Report

Meet the Expert Event

Strengthening local governance for health Leadership: Reforms in PRIs

CPHC Alliance

INTRODUCTIONS

One of the focus areas of the CPHC Alliance is to create a circle of practitioners in CPHC and strengthen the capacities of partners to develop and implement CPHC solutions. Accordingly, in connection with the Universal Health Coverage Day, the Alliance organized a virtual 'Meet the Expert' session on Friday, 9 December, 2022, as the first in a proposed series, featuring Mr. Rajeev Sadanandan, CEO, Health Systems Transformation Platform (HSTP). HSTP has pioneered PRI reforms in Kerala and has immense experience in dealing with the intractable challenge of strengthening PRI participation in health. Through the 'Meet the Experts' forum, the Alliance's intent is to connect partners to experts to collaborate and leverage their respective areas of expertise towards solving intractable problems in public health and nutrition. The event was attended by 85 participants (Ref. Annexure II).

Proceeding of the event:

The event was opened by Ms. Ranjani Gopinath (A senior public health specialist of the catalyst group on the behalf of Swasti) with an overview of the CPHC Alliance and the journey so far. She further highlighted the importance of primary health care during COVID-19 pandemic and the paradigm shift from primary health care to comprehensive primary healthcare (CPHC) through Ayushman Bharat- Health and wellness centers.

Ranjani further introduced first in the event series Rajeev Sadanandan and invited him to share his point of view, experience, and expertise.

Rajeev touched upon the issues of relationships between PRIs and primary health care. He further talked about the role of the Panchayati Raj given in the 73rd and 74th amendment of constitution that all the public health and rural institutions are to be managed by the local government. Considering the fact, in 1996 kerala adopted this strategy and handed over the management of all public health institutions from the sub-center to district hospital to the Panchayati Raj institutions.

He stressed upon 4 major points regarding the role of PRIs in the public health:

1. Efficiency- The health care system in the lower and middle-income countries uses high-level decentralization at various levels for example- Brazil, China, etc. to see how essential public health is provided better when the management is transferred.
2. Economic and socio-environment determinants of health (like sanitation, waste management, urban planning, housing etc). These determinants lie outside the purview of the health department and the primary health care. He further stressed upon bringing a system together and creating the convergence between the determinants of health and delivery of healthcare services to improve the quality and health outcomes.
3. Demand generation (asset of bureaucratic organization at the local level- ANMs and ASHA or govt. organized system) can mobilize the community. He further talked about

the two way communication should happen so that PRIs can deliver messages to the people and vice-versa.
4. Accountability- delivering the services which are accountable to the community.

Rajeev concluded his remarks by emphasizing on the major issues in Kerala which are political issues and somewhat government issues: The adequate health resources are not being available for the people and Kerala has the capacity to adopt these changes.

He then introduced Prof Ravi Varma to present the findings of the largest study conducted in Kerala on decentralization and comprehensive primary health care.

Session on research study done in Kerala on PRIs

This session was laid out by the HSTP research team (Prof. Ravi Prasad Varma who is the additional Professor (Epidemiologist) at the Sree Chitra Tirunal Institute of Medical Sciences and Technology.

Prof. Varma then briefly describes the study in Kerala and how it has changed the public health sector of Kerala. He further briefly explained the broad objectives, approach, IEC, study design adopted for this study.

While addressing the finding he touched upon the following aspects:

- Journey/ evolution in kerala
- Urban and local governments
- Mandatory primary palliative care program
- Stressed upon the re-engineering of primary health centers to family health centers explaining the 2 major actions taken during 2016 and 2017 period, “Nava Kerala Karma Padhadhi” and “Aardram Mission”respectively.

Under “Aardram Mission” in 2017 new patient friendly institutions made, increased manpower, laboratory services, availability of medicines and several other innovations have also been added like ASHA kit, and E-auto were designed for the elderly population.

Besides these the study also highlighted the last mile issues, or the areas still left uncovered.

