Role of Decentralisation in Health in India: Insights and Recommendations for Strengthening Local Health Systems

A Conference Report

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HSTP Health Systems Transformation Platform

JANAAGRAHA

Health Action by People

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FOREWORD

Decentralisation can be described as the devolution of resources, tasks, and decision-making power to democratically elected authorities that are closest to the people and often the first port of call for civic and administrative matters. Through the 73rd and 74th amendment of the constitution of India, decentralisation was expected to bring government closer to the people and, thereby, provide more opportunities for civic participation and the empowerment of local officials. However, actual progress in this regard has been slow and uneven across the country. The COVID-19 pandemic further highlighted the importance of decentralised decision-making.

Kerala has been a leader in devolving power as well as resources to the local governments, especially in the service sector that includes health and education. In health, institutions like primary health centres, community health centres, sub-district (taluk) hospitals and district hospitals were transferred to respective tiers of local governments, with a transfer of assets as well as resources for planning new initiatives. Kerala has experience of more than 25 years in implementing decentralisation. Health Action by People (HAP) supported by the Health Systems Transformation Platform (HSTP), conducted a study to understand the impact of decentralisation on health in the state.

Simultaneously, Janaagraha Centre for Citizenship and Democracy, conducted a study to better understand decentralisation in the context of growing urbanisation in Bihar and select cities outside the state, by focusing on the financial sustainability, accountability, and current capacities of urban local bodies to manage healthcare delivery.

The two studies generated interesting findings. To disseminate and deliberate on the findings from the studies, HSTP in partnership with HAP and Janaagraha organised a conference on the 'Role of Decentralisation in Health' on 27 and 28 February 2023. The conference brought together practitioners, technical experts, elected representatives, policymakers, and researchers to share insights and experiences. The discussions led to an insightful analysis of the policy to practice journey of decentralisation and generated several ideas, as will be evident in this report.

We take this opportunity to express our deepest appreciation to all those who made this undertaking a reality. Special gratitude to Dr. Thomas Isaac and Mr S. M. Vijayanand, and all the panellists for taking out time from their busy schedules and joining us for the course of the discussions. We are grateful to Mr. Hardeep Singh Puri, Union Minister for Housing and Urban Affairs and Mr. Manoj Joshi, Secretary, Ministry of Housing and Urban Affairs, Government of India for gracing the occasion with their presence.

Furthermore, we would like to acknowledge with much appreciation the crucial role of the teams of the three collaborating organisations-HSTP, HAP and Janaagraha for their contribution to planning and executing the conference.

We would also like to express our gratitude to Ms. Anagha Khot for documenting the conference proceedings in this report.

We hope this document will help identify potential areas for research, policy, and programme intervention to strengthen the role of decentralisation in the country's health system in rural and urban contexts.

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HIGHLIGHTS AND KEY TAKEAWAYS: A SUMMARY READ-OUT

Decentralisation in health is re-gaining importance, as demonstrated by the COVID-19 pandemic and recent policy initiatives such as the XV Finance Commission of India and Pradhan Mantri – Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). Decentralisation has the potential to bring improvement in access to and quality of health services, particularly in rural and remote areas, while also empowering local authorities and communities to take more control over health service delivery. The 73rd and 74th Constitutional amendments in India led to creation of a three-tier system of local governance in rural and urban areas, respectively, giving local bodies significant powers and resources to manage local affairs, including health service delivery.

The state of Kerala has been a front-runner in devolving power and resources to local governments, post the constitutional amendments particularly in the health sector, and other states and low- and middle-income countries (LMICs) can draw lessons from their experiences. Historically, the urban local bodies, at least in the erstwhile Bombay Presidency and metropolitan cities, have enjoyed a greater degree of autonomy. The role of urban local bodies (ULBs) in creating healthy cities and urban spaces is also gaining recognition. Despite this, there has been limited evidence on the role played by local governments in health care, both in rural and urban settings. With a view to fill this policy to practice gap, the Health Systems Transformation Platform (HSTP) in partnership with Health Action by People (HAP)[1] and Janaagraha Centre for Citizenship and Democracy[2] organised a conference on 'Role of Decentralisation in Health' on 27-28 February 2023 in New Delhi. This conference brought together policy makers, technical experts, elected representatives, practitioners, and researchers to: (i) share insights and experiences on the impact of decentralised governance in the health sector in Kerala based on a study by Health Systems Transformation Platform and Health Action by People and (ii) reflect on the findings from a landscape study by Janaagraha Centre for Citizenship and Democracy on the role of ULBs in managing primary health care in Bihar and models of urban primary health care in Bengaluru, Bhubaneshwar, Chennai, and Pimpri Chinchwad.

