep into the micro levels of health itself is the success of our decentralized planning. I think this is a special situation for Kerala. I think there was an awakening focused on the need for independence in Kerala like elsewhere in India, even before we gained Independence. The peculiarity is that this energy of renaissance was maintained by the subsequent governments in Kerala. Like Sindhu Madam said, since none of the political parties or systems could resist or negate good things, they have to continue and take it forward. Things went on without major changes in the activities. However, until the 73rd and 74th amendments were implemented, there were many challenges in the health sector and the health status of people.

In terms of Government services, the material conditions were not that great. Some places did not even have a good chair for the doctors to sit. There was a scarcity of medicines. For poor people, it was these charity hospitals that they could depend on. When those charity hospitals became poor, the health services for the common people were also under crisis. People had to spend more money and they also had to travel long distances to avail health services. That made things worse. Health really affects people and society so much. The pain caused by diseases and the subsequent issues, their labor and physical capabilities, etc. caused major crises. The charity hospitals were the major health institutions of those times. But its deterioration caused major issues for common people. So, the

major changes that happened with the help of decentralization was in the health sector itself. The fact that the LSGs were able to improve the material conditions and intervene directly to avail medicines, etc. brought about big changes. In fact, there are some really emotional experiences. I saw a question regarding the concepts behind decentralization of power. It was that people were able to identify their problems on their own and they were able to find out a technically feasible and economically viable solutions with the help of their elected representative and with the experience of a local expert such as a health inspector or health worker. It is also important to note that those solutions were addressed without the help of a vertical planning. I mean to say that plans were made according to the local conditions rather than at a higher level. We know India is a land of diversities. Kerala itself has so much diversity. In that case, since we have different issues at different places, it is important to know that vertical planning has many limitations. Thus, the intervention of Peoples' Planning during that phase was a major relief. The experience of Peoples' Planning brought about so much of a relief to the common man when they felt that someone is listening to me, that changes happened as per my suggestions, medicines are available in my hospital, we have a permanent doctor, I can avail treatment when I visit my hospital, etc. These great models were made when problems were identified, prioritized and understood on how to support the LSGs to address these problems on the basis of that priority. The unique palliative care projects, etc. are considered as such models. These should have been the by-products of the freedom offered by decentralized planning. The feeling that these are our problems; these projects are being planned to address the crisis of bedridden patients in our village have resulted in major social changes.

The intervention in the Health Allied programs is also a major achievement. Interventions were made mainly in the areas like drinking water, waste management, and hygiene. The realization that mental and physical wellbeing cannot be attained only by intervention directly with [medical] treatment and medicines brought about significant changes. A drinking water project was implemented

in my area in that context. Unfortunately, we have a lot of challenges with regards to safe drinking water. The problems of urbanization and issues of waste management, etc. really affect the quality of safe drinking water. Nava Kerala Mission is tackling such issues. This opened up ways for systematic planning, intervention with people, and consulting with people while addressing their own issues. This is because of the implementation of Peoples' Planning itself. I guess that is the central idea behind it.

What are the major projects implemented under decentralization of health? These are the activities. Empowerment of PHCs is a major achievement. Earlier if it was communicable diseases, now even non-communicable diseases also are major problems. I remember diarrhoea and skin diseases were widespread among common people around unhygienic surroundings. I think Madam may know. There were diarrhoea wards, but we don't have such wards anymore. The epidemiological transition is a reality. Many new epidemics appeared. Old ones are resurfacing. Many vertical National Health Programs were implemented here during a phase when there was no say or chances for interventions for the Panchayats, whether it's campaign against malaria or vaccinations for smallpox. But even those national health programs that addressed the common health issues in India were effectively implemented in Kerala's health sector with the help of the Peoples' Planning Movement. Perhaps whether it is Alma Ata or subsequent Millennium Development Goals or even [Sustainable Development Goals] SDGs, we are able to coordinate our health sector by utilizing the opportunities at the level of LSGs and lead us towards development precisely because our primary health care system emerged from the bottom. It just did not happen randomly.

One of the benefits of decentralization, like what Suresh said earlier, was the fact that the idea of Universal Health Care—something that was limited within the circles of just doctors or technocrats—was democratized and spread among common people through our health workers, people, and

elected representatives. Aardram Mission was conceived in that context. Aardram or Nava Kerala Mission, in fact, communicates to us the need of a development planning that is centered around health-oriented activities. This is with a view to reduce the burden of diseases under LSGs, to enhance their capacities, and also to bring down per capita health expenditure. The most dangerous indicator of Kerala is that of the highest per capita health expenditure on treatment. We have a lot of out-of-pocket expenditure. We are facing so many crises, we are moving through transitions from one epidemic to another, etc., and our state average surpasses national and even world average—especially hypertension and diabetes, it is a critical situation. Kerala's per capita alcohol consumption is also really high. Our lifestyle has changed so much in that sense. Lifestyle means a pattern of life followed for a long time. To regain a healthy lifestyle, we can work only at micro levels for that. Then we can bring in infrastructure, medicines, and new projects like palliative care, etc. into this sector.

Now, the central question is which area should be given more focus with the health sector. That is exactly what I said earlier. Kerala's first- and second-generation issues are mainly high morbidity and the high rates of treatment expenditure caused by high morbidity which push many families into impoverishment and bedridden conditions. Such desperate situations affect the mental health conditions of many people in Kerala. So, now we should really prioritize on the fact Comprehensive Primary Health Care or Comprehensive Health Insurance should be made available for everyone. Depending on the age and health status or his social factors or determinants: based on these three factors, we should give health enhancing services to a healthy person, or maybe preventive services. We may have to give treatments to sick patients. Thus, by pointing out each individual at the local level, we should work out things. Now, we have implemented an electronic health report system. So, we should map his health needs focusing on each individual. It can be called a service package. This is also required to achieve the goals of the Aardram Mission as well. Along with this package,

there should be a plan for service delivery and service distribution. For a bedridden patient, these services should be provided by palliative care. The palliative services and survival support for the family also should be delivered to them. All this has to happen under the vigilant leadership of LSGs and elected representatives. It should not just be government officers working for that. There should be a public sphere for that. This is what was planned under the health brigade and Aardram Mission. We really need to nurture this beautiful concept of Aardram even further. It should really flourish. So, the focus within the health sector should really be on providing a comprehensive primary health protection. We would be able to get its immediate results if we provide comprehensive services. First, the morbidity rates will decline. Then, the illnesses will come down, which will lead to the reduction of expenditure for treatments. That is a very important aspect. To reduce the treatment expenditure, we should set up the institutions, improve the quality of services, and better the attitude of workers through Aardram Mission. To make qualitative changes in the attitude and improve conditions, the LSGs can really play the role of a vigilant guard and definitely provide support anytime like Suresh said.

The ownership of LSGs is one of the major characteristic changes brought about by decentralization. We can see this in boards of many schools and hospitals. For example, Marancheri Panchayat Primary Health Center, Marancheri Grama Panchayat L. P. school, etc.:⁴⁸ This, we can see not just on the boards. The people who elected these representatives to the Panchayats are also confident. I see this ownership as a major aspect. I am only adding to many things that are already mentioned here. The possibility for monitoring the activities or to control the direction of it or even to correct the officers when needed, etc. are the peculiar features of decentralization of power. One could say that it even reached a social auditing level

as well. That is yet to be realized. There are many reasons behind it. I would not want to discuss those things here.