- Failure to empower the marginalized communities within the local bodies such as dalits (scheduled caste people), adivasis (the scheduled tribes), and the coastal fishermen.
- Outreach campaigns organized, where the last mile continued to be there, but still catered to the poorest.
- Decentralization brings heterogeneity but there is a lot of support needed to the local government where the situation is not good.
- It has also been seen that community engagement and planning remains low.

Questions and Answer session

This session was spearheaded by Shiv Kumar, Founder Director of Catalyst group with the thank you note for sharing their experiences on the PRIs.

Q1. Leveraging the transforming healthcare delivery, what are the biggest challenges and how are they surmounted? How much is attributed to the constitutional reform of local governance to change the pace of health care delivery? How did Kerala motivate PRI representatives to actually participate in the sector of health?

Capacity planning in India is quite rudimentary which is the reason the study has challenges/barriers. On highlighting the challenges Rajeev talked about by giving an example of NCD prevention and creating a mechanism for it.

He emphasized on how the services will be provided to the people, reconfiguring the living spaces or the urban spaces or rural areas for exercises, influencing people on diet, locating your facility (geospatial planning and services) and etc. Due to lack of knowledge of the people who are involved in the healthcare system right from the chief secretary to the panchayat member they were the biggest limitation. Many of the diseases have never been part of primary health care like COPD, diabetic retinopathy etc. unless and until there are no concurrent findings in the literature. Hence, there is a lack of knowledge and thus augmentation is difficult.

The major motivation was the presence of politicians who would still want to make a difference in people's lives and health is an area where the difference is seen. All the action oriented people (which are basically panchayat members who know the needs of their community) can bring satisfaction, goodwill, and a positive impact on the people's lives.

Harvesting innovations of the community which are being taken care of is most important. NHM learned from the Aardram Mission that the needs of the community are utmost important like-procurement of drugs,labs services, and patient friendly institutions are the necessity of the people, therefore seeing the needs NHM learned from this program and added to their umbrella. Rajeev further pointed out that people volunteered themselves to create awareness about the disease specific program that has been made and included in the health department because of the pressure from the community, needs of the community, or people suffering from that particular disease.

Q2. **Standing committees and working groups having these structures, how much has it facilitated the action at the PRIs? How are these actions still possible through PRI in the absence of these constitutional reforms?**

Rajeev and Prof. Varma stated that good collaboration happened with the planning board members only (economist, politics, bureaucratic) who worked on the organizational, financial or political side. With the influence of the committed political sense and bureaucratic skills which designed the decentralization program and the mechanism of implementation and devolution.

Q3. Lots of boundaries and respect issues between PRI and health department- Did this study setup any bridge and government mechanism which enables the communication to be smoother? Usual argument on PRIs not getting power through mandate followed by capacity, confidence – soft issues on building the confidence of PRIs?

- Initiation of decentralization provided an equal opportunity to western medicines, homeopathy, and ayurveda while most of the funding went to homoeo-pathy or ayurveda . but there was a high demand (approximately 90%) of western medicine.
- Govt. a medical college in Kerala invested in training on young graduates in working with the community. As the young people are the biggest motivation factor for change. While it motivates the young boys and girls to use the opportunity to build their dreams.
- Rajeev while giving an example of japanese encephalitis (JE) epidemic in one of the districts in Kerala. The major focus was to work on the social determinants of health rather than on building the government or medical college which was the collective effort of the chief minister, Jila parishad, MLAs, Panchayat members etc. to curb the outbreak of JE.
- Rajeev further emphasizes on the team building activities.
- Dr. Varma stated that capacities being different but mandates have to be in uniform manner. At the time of Aardram Mission there was an upgradation of each legislative, and state assembly and help desk was then invented for elderly population. Approx 200 self help groups have been made. Identifying problems and suggestions for support was the main activity undertaken in SHG. Various capacity building sessions/workshops were being implemented and learning was taken from these.

Q4: Storytelling brings out a change in Kerala- are there any stories/videos being developed.?

Videos and stories have not been done as a part of the study. Informal and semi-formal videos have been made and can be obtained from you tube.