The conference was designed in the form of presentations and moderated panel discussions on various aspects of decentralisation in the rural and urban context. The panellists and participants shared wide-ranging insights and reflections which are captured in this report. The conference documentation is expected to contribute towards identifying potential areas for research, policy, and programme intervention to strengthen local health systems.

[1] http://hapkerala.org/

[2] https://www.janaagraha.org

Key Takeaways

- **Decentralisation takes various forms and is often implemented as part of wider reforms; hence it is difficult to per se, untangle the exact impact of decentralisation on health.** International evidence shows that adequate mix of technical skills, effective decision-making, process focus, government support, and responsive governance are some factors that influence decentralisation.

- **Successful decentralisation focuses on process and not merely on technocratic solutions.** Striking a balance between technical expertise, oversight and local decision-making is key to successful decentralisation. As also, is continually building technical and institutional capabilities, engaging with the political economy, and considering socio-economic disparities and health system contexts.

- **Kerala's success in decentralisation was due to a convergence of constitutional, political, and intellectual factors, effective planning, values-driven decentralisation, and building capacity through doing.** Kerala's decentralised financial system, People Plan Framework, freedom and accountability, active facilitation, and fraternity are also essential components of successful decentralisation. While there are still areas for improvement, Kerala's experience can guide others as they seek to empower local communities.

- **Dynamics between local government and state/centre affects the extent of decentralisation.** There is a need for better coordination between state and local bodies, as well as more effective allocation of funds for healthcare, which is crucial for improving public health outcomes.

- **Though decentralisation experiences are context specific, decentralisation does create the necessary conditions for better health outcomes.** Evidence from Kerala shows that while the final outcomes may vary across different regions and periods, by providing a democratic space for citizens to intervene, decentralisation creates an opportunity for improvements in health outcomes.

- **Decentralisation has led to several benefits**. Provision of augmented funding and human resources at the local level has resulted in improved health infrastructure, accessibility, quality of healthcare services, and better outcomes across different health programmes and initiatives (e.g., Nutrition, TB, HIV/AIDS, Vector Borne Disease Control, RMNCH+A, Primary/Family Health Care etc) in Kerala.

- **Models of compassionate governance can exist in public system.** Decentralised spaces have played a critical role in the initiation and expansion of compassionate governance initiatives such as BUDS and Palliative Care Model in Kerala.

- **State government support is essential for scaling up and institutionalisation,** through initiatives like modification of fiscal structures, augmentation through policies and guidelines.

- **Decentralisation is about power. It is about 'power to the people through panchayats and ULBs'.** Constant vigilance is needed to keep

decentralisation agenda active, safeguard community participation in its true sense and ensure that there is no roll-back. But a tendency to shift power from government officials to elected representatives instead of the community has been noticed in Kerala.

- **Adopt a multi-level planning approach and integrate health plans at central, state, and local level** to ensure health programmes are coordinated and aligned with national and state health policies and contribute towards achievement of common objectives.

- **Balance devolution and centralisation in health planning.** Initiatives like those of the XV Finance Commission offer unprecedented opportunities. At the same time, it is critical to trust local government and not micro-manage from the Centre, or develop separate plans under various programmes rather than a comprehensive health plan thereby undermining the systems for devolution that have been put in place by states.

- **Missed opportunity.** Evidence from Kerala shows that the National Health Mission, which was set up to promote decentralised decision making to support local needs and local level planning were not in synchrony, with health planning by both proceeding in parallel, leading to a lost opportunity for strengthening the decentralisation initiative.