Lessons for other states from Kerala: The most important lesson is exactly what Sindhu Madam said. Even the most counterproductive person, pointing out issues of caste, religion, race, class or politics, will not be able to stay away when something good is happening to the society. So, I strongly believe that there is a potential within this to break all the barriers, provided the system tries its best to genuinely do something good. Working groups like these are organized beyond such political differences. There is a lot of potential for Grama Sabhas for such cooperation. The other is the potential for peoples' participation. Perhaps we may not find this potential in North India. We will see a group of people assembled in front of a community chief. A group which says yes to all that he says.

Regarding NRHM, I agree with one of the things pointed out by Suresh. There are many vertical programs supplementing our local planning. That is important. Sometimes such vertical programs have also become parallel. But during COVID particularly, NRHM was able to provide us with such a huge [amount of] human resource, whether it is doctors or staff nurses. 15th finance commission⁴⁹ recommendations have come. That means empowerment of all the PHCs. When that happens, there is a guideline that there should be a system of multi-level service providers and a male-female health worker as well. So, the crisis is that our sub-centers do not have such a human resource. NRHM can really support in that situation. At present, they were able to really provide human resources as per our requirements. It is an important thing. Perhaps many of the national health programs are funded by NRHM. We are not ignoring all that.

But as part of Peoples' Planning or as part of

48 Marancheri is a panchat in Malappuram district of the southern Indian state of Kerala.

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

planning, perhaps Madam may remember, a concept called the Comprehensive Health Plan⁵⁰ was introduced 2013 or 2014 onwards, I think. This Comprehensive Health Plan was a continuation of Universal Health Coverage (UHC). When we were planning this, we faced number of issues. First, we were worried about audit issues. Implementing officers were given training and were empowered. It was the time when the Sulekha software⁵¹ was launched. All the implementing officers and doctors in the Health Department were assembled and were given training on Sulekha software, and some basic lessons on plan formulation, financial guidelines, etc. in [Kerala Institute for Local Administration] KILA 37. But it was not an initiative by NRHM. We could only say that we were utilizing NRHM funds, because there is a fund called social development fund under NRHM. So, we were able utilize that fund usefully. "Arogyadarshan"⁵² was another program showcasing really good projects and we broadcasted it in Doordarshan⁵³ as an FGD [Focused Group Discussion]. We presented it as a panel discussion. The governing council members of the winners of the 'Best Panchayat Award' had come and explained their activities and how they were able to achieve this award. We were able to do it because we knew how to make use of that system well. Such possibilities are still there. With better willpower, we can still do it. Ward Health Committee gets a small amount. Now, the Grama Panchayats receive Rs. 10,000 each. Similarly,

Suchitwa⁵⁴ Mission brings in some funds. There are some funds from the permissive sanction funds of the Panchayats. We should be able to make use of these funds well. It is a limitation that we are not really able to make use of Ward Sanitation Committees. It is like a drawback. In some places, it is not done properly. In some municipal areas, there are some limitations. In the rural areas, it's functioning well.

This is what I had to say about it. We have something called "Arogya Kerala Puraskaram"⁵⁵. To be honest, people like Suresh are the main forces behind it. It's done by assessing the initiatives of a Panchayat based on how much of the plan allocation was spent from the funds allotted by the micro sector board projects and also by investigating their innovative and allied sectors activities, etc. From 2016 onwards, it was renamed as "Aardra Kerala Puraskaram". However, I am going to wind up by saying just one more thing. I talked a lot. I can say that I was really excited after listening to all the other speeches. I just finished a trip to Thrissur⁵⁶. It is indeed decentralization that gave Kerala a facelift. A number of good souls who travelled with it and took it forward have brought about a lot of changes. I could be involved with "Ardramee Aryad"... I don't think Snehajan Master remembers me. When I saw Master's photo here, I was reminded of those days when I had visited there. So, such small projects were made possible

50 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 boosting regulatory mechanisms to ensure quality of standards. The order was issued by the Ministry of Health and Family Welfare; accordingly a district health plan of the district was drawn out for every LSG 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

51 Sulekha is the plan-monitoring software developed by Information Kerala Mission for Local Self Government Department of the Government of Kerala for the formulation and monitoring of the nearly 2-lakh annual decentralized plan projects of Local Governments. See: <https://plan.lsgkerala.gov.in/formulation/>

52 Arogya Darshan is a programme series jointly produced by National Rural Health Mission (NRHM) Kerala Health Services in collaboration with Doordarshan Kendra, Thiruvananthapuram. It depicted innovative health initiatives implemented by the local self-governments as part of the Comprehensive Health Plan. See: The health series which is first of its kind in television is the visualization of these health projects by the award-winning local self-governments. See: <https://www.newindianexpress.com/cities/kochi/2014/jan/01/Doordarshan-Celebrating-30th-Year-558313.html>

53 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/>

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

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

56 Thrissur is the headquarters of Thrissur district, which is located in the center of the Indian state of Kerala

as a result of Peoples' Planning. We should all join hands together for Aardram Mission as well, because it is a social need to reduce the treatment expenditure of people. I will stop here with one more thing. Our planning and activities get stopped at the level of Primary Health Centers. There is an institution below that: health sub-centers. We need to empower these sub-centers. Aardram Mission is envisaging five clinics: Nutrition Clinics, Clinics for the Elderly, Wellwoman Clinic, and NCD clinics. When we examine the data from last year, we can understand that the LSGs should focus more on screening everyone above 18 annually once. When we analyze the data, we will get three categories of people: people who were under treatment, disease prone, or at the stage of hypertensive or pre-diabetic stage. The people in the hypertensive or pre-diabetic stage are part of a precious group. We should help them not to become sick by lifestyle modifications. 20-30 is the percentage of hypertensive population. All this should happen at the sub-centers if it has to be effective. Because medicines for lifestyle diseases were distributed through sub-centers. It was stopped with a court order. But the court has given permission now to resume it. So, we should restart distributing NCD medicines through sub-centers. Sub-centers have to be properly empowered. And Aardram Mission is planning geriatric clinics at the sub-centers for elderly care. These clinics should be there everywhere. That is about sub-centers. The elected leaders should really learn about Aardram Mission: about what all services are provided there, the protocols, and monitor whether that is followed, etc. In case their services are not provided for genuine reasons, the Panchayats and the people should support them to overcome it. Or else such services should be implemented and ensured with a strong will. That's all that I have to say. I spoke a lot.

Sairu Philip: I think Snehan Sir can start from where Sibi Sir stopped, because Snehan Sir has so much experience especially regarding NCD clinics, lifestyle disorders, etc. So, I invite Snehan Sir to talk to us.

Sreejini J: Due to some issues with the audio, he

just left the meeting. He had told us that he would be joining us soon, but now he is not responding.

Sairu Philip: I thought he could add more to it from where Sibi Sir stopped. Does anyone have to say anything to supplement this until Snehan Sir joins? Mujeeb Sir, do you have anything to say?

Mujeeb Master: I have a couple of more things to add to this, Sir. Sindhu Madam pointed out something that we are discussing now in the context of 25 years of Peoples' Planning: that the powers are retracted. But I think that waste management is one of the basic responsibilities of the Panchayats. It is part of their mandatory responsibilities. But please have a look. Kerala is becoming a heap of waste. It is not that we don't have LSGs. It is with the interventions of the Haritha Kerala Mission that we could scientifically manage the waste, at least to an extent. So, if the people who are given the power are not really utilizing it, we will have to give back all the fines that we had collected. We discussed the LIFE Mission here. It is important that we discuss it here itself. 71,000 houses' constructions were stalled at many stages during 2015-2017: some at the foundation level, some with the walls, some at the level of lintel. Why did that happen? Those houses were sanctioned, and funds were allocated by the LSGs. It was completed with the money sanctioned during the first phase of LIFE. That's because these houses were sanctioned for people who were not in dire need for houses, and they moved to another house later. The Panchayats are unable to intervene in this. That is the issue here. And it is in that context that we come up with 400 square feet limits. I am not beating around the bush but yes there is an issue. Same is the case with Aardram. Indeed, there were some advancements when it was handed over to the Panchayats. But it is also important to realize that we come up with advancements now that we may be able to imagine after 30 years. Kerala's vision is going in that direction. You see the advancements in online learning methods. We are using technologies that might have been introduced 15 years later. Would we ever have experienced this Zoom platform had COVID not hit us? I don't think

I would have used it. We are using technologies that are 15 years ahead of us. So, we did all that to enhance the activities of Aardram Mission. But what is the base of the Aardram Mission? Suresh was indicating here that it's a special body that includes health chairman and Panchayat, etc. We need to see that it is that body that takes forward the whole activities of Aardram Mission.