Q5. What are the challenges faced by the VHSNC members in discharging their duties at the community level?

- Outreach activities planned for the Aardram Mission and it requires nurses and doctors to do outreach clinics.
- Various handbooks and guidelines have been issued on how these activities should be done and how the ward health nutrition sanitation committees should carry out and key components of local mobilization of the people (which is known as arogya sena).

Q6. How GPDP planning process going on in Kerala? How they are incorporating health related plans in GPDP planning? Except 15th Finance commission fund is there any other fund which has been devolved to gram panchayat for health-related planning?

- The GPDP it follows the Kerala template and does not want to give another title because of the decentralization planning process. The original template of the GPDP is still being maintained in Kerala.
- The 15th finance commission is a good example of how bureaucracy at the finance commission came up with.
- Regarding the convergence forum there is a standing committee, working and functioning groups and development seminars that happened in the government. These forums are important especially for the medical officers to attend as they are good at negotiating with local governments.

Q7. What is the barrier to creating a ripple effect from one successful PRI to the next one? Do PRI-based incentives instead of health worker incentives work better? How do we leverage technology for creating awareness/bringing local solutions using existing resources available provided the current citizens charter system doing its role?

- Ripple effect which is facilitating the platform where people can come together and share their stories. For example, resources of palliative care, conducted cultural events through which they receive a lot of money and have no idea of how to handle the money. The panchayat at the district center provided the idea of having a bank account where all the money can go into the account.
- In 2011 incentivized the people by acknowledging their work to the winners of Arogya Puruskaram and the rewards have been given to the best panchayat, best gram panchayat, block panchayat, district panchayat who do well on defining parameters.
- As such there are not many technologies in use for uploading the projects , one is sulekha platform where local government and health department can see the relevant projects for them.

Q8.- We are facing issues empowering families of TB cases to avoid defaults . Reason being families do not accompany patients to HWC. How did you work around friends and families?

- TB in Kerala is of late 90s and TB is now towards the elimination. The DOTS were the initial program provided by ANM and other health workers. So there was not much connection between the health workers and patients. So it should always be the local people of their community like the local headmaster, local librarian,people trusted person, or volunteer dots providers, which reduces stigma and improves connectivity.
- As local people will spend time with the patient and they are aware of their needs or the medicines. So that's why the human element comes into the picture.

Q9- What further could be done to strengthen the community's participation in planning? Are there any models that we could learn from or were there any pilots/success stories within Kerala? Does this area seem to have remained weak in spite of decentralization?

- The planning process can strengthen community participation. Rajeev while addressing the question has talked about the huge levels of expectations, and huge energy levels as it was more processed based.
- The classic dilemma of public health is that public health is good, resulting in non-event. The good event confronted Kerala's NCD management. High levels for diagnosis center but very little enthusiasm for ensuring the conformity to disease (diabetes) management.
- He further highlighted that prevention and promotion is not a market, it's a lot of money that goes into diagnosis and treatment.

Q10.Has Kerala Gram Panchayat Cost of an action tool to inform how the future could look like?

Medical officers who knew the cost of inaction were suffering from treatment lethargy and these can be actively managed based on the output indicators and treatment. Further to the discussion Rajeev mentioned that the active management for NCDs cases were at no.1 district accounting to 60% of the population. It was more of a disappointment that people who are aware about the cost of inaction are not acting to prevent it.

Q11. Despite an increase in reservation for women in local bodies, they are still on the backfoot while male members of the family are taking decisions on their behalf. How can we increase participation of elected women representatives in decision-making & planning?

- More than half of the elected representatives are women. The society is patriarchal and husbands are the one who takes decisions and women sit and listen to them.
- There have also been funds which have been kept separately for transgender community.

Q12. What strategies have worked in fair and inclusive engagement of PRIs with the families in their coverage (especially when there may be multiple caste groups or socially marginalized groups).

- Rajeev and Prof. Varma addressed the question by giving an example of the Malappuram district where there was a high percentage of muslim women and there was always this assumption that muslims women were reserved. But the amount of mobilization happened and the way these women accepted the opportunities given to them, that in the next panchayat election most of the representatives were women from these communities.