- **Create sustainable systems.** Health service delivery infrastructure expansion in several states is primarily staffed by contractual staff. The state government needs to support local governments in creating cadre positions to ensure sustainability of human resources.

- **Decentralisation in Urban vs. Rural settings.** Overall, the effect of decentralisation is more emphatically seen in rural Gram Panchayats than in ULBs in Kerala. At the same time, politically, 'urban' is increasingly gaining salience in many parts of the country, where going forward decentralisation pathways may not be linear, but context will be queen and content will be king.

- **Mere passing of responsibility to ULBs is not decentralisation, it is a millimetre away from abdication.** In absence of full devolution of power as envisaged under the 74th Amendment, ULBs dependence on state resources curbs innovation necessary for public health delivery. True decentralisation occurs when a central/state government(s) shares responsibility and contributes to capacity building to raise funds, operationalise, implement and monitor and depends on the extent of community participation. The XV Finance Commission allocated Rs. 26,000 crores to ULBs. However, the subsequent operational guidelines by states tend to somewhat restrict the role of ULBs, giving more primacy to states and districts. Also, there is a need to build absorptive capacity at local level.

- **Urban health is gaining centre-stage, yet much remains to be done.** There is a growing emphasis on addressing the health needs of urban population and bolstering urban health services. Yet, only ten major municipal corporations in the country manage health systems.

- **City is a system of systems. Urban health demands a distinct yet holistic approach. It is critical to address layers within cities, consider the intersection of city systems and health systems, and not view urban health through a sectoral approach alone.** To be truly effective, the planning, community needs assessment and structures for urban health services need to be 'locality specific', only then true convergence is possible. The XV Finance Commission and PM-ABHIM provide an opportunity to examine the needs and challenges in urban settings and take a leap forward by developing fit for purpose urban health models.

- **Models of urban primary health care are emerging (e.g., Mohalla Clinics, Namma Clinics, Jijao Clinics) yet urban context is largely untapped - the determinants of success have not been fully understood -** be it in terms of - getting community structures to work, or building capacities, or ensuring community voices are represented. Some early learnings from Bhubaneshwar, Bihar, and Delhi showcase efforts in leveraging community structures in urban settings. There is a need to brainstorm on how urban health agenda can be moved forward within the decentralisation framework.

- **Public Participation.** It is important to go beyond creating efficient government systems and get citizens to directly participate in programme making and implementation at local levels. Important to incorporate the voice and agency of people in decentralisation process.

Agenda for the Future: Possible Actions

- **Revive community-based planning for health, undertake responsibility mapping, implement a multi-level planning approach,** and integrate health plans at central, state, and local level.
- **Advocate for creation of institutional mechanisms/platforms for the National Health Mission (NRHM/NUHM) to consult with rural and urban local bodies.** The NUHM framework is in the process of being revised. Importance of convergence, platforms for institutional mechanism, definition of role and responsibilities of ULBs, creation of uniform structure for ULBs are some issues under consideration.
- **Nurture, mentor and work with gram panchayats and ULBs to create successful models of decentralisation** (e.g., demonstration of how a comprehensive health plan can be developed and implemented; models of urban health care).
- **Design, implement and institutionalise systematic leadership development programmes for Gram Panchayats and Urban Local Bodies while incorporating a dedicated focus on fostering women's leadership.** This approach would enable them to prioritise health issues, strengthen their skills and expertise in health planning, and contribute towards effective implementation of the XV Finance Commission grants.
- **Leverage new spaces and financial levers offered by the XV Finance Commission, to go beyond the gram panchayat, and develop block and district specific plans.** Community awareness about their entitlements coupled with capacity building can influence the extent of engagement.
- **Develop a methodology** for use of State Finance Commission (SFC) grants by Gram Panchayats, intermediate Panchayats and ULBs, which is adapted to state/city context.