The basis of decentralization of power is the Grama Sabha. I am reminded of the first Grama Sabha of the 88-89 period. Around 300-400 people were gathered in a ground. And then we are divided into groups. I think there were eight groups. Now, we have even 13 groups or so. And we start our discussions. What did we discuss? We did not discuss the need for medicines or doctors. I still have that book we used for the discussions even today. What came up in that discussion? Like I said earlier; that a person needs a toilet, we need drinking water: health and sanitation were put under one group. A sound health consciousness and subsequently a realization that people were able to recognize the factors leading to health were the factors that took the decentralization process forward. I have another experience. I am a member of a Panchayat that compulsorily convened a Grama Sabha for children. We got a national award for that. Do you know what was the experience that we gained from conducting children's Grama Sabha for a year? They were suggesting things even better than the grown-ups: that the Panchayat should organize events against addiction, there is this sanitation issue, some hygiene issue near our house, etc. Even today, when we go to the Grama Sabhas of the grown-ups, they still talk about constructing and renovating houses. But during '98, the children used to discuss things like grown-up people. That proves that our decision on the participation of people in decentralization was never a mistake.

When we talk about COVID, I need to say something here. We used to talk about water bodies projects. What is that? We need to control the storm water, slow down its speed, and put it to rest at the slanted lands of Kerala. We did a similar activity in the case of COVID. We slowed down the furious COVID first. And now, we are trying to put

it to sleep. But what happened in other parts of the country? It flooded the other states and, with that strong flow, we saw oxygen shortage and dead bodies in Ganga river and heaps of waste here and there. Why did that not happen in Kerala? That is an appreciation to the foundational participation of people in health. We should definitely say that.

Another thing that I wanted to suggest is that more people like Sairu Madam should be there in the Medical Colleges. I think it was in 2016 that we met. I came to the Medical College for something and at that time we were strangers. I was the member of a ward that was facing a serious crisis. The crisis was that it was always the ward with the least number of vaccinations. I used to get the prize for the least number of vaccinations. Sairu Philip Madam came to that kind of a ward with her medical students. 100 medical students visited the 400 houses in that ward, and they conducted awareness classes with the help of doctors. And now I have moved from the first position to third because of that. I was trying to say that we are not able to exploit the services of the medical professionals at the ground level. It still remains as a limitation. Even though there is a compulsory rural service for doctors, where is social service these days? These days, the PGs and doctors are not really keen to come for social service to help the ground level activities. We really need to make some networks for that. If we have more people like Sairu Madam in the Medical colleges, that can be resolved.

Another thing I want to say is about palliative care. I look at it from a different perspective. What is palliative? They call up and ask when are you coming to bathe my father or maybe mother? That is a major issue with palliative care. Think of this. We used to bathe elderly people in our houses. We used to comb and tie their hair. We used to give them treatment with the help of our family doctor. Now, we are witnessing a situation where people are waiting for palliative workers to bathe their parents, to tie their hair, or to apply some powder on a bed sore. That is not how Kerala should become. I strongly believe that we need to go back. I agree we need the services of our palliative care, but to what extent? I think we need to train our

children and inculcate a mindset to take care of the elderly at our home. I have another thing to say. Anganwadis⁵⁷ collect the most data in the world. They have most first-hand data, with the Integrated Child Development Services (ICDS)⁵⁸. Have we ever got a chance to make use of that data? I am not sure about the departments. It was not adequately supplied to the Panchayats. Data is very important for planning. When do we need to plan? When we have less resources and more demands. That's when we need to plan. And not when we have a lot of money and only limited needs. We can distribute it randomly. But the data collected by Anganwadis are utilized not just locally but also on a larger level.

I got reminded about something else when we spoke about Anganwadis. These days, we distribute nutritious food for adolescents. The boys at the Grama Sabha for children asked me why are they not getting it and why is there a discrimination, etc. I am not pointing to that angle. But do you think people are educated about why adolescent girls are given such a nutritious health supplement? In my ward, we distribute something called 'Nutrimix'. Who are they giving it to? It's the dogs and cats who are getting healthy. Should we not investigate why adolescent girls are not eating it? I conducted a proper study in my ward. I was trying to educate them that it is the right of a child to be born healthy. It has the right to survive. It is for that right that we are giving this supplement. The adolescent girls are going to become mothers in a matter of two or three years. Only a healthy mother can give birth to a healthy child. The Government is spending so much money and doing these things to become a healthy mother. We can make a variety of food items with this, not just eat it as the powder. We can see a lack of education in all such projects. For example, tablets for Elephantiasis and for worm disease. It is a major initiative in the health sector. I am a teacher. I am a headmaster. Do you know

what the children do when we give these tablets to them? How do we give it to them? In a packet these days. It used to come as loose tablets earlier. The children will throw it away. We educated them on that as well. So, such a situation was made possible by the Peoples' Planning as part of decentralization. We were able to do that because we could educate our people about the idea of peoples' participation in development.

If we talk about NRHM, the doctors at NRHM have a pay scale and the doctor appointed by the Panchayat gets a different scale. It is not the same. Within one office, you are appointing two doctors with two pay scales. The center will only give that much. Is that fair? NRHM can intervene from the top and come up with some projects. The Panchayat cannot construct a big dam. That should be decided from the top. But, we should be able to decide on some small things like appointing doctors, paramedical staff, etc. The NRHM is not giving powers to Panchayats who are capable of doing smaller things at the bottom. I don't know if Sairu Madam is aware of this. We were given powers to appoint a doctor for our evening OP but later that was retracted by the District Medical officer (DMO)⁵⁹. They said only they are eligible to conduct an interview to select doctors. It should be done at the DMO level, and they will give a list. The appointment should only be made from that list. And the salary should be given by the Panchayat. We put up a fight, but it was futile. We can appoint but they won't sanction it if it is outside the list. Such dual interventions in the health sector really creates some issues.

Now, you see extreme poverty. This should be read along with what Sindhu Madam said. Why is there extreme poverty in the Panchayats? What stops the Panchayats from giving them food? They have freedom and they have funds, but why is it

57 Anganwadi is a type of rural childcare center in 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.

58 Launched on 2 October 1975, the Integrated Child Development Services (ICDS) Scheme is one of the flagship programmes of the Government of India focussed on early childhood care and development. It is the foremost symbol of the country's commitment to its children and nursing mothers. The beneficiaries under the Scheme are children in the age group of 0-6 years, pregnant women, and lactating mothers. See: <https://icds-wcd.nic.in/icds.aspx>

59 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/>

happening still? So, we are coming up with indices at the state level to address the issues of extreme poverty in the Panchayats. I read it in a recent newspaper. There is no point in complaining that our powers are taken back in a centralized manner. Some of such drawbacks have to be addressed from the top. I am winding it up here. We talked about ward committees. Each ward committees get Rs. 10000 -25000. Do you know what all types of projects that are coming up? For example, mosquito borne diseases like Dengue fever. We spent Rs. 7 or 8 per house and covered the toilet pipes with a net for 450 houses or so. We were able to control the mosquitoes to an extent with the help of that. The funds allocated for the health sector is also for the ground level activities. Bodies that work closer to people will be able to make good use of the funds when they receive it.