- Kerala has a high level of patriarchal mindset therefore this is the reason why there is less number of women representatives.

Q.13 What are the plans for the most remote and marginalized villages?

- The people living in those villages belong to the coastal community, and they belong to the geographical remote people which were intensely populated and were very poor. That is why these people were left behind and remain a challenge.
- Intersectoral coordination should be there, the people in the health department and tribal people don't communicate. Networking, and connectivity is a big problem.

Q14.what is the convergence forum at GP level, how are standing committees contributing to the planning process, do FLWs contribute to the plan, Do SHGs participate in planning?

- The people in the standing committees provided technical support. There is abject poverty that is why there is much more to do than health. Health staff, ASHA, ANM, Junior inspector, nurses recognised the advantage of decentralization brought to them. As 20 years ago there was an acute shortage of medical supplies and with the advent of decentralization in the state, the medicines are easily available now.
- For SHGs, the savings were borrowed from the BRAC , basically the “swasthaya Sakhi”.

Q15. How can convergence between PRIs and health systems strengthen?

- The decentralization program at the gram panchayat level actually works very well. But the weakness is as you go forward the system is not designed to capture because of the villages, urban planning at the village or the mindset of villagers and the main idea was to look at what is appropriate for the villagers.
- The Aardram program did not have a block levels component because convergence did not affect at that level and as you go higher the level of decentralization becomes weak and it doesn't work at the district level.

Q16. What are the differential capacities of PRI? Do they get mapped, do they have governance measurements which tells us PRI category A,B,C and what are the implications to the health program?

- This is the argument against decentralization. China has a highly decentralized system. The local government in Shanghai has much more resources available as compared to the interior parts of china. While the finance commission focuses on revenue utilization. Income differential between the panchayats are at the higher levels and the equalization doesn't work. This is one of the demerits of decentralization.
- Capacity is more at the gram panchayat level. The president of the gram panchayat whose capacities are much higher or the commitments are much higher, so when the

assessment/ or mapping is done , there is a huge differential seen between the achievements of the panchayat.

Q17. Do PRIs do vulnerability mapping of their communities?

- Vulnerability mapping is the weakness of Kerala's decentralization. The tribal population is being ignored by the politicians because they constitute a very insignificant vote bank. In gram panchayats also, the salience of these groups should not be left out, but our study also shows that it doesn't really happen.
- Classic disadvantage is minorities might get left out in Kerala's decentralization.
- The marginalized are left out and they don't get the same attention than the people who are in power. State requests and local govt requests are to map the vulnerability to those areas especially who are like disaster prone, floods, sea oceans, migrant settlements etc.
- Facilitating the integration of migrants into the health system.

Q18. How will we apply the Kerala model in regions where the community networks are weaker or not well organized? Should we focus more on community networks building alongside HWC capacity building?

- Policy dialogue with the former health secretary was in 2 ways: demand side or supply side
- Tamil Nadu addressed the issue while working on the supply side and didn't wait for the demand side to come up.
- A focus group discussion was held with women in one of the villages of Uttar Pradesh by Rajeev on the prevalent understanding of the women in UP. As the women in UP are not demanding the health services. In spite of knowing the services they want but still not getting it. It was very evident that the services need to be there for them but not getting them either the services are not available or the quality of the services are not good enough.
- Kerala tries to escape the responsibility of the quality of services. If we deliver the quality of services the demand for the services will be there. If the supply increases the demand itself increases.

Economic mental model to deal with demand and supply ?

- The advantage of having such a large slack is that the unmet demand is so high that the NHS handles 2000 cases per primary care while in Kerala it was 30000 earlier but later it reduces till 10000 cases per primary care team.
- When the services increase or the quality of services is increasing, approx 60% of the population who were going to a pvt hospital switched to the government hospital which led to the crisis.