I will stop with my experience in '98. We were preparing a Comprehensive Health Plan at that time. We used to take out a paper and write an introduction. We were given training on how to write projects by the clinics. I used to write 20-30 pages, etc. for long hours at night to prepare the Comprehensive Health Plan. We will get a rough idea about the health sector and the locality. Innumerable seminars, posters, processions and classes, etc. were part of it. But later what happened? Now when we use software and put things into the boxes in the computer, sometimes some projects won't even get uploaded. Some codes won't work. That is when the innovative projects were introduced. Now we can do that. As part of decentralization and Peoples' Planning, we were able to make some slots where we can intervene. But we went forward from there. To rectify some of the challenges we came up with programs like Aardram Mission. But it should not be centralized in Trivandrum always. With some primary support, it should be handed over to the LSGs. For example, the Block Panchayats will devise a drinking water scheme and hand it over to the Panchayats. Panchayat will in turn hand it over to the consumer committee. The maintenance and electricity bill payments, etc. will be done by them. That is how we can run that well. Otherwise, there

will be an issue of ownership. It will be like someone complaining about the maintenance of the house after the Panchayat extends support. So, the Governments should be willing to give back their centralized projects and focus on the initiatives with the local governments' involvement.

Like what Suresh Sir said, we cannot forget one organization when we talk about decentralization and Peoples' Planning: Sasthra Sahithya Parishath 35. It contributed selflessly and immensely to facilitate an intellectual environment to foster scientific and rational thinking, and environmental and public health awareness. Today's Aardram Mission and concepts like Family Health Centers, etc. are the results of the contributions from the sharp brains and an intellectual ploughing facilitated by this organization. People like Dr. Iqbal and Sairu Madam have contributed significantly towards this. However, in this Seminar, we were able to talk about the many projects we had taken up as part of decentralization of health in Kerala, like cancer detection programs, initiatives for differently abled²² and mentally challenged, etc. We are screening them with the help of DMRP in Calicut university and we have a vocational training and placement program now. I am not talking about all that due to lack of time.

Sairu Philip: We are not yet able to get through Snehajan Sir, right?

Sreejini J: Unable to get through. I will take another interview with him separately.

Sairu Philip: Thank you. So, do you have anything else to say? In fact, in the two hours that they spent here, they shared a part of their life here, right? Do you have anything to say, Suresh Sir?

Suresh Babu: I would like to gently add on something here. I think Mujeeb Sir gave us some energy. So, I would like to warmly add on something. During the Peoples' Planning Movement, we used to sing, "Let there be toilets in each house before ACs in the palaces." We achieved a hundred percent, Open Defecation Free (ODF)

and then ODF-Plus⁶⁰ between the mosquitos and toilets. We used to run a campaign to put a net over the toilet pipes. But that does not prevent dengue fever or Zika. You should give me a chance to talk about some science here. In fact, there we see a mosquito called Armigeres. Sometimes, they may be Culex mosquitoes. Among them Armigeres is harmless. Culex rarely creates problems. That causes Elephantiasis. We are troubled by Chikungunya, Dengue, and Zika. That is caused by Aedes mosquitoes. So, we need to make changes in our new campaign. It's not that we don't need toilet nets, but that we need to add a new campaign based on our experiences.

Sairu Philip: Okay. That's great. I think it was a cumbersome day today. But these two hours. I specially thank you for inviting me for the Witness Seminar, where Mujeeb Master, Sindhu Madam, Suresh Sir, and Sibi Sir shared their experiences. I thank each one of you for your time and for sharing your experiences. I am sure there will be many more things if we continue. Anyways, thank you very much.

Sreejini J: Devaki Madam is our coordinator. But since she has a small baby, she had to leave early. So, I am closing the ceremony. Actually, we had been here for two hours since 7 o'clock in front of the computer. Like Sairu Madam said, we have been walking around with a camera since 1996. Each one's experience comes up as a visual image in our subconscious mind. We have never seen that personally. But when [everyone] was sharing their experiences: when Mujeeb Sir said about his 11th, we were really seeing him as a 11th standard student. From then until 2021, it was a good experience. We, as researchers, have only read some papers. But all this happened at the ground level—how did these innovations happen, the relevance of Panchayats, etc. all came out in this Seminar. It does not end here. From the video recording of this Witness Seminar, we will come up with a transcript. If anyone has anything to support this in their Panchayats; may be as pamphlets,

booklets, or in the form of some documents, you can give it to us as reference materials. And if you want to add anything more, you have full freedom for that. Once we send you this transcript, if you feel like adding or removing anything, that is possible. It's a big loss that we missed out on Snehajan Sir. When we speak one on one, we will get more ideas [here] than when we speak alone. However, I will send this video and take his point of view. Thank you so much to all those who participated and spent time with us. Thank you.

Proceeding ends.

60 Within India, open defecation has been a primary factor contributing to pollution, malnutrition, and other challenges. India's Prime Minister launched the Swachh Bharat Mission in 2014 to help eliminate open defecation in the country's rural regions. In 2019, "all villages, Gram Panchayats, Districts, States and Union Territories in India declared themselves 'open-defecation free' (ODF)". The Mission is transitioning into its second phase, entitled "ODF-Plus". See: <https://swachhbharatmission.gov.in/SBMCMS/about-us.htm> and <https://www.canr.msu.edu/news/india-the-problem-of-open-defecation>

Individual (follow-up) Interviews

1. Interview with Mr. Sayi Kishore C.

17th August 2021 | Held via Zoom

Individuals Present: Mr. Sayi Kishore C,
Sreejini J, Hari Sankar

Sreejini J: In your opinion, what is behind the decentralization of power in Kerala? I mean, what was the motive behind the effort for decentralization? Can you think of any examples, particularly something that you evidently experienced at the ground level?

Sayi Kishore C: I don't know if we can call ours a unique development 'model.' Scholars like Amartya Sen⁶² argue that it is a unique 'experience' in Kerala: an experience that [has] focused on equity and distribution, that has not been replicated by anyone yet. It moves towards a crisis post the 1970s⁶². The subsequent governments faced crises, particularly in the primary development with respect to sustaining, expanding, and taking the social development and higher indices already achieved further. In that context, decentralized planning was envisaged by the Government as an outcome of some major deliberations to resolve this. Perhaps the first step was probably the passing of Nagarapalika Panchayati Raj Bill⁶³ by the Central Government. The incumbent Government arrived at the idea of decentralized planning that completely reimagined the development sector. It was the result of an exploration about how to exploit the potential of this bill to address the challenges faced by the state. By projecting EMS as the face of its activities, people

like Dr. Thomas Isaac⁶⁴ were able to legitimize it in the name of decentralization of power and planning, despite being a departure from the Left policy.

In the larger scheme of things, along with the remittances from non-resident Keralites, decentralized planning in association with the people has played a significant role in Kerala's pursuit to get over these crises. I strongly believe that decentralized planning has really stimulated the primary manufacturing sector, secondary service sector, and other service sectors like health and education.

Hari Sankar: Regarding this, it is usually considered as a top-down approach in our place. So, in your experience, do you think there were any such ideas in your Panchayat or elsewhere, maybe as a precursor before this was officially implemented? Any experiences like that?

Sayi Kishore C: Not in my experience. Even in my service experience or in my Panchayat's⁶⁵ experience, I don't think any such organised attempts have happened linking it to any development processes. Barring some activities under the leadership of Parent Teachers Associations (PTAs) of some schools and maybe some efforts by the natives to develop some hospitals, etc., I don't think any such unified efforts have happened throughout Kerala.

Hari Sankar: Sir, our discussion is mainly about decentralization in the health sector as a whole. Because there had been many debates and

62 After the mid-1970s, due to the fiscal crisis in Kerala, the state's expenditures on social (e.g., health and education) development were reduced. See: Harilal KN, Joseph, KJ (2003). Economic and Political Weekly Vol. 38, No. 23 (Jun. 7-13, 2003), pp. 2286-2294 <https://www.jstor.org/stable/4413657>

63 The Municipality is known as Nagarapalika. The 73rd and 74th Constitutional Amendments of 1992 granted constitutional status to the Panchayati Raj Institutions (PRI) and the Urban Local Bodies (ULB), respectively. See <https://www.india.gov.in/my-government/constitution-india/amendments/constitution-india-seventy-third-amendment-act-1992> and <https://www.india.gov.in/my-government/constitution-india/amendments/constitution-india-seventy-fourth-amendment-act-1992>

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

65 Sayi Kishore C.'s Panchayat, called Thanalur gram Panchayat, is situated in Malappuram district of Kerala.

discussions on People's Planning. So, we are organizing this to focus specifically on the health sector. So, could you please tell us about some of the important aspects of People's Planning in the health sector?

Sayi Kishore C: Today is the 25th anniversary of People's Planning. It is a day that Kerala should remember with gratitude, and they should also take a pledge that they will continue People's Planning with more and more participation in the future also. As someone who has been involved with the initial phase of People's Planning, I think its first engagement in the health sector was in developing infrastructure and buildings. The Panchayat's primary focus in all the sectors was on the development of infrastructure. They were exploring if there was a possibility to construct a hospital with in-patient facilities in the Panchayats. Most of the time; they were not ready to imbibe the true meaning of primary healthcare. Moreover, the leaders of LSGs did not really pay attention to the questions of where to find the additional HR in the hospitals with in-patient facilities. They did not plan the technical aspects well. It was during this initial phase of People's Planning, when the Primary Health Centres across Kerala received excellent buildings without spending enough planning on the posting of additional staff required for the same. It was a significant jump in terms of infrastructure of the health sector. When I was working at a Primary Health Centre in Thrissur near Kodungallur, the facilities were quite limited. There was not enough space to even sit properly if all the employees, including field workers, had come together. But at the same time there was a new building adjacent to it. It was closed. The Panchayat governing council was adamant that they will not open the building until in-patient treatment starts. Instead of formulating health projects to identify the local health requirements and addressing them, during the initial phases of People's Planning, the Grama Panchayats invested heavily on their infrastructural requirements and attempted in different ways to construct centres for in-patient treatments: a long pending dream for them. To be honest, when they extended new projects as part of Aardram Mission,

the buildings in the PHCs that had not been used until then were really useful. I think it was after at least five years of People's Planning that the Panchayats were able to imagine new projects that addressed their local requirements. During the initial years, the activities mostly focused on asset development.

Hari Sankar: Sir, you mean to say that infrastructure development was happening in these places in 1995? By 2005, these places...

Sayi Kishore C: Yes, indeed. I think it was in the second phase, I mean during the next five-year plan that the Panchayats started taking up the new activities. The changes in the infrastructure have made some major changes in the work culture of the health institutions. There were good chairs and tables. Good buildings came up, which led to improvements in the confidence and efficiency level of the employees. I know things personally. When I was working in Primary Health Centre, the facilities were quite limited. Those things have changed now. Employees' working conditions have improved. It must have enhanced their quality of work too. The improvements made in the working conditions of the health workers with the help of People's Planning was in fact a steppingstone for them to get involved into the health issues of the people. When the LSGs were convinced about this, it paved the way for novel initiatives in the health sector. At one point of time the dual control of LSGs and the Department had caused some confusions, concerns, and even some confrontations between the health workers and elected representatives. It still continues, though in a limited way in some places.

Hari Sankar: What was the role of the People's Planning Movement in making the decentralization process smooth? Could you please tell us about the activities carried out as part of the campaign in the health sector?

Sayi Kishore C: First, the local challenges were identified. Secondly, the health data enumerated from this, though limited, were analyzed, and projects were planned as per the local health

needs. The Panchayats were given not just powers - they were given funds and functionaries required for them. That is the reason why they were able to perform efficiently in the health sector and elsewhere. To quote an example, it was the LSGs that intervened for the first time in the areas that were really important for the society: first - prevention, early detection and management of non-communicable diseases, and then second - activities related to palliative care. These two are the flagship programmes⁶⁶ of the health sector in Kerala. Though this was initially started by the LSGs, later the Government realized the potential and importance and took it up as their major State program. So, I think the most important role played by the People's Planning in Kerala was to realize the needs of people at the bottom level. The LSGs were also able to take up major projects as part of this role.

Hari Sankar: How were the local needs identified during the meetings that you attended initially those days? What was that process?

Sayi Kishore C: In the initial phases, there was so much excitement from the people. I think it has almost settled down by now. Barring those Grama Sabha meetings that provide any personal awards or benefits, rest of the Grama Sabha meets are not really that crowded. In many places, most of the projects are planned by the clerks in the Panchayats, the situation was like that. After the digitization process, project planning has become very mechanical XX without the proper involvement of Medical Officers²⁷, HIs³⁵ [Health Inspectors], etc. It has become very mechanical: as a project prepared by the clerk of the Panchayat at least in some places. Many of the Executive Officers are hesitant to take up innovative projects that are a response to the local needs of the people other than the mandatory ones. Several Executive Officers are even instructing the Health Inspectors who

participate in the initial plan discussions to not take up any new projects. Because they were worried about their HIs taking up new projects, many Panchayats sent their clerks to these meetings. There is a reluctance among the officers in all the departments to identify, prioritize and plan projects in response to the community's requirements. And there is not much social pressure to do that as well. The Team Training conducted by Aardram Mission with the representatives of LSGs, officers of Health department and ICDS have made some changes to this situation. The assessments carried out as part of "Aardra Keralam" award⁵⁰ are indicative of considerable improvements made by the LSGs in matters like project planning and implementation. At the same time, formation of plans has become merely a bureaucrat level activity. There is a decline in people's participation. In the initial phases, with the involvement of local resourceful personnel, retired professionals, common people, etc., People's Planning Movement had really lived up to its name. Now, I am really doubtful about the extent of participation of people in Peoples' Planning.

Hari Sankar: But sir, was it like only qualified people were needed to plan the projects after a specific point of time? Or was it a gradual process?

Sayi Kishore C: For every program, people will be excited at the beginning. I think it declined gradually after a point of time. There were instances of heated arguments and debates about the local health concerns in some Grama Sabhas. Such debates are often very productive. Such debates are not happening now for sure. In fact, we have situations these days where the minutes of Grama Sabha meetings get signed from nearby houses to make it full quorum. I have really seen the transition personally. That is why I am saying this.

Sreejini J: Sir, I have heard many people discussing about a hesitance to People's Planning. Not the

⁶⁶ The state-level NRHM in Kerala has designed the Non-Communicable Diseases Control Programme in the state to address the burden of NCDs, also called Amrutham Arogyam, following the centrally sponsored NCD programme. See <http://arogyakeralam.gov.in/2020/03/23/ncd-non-communicable-diseases-control-programme/> See <https://kerala.gov.in/documents/10180/46696/Pain%20and%20palliative%20care%20policy%202008> for the Pain and Palliative Care Policy of Kerala

whole Health Department but modern medicine, I mean allopathic medicine stayed away. Is that true?