Commercial and behavior determinants-

- Tobacco cessation reached from 27% to 12% entirely, and this is through BCC, community mobilization, educating people, and awareness. Putting syntax on fatty food increases the salience of the issues.
- Rajeev further shared his experience on meeting the food producers in Kerala and told them to reduce the sugar and salt content or trans fat less oils can be used.
- Many interventions can be possible but the problems with NCDs and many other diseases is they take time. While sharing an example of TB, that 6 month followup period is required with the TB patients while for NCD is a lifelong prevention required and which is not accepted by human nature.
- Most effective public health intervention is single shot immunization which is not possible in NCD cases (like diabetes, hypertension). So to find the solutions, syntax was put on all the fatty foods not because of the money but to control obesity.
- Tobacco was able to go down either due to rigid enforcement of the distance to the schools. But could not down the alcohol.

Q19. What 3 things other states should do/donts?

Dos.

- Conversation at all levels voices should be heard, and the platform should be created.
- Experience sharing showcases to trained people, and let others learn. See ourselves as catalysts.
- Central augmentation is needed.
- Interacting with the community in Kerala is not correct. Learn from what people did during COVID times and trust them. Plans will be moved by political leaders.
- Planning capacity at the state and national level. Prevention intervention can override the implementation strategy.

Don’t

- Don’t assume capacity at the top level.

This ends the questions and answer session and Shiv thanked Rajeev and Prof. Ravi and first ever meet the series expert anchored by Binali and Dr. Ranjani.

Partnering with Alliance

This session was headed by Binali who is lead engagement of the Catalyst Group on the behalf of Swasti. Taking over the session she further thanked Rajeev and Prof. Ravi for patiently answering all the questions and also acknowledged the presence and participation of the members of the CPC alliance and partners of community action collab.

Binali further took the event to the last stage and talked about the 2 important tools and approaches:

Dynamic database of PHC:

- Developed in collaboration with several partners. The journey started as the collaboration between the HSTP and Swasti for a project way back in 2019 on detailing the landscape of the PHC in India and identifying the PHC innovations that exist. After this collaboration the dynamic database became an ever growing database for the solutions of the PHC in India.
- This database comes with an objective to develop a comprehensive resource that serves tools for researchers, decision makers and influencers of the ehealth system. This is to support design, efficiency and effectiveness of improving the PHC in the country as well as to create an interactive space.
- Currently this database has 180 innovations and exemplars that are categorized based on the PHC framework, and developed as part of the landscape project demonstrating how different components of the PHC system work together for the citizens.
- Binali further thanked Rajeev and Shiv who are the key advisors to this project. She further explained the importance of building this database stronger, and better through collaboration.

CPHC Alliance

- Binali further explained that if there is no network, no alliance, no collaboration happens without like minded people coming together and further talked about Swasti being the backbone organization of the CPHC Alliance.
- Motivated the partners to collectively come and make healthcare affordable in this country when needed.
- Any one who is a practitioner, stakeholders, PHC Space, serving Public and Private healthcare system, funding organization, family foundation, not for profit, an academician, ehealth economist and grass root level organization working with an common agenda in the arena of PHC can be a part of this alliance.
- At the end of the session a membership form was displayed to all the members who were currently presented in the event.

Link to the Database- https://www.learning4impact.org/phc-innovations#database-section

Annexures:

Annexure 1- Agenda

S.No	Time	Time Slot	Session	Facilitator
1	10 min	10.00-10.10	Introduction to the CPHC Alliance and our Expert	Ranjani Gopinath
2	10 min	10.10-10.20	Opening remarks by the Expert	Rajeev Sadanandan
3	15 min	10.20-10.35	Presentation of research study on PRIs	HSTP research team
4	25 min	10.35-11.00	Experience sharing on PRI reforms - key challenges and solutions	Rajeev Sadanandan
5	75 min	11.00-12.15	Question and Answer Session	All participants, facilitated by Shiv Kumar
6	15 min	12.15-12.30	Partnering with the Alliance	Binali Suhandani

Annexure-2

List of participants

https://docs.google.com/document/d/1M80B3YFW7pF-dbg2SVLloh_t5vuMSi6ZqZGe8AgilZY/edit

Thank You!