Sayi Kishore C: I have heard this from many quarters. That has happened even where I had worked. At several places, many health workers and especially doctors had their own concerns about this dual control. Maybe in some rare cases, at least some Panchayat Presidents had exhibited tendencies to take advantage of their power. In most of the places, the elected representatives have used their power to ensure efficiency and punctuality of their institutions and officers. But this tendency to overexercise power, at least in some places, became hot news. And to resist this, not just medical doctors, other staff also defended it across Kerala. The departments which did not have much power earlier, in expectation to gain more and more, got involved in the People's Planning process. The Health Department, historically alleged of its complacency: whether right or wrong, stayed away from it initially. It may be because of that, the LSGs took up the construction related activities that were not executed by the health department officials, during the initial phases.

Hari Sankar: Sir, when I spoke to Vijayakumar sir and Aravindan Sir about this, they mentioned some people who were already actively engaged in identifying and addressing local health issues as part of organizations like KSSP, even before decentralization was institutionalized. Who are those people in your opinion - those who lead this properly from the front?

Sayi Kishore C: I am not a Parishad activist. In fact, I have several differences of opinion with KSSP. But I still think that it was Parishad itself that led the People's Planning Movement. But later, Parishad itself was subjected to a sort of institutionalization and moved away from it gradually. Though not as an organization, it is still the Parishad activists who are at the forefront of and giving a sense of direction to People's Planning activities even today. To be honest, there was a conflict in this: an ideological conflict in a sense. The organizational principle

of Communist Party fundamentally supports centralization. I have heard that there were several ideological conflicts within the party regarding decentralizing power. That is primarily a Gandhian concept. But it was people like Dr. Thomas Isaac who realized that it was decentralization of resources, power, and the executive system as an effective method to surpass the crises Kerala was faced with. I discussed earlier how they could bypass the hindrances put forward by the organizational principles of the party. It was a major step forward in the history of modern Kerala. During that time, irrespective of LDF or UDF governments in the Panchayats, it was Parishad activists themselves who took the lead of Peoples' Planning activities. They played a vital role from designing projects required for people, to the technical aspects of the movement.

Hari Sankar: This was in the beginning. But later it became a formal process. So, when compared to other states, in Kerala, our networks, such as Kudumbashree, are really strong. And we do have a number of active youth organisations as well. In your opinion, have the youth organisations who actively engage in many social issues, other than at the level of NGOs, helped the decentralization process in the second phase?

Sayi Kishore C: I don't think the youth organizations linked to the political parties in Kerala played any significant role either in the planning process or even at an academic level. I feel it was mostly senior people who led the People's Planning at the forefront. The youth organizations have played a major role in some initiatives where there was a need for some physical labor. For example, an activity of extending the width of a canal near my place. They are involved at that level. But I don't think they have participated at the level of a thought process.

Hari Sankar: What about organizations like Kudumbashree?

Sayi Kishore C: I think Kudumbashree⁶⁷ was

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

not there in the initial phase. It started in 1999. Initially, Kudumbashree was introduced as a poverty alleviation program, but later it has played a significant role in engaging and realizing the People's Planning activities at the grassroot level. But even though they have a strong structural potential, Kudumbashree has not really been involved in the health sector much. Initially, it showed some characteristics of chit funds at many places. I felt that despite its potential to engage in health-related activities, it gradually lost the energy it had initially and gradually took a step back.

Hari Sankar: We asked you this question precisely because of that. This has been happening since 2007 by the introduction of programs like National Health Mission, etc. So, when we explored the literature, there was good documentation during the 1995 phase. What is their role in decentralization related activities post the implementation of NRHM since 2007?

Sayi Kishore C: I don't think NHM has any role in decentralization: not in my experience. But it has played a vital role in enhancing the basic facilities at the Primary Health Centres. And that has been carried forward by the local bodies as well. That's all. That happened parallelly until the Aardram Mission was implemented. ASHA workers in fact played as a link between NRHM and LSGs. LSGs had a significant role in selecting ASHA workers at the local level. It is beyond doubt that ASHA workers had played a vital role in extending the health activities at the grassroot level. The recognition they gained as ASHA workers became a steppingstone for many of them to contest and win elections later. Since the implementation of Aardram Mission, the coordination between LSGs and NHM has improved significantly.

Hari Sankar: They have introduced projects like Comprehensive Health Plan, right?

Sayi Kishore C: Those plans died out like that. It didn't go forward. I guess it was during the 10th plan that the Comprehensive Health Plan was introduced as part of declaration to increase the share from the Central Government in health up to 5%. Extensive training programs were organized

for health workers including Medial Officers about: what is Comprehensive Health Plan, how to efficiently prepare projects utilizing the Central Government's contribution in consideration to the local health requirements, etc. Many sleepless nights were spent at the PHCs to come up with the projects within a limited time frame. My house construction was over but have not shifted to that house at that time. In my house three or four PHC people prepared these projects with the help of already collected data. But the Central Government contribution didn't arrive as per the plans. It is still a mystery for me regarding from where did NHM receive this additional contribution. It didn't make any changes except that many of them had lost several days of sleep. Those project documents are still kept intact in bound volumes in many of the institutions. Though the training on data collection and how to convert the collected data into projects was not useful at that time, it is true that many institutions and officers who came up with brilliant projects got its benefits later.

Hari Sankar: Sir, in the context of Aardram Mission in 2015, what is the role of LSGs in implementing it?

Sayi Kishore C: Panchayats have played a major role in implementing Aardram Mission. When the Aardram Mission was envisaged, we all expected it to become a transformational change with a focus on prevention of diseases. But gradually it got limited to a clinical system. Some vested interests played behind this. Many people who led the Aardram Mission at the level of idea and practice moved out of it during that time. The Government also felt this change as favourable as the changes in the clinical level are more visible and tangible. But we destroyed a chance to rebuild the health sector in Kerala. It will take several years for the results to be visible in the society whether it is health promotion or prevention. But quick results may be possible for the development of basic clinical facilities. So, Panchayats were also quite keen on that. They took a keen interest in extending evening OP timings and expansion of buildings. Hence, the Panchayats have intervened actively in those things. Several democratic engagements took place in the form of sponsorships and the like, under the

leadership of the LSGs. Similarly, major changes have happened in terms of providing additional HR, improving the buildings, etc. Many hospitals have experienced several such peoples' interventions. Big things, like even constructing buildings, have come as sponsorships. LSGs have played a significant role in all these things. I mean the role of LSGs in the evolution of our Primary Health Centres to the current condition is unmatched. But as someone who had been involved with it from its inception, if you ask me if this evolution was the expected and desired outcome during the formative years of Aardram Mission, then my answer is no. The major miss that happened to Aardram Mission was the loss of its focus on preventive activities or the comprehensiveness of health services. I don't think there was any effort to regain it from the part of the Panchayats as well.

Hari Sankar: Like you said, this was the case even in '95 in terms of infrastructure.

Sayi Kishore C: But in addition to the infrastructure, there was a qualitative change in the services as well. Evening O.P [Out-Patient]. 'til 6 o'clock is not a small achievement. It was beyond imagination for LSGs in 1995. They were able to bring about a visible change. Because the Aardram Mission was spread out just before the LSG elections, the political parties had a feeling that they would be able to project it as a development model worth projecting. The evening O.P. particularly is something that can make an impact on peoples' minds: similar is the case with development of labs, pharmacy services, etc. Facilities such as good seating space, good buildings, etc. made some remarkable changes in the clinical field. That really helped the LSGs during the elections as well. But the Aardram Mission stagnated there.

Hari Sankar: Those days, the motto was to become patient friendly right? And you mentioned about change in the behavior of people and training at KILA for the same. There was a visible change in the behavior of elected representatives as a result of these trainings, which we have mentioned in one of our studies as well. I am asking you if in your own experience, did that lead to any changes?

Sayi Kishore C: Patient friendly is getting transformed into people friendly. That was based on an idea. Public Health Institutions are responsible not only for the people who come in the hospitals but also those even outside its compounds. That was the great idea behind it. People like Panchayat president, health standing committee chairperson, secretary, health department staff, Integrated Child Development Scheme (ICDS) supervisor, etc. participate in the Panchayat level training. There were indeed some major changes as an outcome of that. These trainings were successful in convincing the LSGs about various things like the changes expected as an outcome of Aardram Mission, what is meant by Comprehensive Health Protection, potential of LSGs for intervention, what can be offered by the Government and NHM, and the need for a cooperative and coordinated action, etc. Beyond the transformation of O.P., they were able to effectively engage in the development of health sub centres. It was during the training that the members of the Panchayats understood what the sub centres were and the need for these sub centres to transform from time to time. They realized the potential of the sub centres and were able to intervene at least at some places accordingly. LSGs intervention within the comprehensive health protection was in the areas of prevention of diseases and enhancement of health. In general, sub centres used to remain ruined and useless buildings across Kerala. That situation has changed a little bit. This activity did not progress much because of several crises including COVID. In addition to that, the LSGs have made some strong realizations on the fact that health as such can be achieved only by intervening in other allied determinants and also with the development of peripheral units and inter departmental coordination.

Sreejini J: Sir, you said that, like Hari said, the influence of NRHM came about post 2007. But NRHM gave emphasis on infrastructural development. Why did their involvement fail? Is it because it got limited to a lower level of infrastructure? Because this came from the Centre as a major initiative. Why did it fail in Kerala? In your opinion what was the reason behind their lack of involvement in many health programs?

Sayi Kishore C: At the rural activities, ASHA workers were more visible in the NRHM activities. Later, they sanctioned funds at the ward level and sub centre level. This has really facilitated a grassroots level engagement of health activities. But if the question is whether NRHM was able to make any effects in the health sector of Kerala in the later years, my answer is no. Not just NRHM, any government will be keen to engage with the initiatives that can bring in some visible change. For example, we have dialysis centres across Kerala. Dialysis centres are being set up even at the PHC level utilizing the MLA/MP funds⁶⁸. None of the Governments are seen engaging with any preventive activities against conditions that lead to dialysis. Perhaps the Governments had to focus on that more or even spend more money. Instead, they started dialysis centres. Why would that happen? Because it is more visible. Perhaps, I think, after the formation⁶⁹ of united Kerala, the first Governments focused more on programs that would yield long term effects or long-term results rather than visibility. They put efforts to engage with social determinants that were decisive in prevention. We are reaping the benefits of that, in fact. But then the subsequent Governments, not just in Kerala, everywhere changed their focus. The elected representatives are keen on what can be made visible when they come to power. Those will be presented as contributions and achievements before the next elections. It may take well more than five years for the results in the preventive health aspects to be visible. Maybe, I guess, that is why they take up projects that are more visible and that yield quick results instead of projects that may produce long term results. In fact, we failed in re-imagining NRHM to shape our health sector to suit the conditions that are specific to Kerala. With the Aardram Mission, though at the clinical level, NHM activities are more coordinated with the LSG activities and have become more efficient.

Hari Sankar: Next question is regarding COVID.

We witnessed major cooperative democratic efforts in defending COVID. LSGs stood at the forefront of it. I would like to ask you about how much decentralization, and related experiences and resultant institutional strength, etc. helped to overcome a crisis like COVID.

Sayi Kishore C: Such crises are more recurrent these days. We have been seeing such major involvement of LSGs since the floods. We saw this as a continuation. Such people's initiatives have started to get formed since then. But the question is whether we will be able to maintain this tempo for a longer period of time. A peculiar characteristic of volunteerism all over the world is that it is impossible to retain its energy for a long time. To resolve a sudden issue or to lighten the impact, people get together without expecting anything in return voluntarily. Or maybe for missions such as the literacy movement. By the time such movements achieve their targets, such groups slowly disappear. To sustain it without dropping its energy is the major challenge in front of LSGs. As part of Aardram, something like a Health Brigade was planned. A health guardian for 20 - 25 houses. That was the idea. That in fact worked very effectively during COVID in the form of RRTs. If there are no other felt crises after this one, I really doubt if we can sustain such groups for a long time. Now the Government is planning on door-to-door services. Volunteerism plays a big role in this. In this context, we are going to seriously explore how to maintain this volunteerism. We are going to do that for COVID observation, to reach food for the patients and their family members, to deliver medicines for elderly, to facilitate support for those who lost their livelihood, etc. Such interventions from the people have played a major role. The field level workers of the health department and the LSGs have played a vital role in coordinating and keeping it efficient.

Hari Sankar: Works of RRTs were generally very much appreciated at the ward level and the like.

68 The Members of Parliament Local Area Development Division is entrusted with the responsibility of implementation of Members of Parliament Local Area Development Scheme (MPLADS)

69 Formation of the state of Kerala took place on 1 November 1956, after the Reorganisation of States. It comprises of the former Travancore-Cochin State (except the present Kanyakumari district and Shencottah taluk of the present Tamil Nadu), Malabar District, and the Kasargod taluk of South Kanara district of the then-composite Madras State. Source: <https://www.keralapsc.gov.in/history>

Sayi Kishore C: In fact, there was not much of a definition there. Depending on the need, they work there accordingly. There were situations where they had to feed the chicken and dogs at COVID patients' houses. That is the level of sublime humanity behind these interventions. That is there with all of us. But it is a great thing to activate it and sustain it. Such initiatives should be acknowledged world over. Many international organizations have really appreciated such voluntary actions in Kerala.

Sreejini J: There is a role played by political parties in the process of decentralization. I mean there is a trend of alternate Governments in Kerala. It's only now that we have a continuity of governance. Some people say that communists and the alternate UDF Governments tried to sustain it. Some people say that they totally erased it. We have heard such opinions in many seminars and meetings. In your opinion, what was the role of political parties?

Sayi Kishore C: I have worked in Panchayats ruled by various political parties. In my opinion, there are no other political parties like CPIM and Muslim League who led the People's Planning Movement in Kerala. There was no difference between UDF or LDF. Within the UDF, though Congress was not very keen on that, its other constituent parties, and all the parties within the LDF have taken real interest. There was a widespread excitement beyond political party differences at least at the local level, if not at the top. Each of them had planned and devised innovative projects in health and health allied sectors and took it forward. There may be some local differences. I can vouch for one thing. Malappuram district embraced the People's Planning Movement¹² beyond political differences. But like the other parts of Kerala, here also the people's participation has declined when compared to the early years. Perhaps as a party, there may be differences in the way which the higher-level saw things and whether they were keen on it, etc. But I never felt that anyone tried to destroy it, if not try to revive it. Along with the structural drawbacks, I think everyone has tried to keep the People's Planning alive, even though we saw some gimmicks of changing the names, etc. recently.

Hari Sankar: In that case, what are its benefits? In general, what are the benefits of decentralization of health in Kerala?

Sayi Kishore C: Primarily, like I said earlier, the changes that happened in the infrastructure. You will be able to make sense of it if you observe from the initial phases until the Aardram phase. There have been major transformations in terms of infrastructure. Secondly, they were able to plan and implement innovative projects based on the local health requirements: be it palliative care program across Kerala, or NCD program, or cancer care-related programs, the major impact of decentralization was mainly its engagements with local health needs. Many projects were successfully implemented in the areas of non-communicable and communicable diseases, prevention, and its control. Now that they have to take up several mandatory projects, especially palliative care, and salary for additional HR, etc., the LSGs are slightly hesitant to take up other innovative health projects these days. Since they have to spend almost all the funds dedicated to health for these projects, they say that they don't have funds for other projects. They complain that the Government comes up with projects like Aardram and leaves its burden on the Panchayats. Because it is the Panchayats' responsibility to provide the doctors, staff and paramedical staff. In fact, in LSGs, they are allocating the funds for each project for the year. After this allocation, nothing much will be left. The governing council says that there is not much funds left in the health sector after keeping aside the salaries for the doctors and para medical staff under Aardram Mission and for palliative care. So many Panchayats are hesitant to plan new programs in the health sector citing the reason as lack of funds.

Hari Sankar: Is this peculiar to Kerala? What are your observations regarding why this worked out in Kerala? Anything particular to Kerala? Its unique political conditions or social conditions?

Sayi Kishore C: There are some factors that facilitated the Kerala Model or Kerala Experience. For example, I think the renaissance of Kerala played a major role. Often it worked at a horizontal level by

bringing in reformations within all the castes and at a vertical level by disrupting the hierarchical power structure between the castes. The united Kerala was made possible with the help of energy disseminated by the renaissance. The subsequent Governments took it up and they went ahead with necessary legislation. That makes Kerala different from the others. Though the other states also experienced renaissance, the governments that followed did not embrace the energy. Universal public education, public distribution, access and availability of health services, higher awareness of human rights, and scientific temper, etc. even further enriched it. Hence, there were great imaginations about equity and redistribution even at an earlier phase of Kerala. It must be that social awakening facilitated by this energy that accorded a great deal of legitimacy for People's Planning and that even at the wake of its 25th year, the reason behind it was carried forward with such enthusiasm. When I say energy, I don't suggest that it is still the same energy at the beginning. But it is true that it is still alive now.

Hari Sankar: So, there are some unique conditions in Kerala. In that sense, what are some of the things that other states can replicate or imitate from our model, in your opinion? Is there anything like that?

Sayi Kishore C: Definitely. People like Amartya Sen used the term "experience" exactly because it is a model that cannot be replicable. When this Nagarapalika Panchayati Raj Act was implemented, though it was implemented all over India, it made some special changes in Kerala. We took it way forward from the spirit of the Bill. We also exploited it as a possibility to overcome the crises that had arrived as well. It was important that funds were handed over to the Panchayats. They were also given functionalities required. Even today, the debates about power and the boundaries of power, etc. are still not settled after 25 years. Regarding the other states, only Karnataka implemented it before Kerala. It was during the rule of Ramakrishna Hegde⁷⁰ that such experiments took place. But it was lost mid-way through. Though not like Kerala, other states also have the potential, but I am not

sure as to how far they will use it. As of now, there are no such meaningful efforts in other states.

Hari Sankar: Sir, do you have any particular experience? Anything that happened after the implementation of decentralization? At any particular locality or any particular projects?

Sayi Kishore C: In 2007 I was at Tanalur in Malappuram. We had initiated something called the Tanalur Health Model. With the help of Parishad activists, we had administered a scientific questionnaire and collected data on the health of all the natives. Data is a big thing. Panchayats across Kerala have collected so much data, but I really doubt if they did anything with that data. We analysed the data and planned programs based on that- data regarding lifestyle diseases, how many people take services from the public sector etc. When we analyzed it, around 70-75% of our people took services from the private sector. For all the NCD patients, we started an NCD clinic at the sub centre. Checked BP for everyone. Since gluco strips were very expensive then, we could only check symptomatic cases. There were no NCD clinics like this across Kerala. And we started a program to distribute generic medicines to all the NCD patients of the Panchayat. Medicines for all the categories like, mental health issues, heart issues, diabetes, neurological disorders, hypercholesterolemia, gout, hypothyroidism etc. Any private doctors can categorise diseases like this and prescribe medicines in the generic form. Panchayat will provide it. From the sub centres the patients will get it for two months every time. That is how that program was implemented.

And then the Panchayat was grouped into six zones and cancer detection camps were conducted in association with RCC and its Regional Early Cancer Detection Centre. Symptomatic cases were given follow up tests and ensured treatment. Many activities were conducted with the support of people to promote exercise and healthy food. We set up a playground in the Panchayat. Awareness and Cholesterol diagnosis camps were conducted with the help of heart specialists. To identify people

70 Ramakrishna Hegde served as the Chief Minister of Karnataka for three terms between 1983 and 1988.

with kidney disorders, Microalbumin test camps were conducted with the help of the Nephrology department of Medical College, Kozhikode. We conducted wide awareness campaigns in the Panchayats which showed hesitance to vaccinations. We organised mosquito extermination campaigns.

The beauty of this huge project was that such an initiative from the health institution was planned and implemented with the participation and wholehearted support of the Panchayat. Many of these activities are organised with the help of institutions, organisations, and people without spending a penny from the Panchayat. Same is the case with palliative care. We did not do home-based care in palliative care. We had initiated a system to avail waterbeds and other auxiliary instruments for them. That also went on successfully. The generic medicine program saw support from the people and many doctors who were with the people.

That program failed with the coming of KMSCL⁷¹. After it came in, there was a condition that medicine had to be bought from KMSCL. They were not distributing it properly. We had to deposit money initially with KMSCL and they did not give medicines in time. So, when we were not able to give medicines to the patients at the right time, that project failed. So, such structural and policy level changes that happen with the Governments, used to affect such programs directly or indirectly. Some changes might lead to the failure of programs planned to address the issues of the people.

Many times, the programs also lose continuity. Perhaps if the HI gets transferred, or a medical officer gets transferred, the major challenge is that such projects lose the continuity and momentum. There are three reasons for a People's Project taken up by the Panchayats. One, if the governing council changes. Second, the medical officer of the Health Inspector gets transferred. Third, when the alternate Governments' policies affect the projects directly or indirectly. These three reasons, across the state

if you observe, would cause the activities to stop. That is my experience. The Tanalur Health Model that was known as "Sneha Sparsham"⁷² was a much celebrated one. But it was discontinued.

Hari Sankar: Is it that we are unable to institutionalize it?

Sayi Kishore C: Yes, indeed.

Hari Sankar: That is still there as a drawback?

Sayi Kishore C: It was always there. It is still there even today.

Hari Sankar: Sometimes, some projects like Palliative care etc., weren't there any attempts by the system to absorb this? Is it not that popular? Or is it only possible if it happens at that level?

Sayi Kishore C: Yes. Only when the LSGs initiate such programs, and they receive such a wide recognition, and other LSGs try to replicate it, the Government will take it up as mandatory across the state. Palliative care is made mandatory like that. Though pressure from the top is actually against the principles of decentralization, the Panchayats had to succumb to it.

Many implementing officers, especially Medical Officers have a major anxiety regarding implementation—whether they will face an audit objection. When we go for a working group meeting or project brainstorming meetings, Medical Officers usually say something: not to take up any projects that involve a lot of expenses. They will instruct like that first itself. That's how they are sent. So, these mandatory projects and medicines purchase projects are enough. Let us not take up anything else. Most Medical Officers are sent with a request to not plan anything new. There are such situations like that in Kerala.

Proceeding ends.

71 Kerala Medical Services Corporation Limited acts as a central procurement agency for essential equipment and drugs needed for all the public healthcare institutions under health department of Kerala. See <http://www.kmscl.kerala.gov.in/KMSCL/>

72 Sneha Sparsham is a project under Kerala Social Security Mission which intends to protect and help unweaned mothers. See http://www.socialsecuritymission.gov.in/scheme_info.php?id=OA==



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