- **Begin to collate empirical data to prepare a Memorandum for the XVI Union Finance Commission on Health Grants.**
- **Invest in systems of governance, adopt a holistic 'city systems' lens with a layered, segregated and context-specific approach for addressing health in urban settings**. Provide states and ULBs, a menu of options that can be adopted/adapted based on local needs, typology of municipal bodies, city tiers (e.g., metro, tier I and II cities, census towns) rather than one-size fits all approach.
- **Provide practical insights and guidance to ULBs on urban health**, based on what is possible within current policy and programme framework(s).
- **Learning from state and city experiences: Best Practice documentation and Research Agenda**
    - Examine the extent of decentralisation ('as is where is decentralisation') and compile exemplary state-level practices around decentralised health sector governance for knowledge-sharing and replication (e.g., Meghalaya, Nagaland, etc). Based on this, provide states a menu of options rather than using a one-size fits all approach.
    - Critically assess the role of local governments in responding to COVID-19 pandemic across rural and urban settings and lessons learnt.
    - Critically examine decentralisation in health - from national to local level- to identify which functions can be decentralised and what should remain centralised.
    - Examine the extent and role of ULBs in engaging with private sector (including informal providers) in select cities/states and recommend options on potential models and pathways for private sector engagement.
- **Leverage digital technology** to create awareness among people, provide information about available services, improve access to health services and ensure better resource management.
- **Leverage the opportunity** for communitisation of SDGs to improve demand at local level. Also, leverage the SHG platform in rural and urban areas to promote decentralisation.
- **Develop and implement pro-active strategies, to ensure health needs of minority groups, tribal population, migrants, and women** are addressed and equitable access to healthcare services is ensured.
- **Health Rights Charter.** Develop and advocate for a health rights framework for citizens, especially the poor, homeless, and informal workers.
- **Monitoring, evaluation, and data-driven decision-making.** Establish/strengthen data systems and mechanisms to track the progress and effectiveness of decentralisation initiatives and health programmes, using data to inform policy and resource allocation.

ABOUT THE CONFERENCE

The importance and role of decentralisation in health is re-gaining prominence today. The COVID-19 pandemic highlighted the importance of decentralised decision-making and local-level response and community participation in the health sector. Recent policy initiatives, including but not limited to the recommendations of the XV Finance Commission of India pertaining to provision of health grants to local bodies[3], Pradhan Mantri – Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), and the focus on Health and Wellness Centres (HWCs) under Ayushman Bharat (AB) have also contributed to renewed interest in decentralisation in health.

Given India's significant health challenges, decentralisation is seen as a pathway to improve access to and quality of health services, particularly in rural and remote areas. Decentralisation can strengthen local governance, empower local authorities and communities to take more control over health service delivery, and to tailor services to local needs and priorities. Decentralisation is also seen as a way to help achieve Sustainable Development Goals (SDGs), including SDG-3, which aims to ensure healthy lives and promote well-being for all at all ages.

Public health was one of the subjects whose control was vested in rural and urban local governments by the 73rd and 74th Constitutional amendments in India. The 73rd and 74th Constitutional amendments, adopted in 1992, established a three-tier system of local governance in rural and urban areas, respectively. The amendments gave local bodies, including panchayats and municipalities, significant powers, and resources to manage local affairs, including health service delivery. Following the spirit of the amendments, various states enacted Panchayati Raj Act(s) to empower the rural and urban local governments to manage the sectors that were transferred to them[4].

The state of Kerala, which has been a front-runner in local self-governance, went beyond other states of India in devolving power as well as resources to the local governments. In the health sector, institutions like primary health centres (PHCs), community health centres (CHCs), sub-district (taluk) hospitals and district hospitals (DH) were transferred to respective tiers of local governments, with transfer of assets, management of personnel as well as resources for planning new initiatives. Unique to Kerala, this was not a passive exercise in confirmation with the central and state government statutes; rather, it was taken up as a political campaign aimed at transfer of power to local governments. Kerala has been the only state to actively celebrate 25 years of the decentralisation journey. Decentralisation helped the state to deal effectively with the outbreaks such as NIPAH virus and the COVID-19 pandemic among others.

The recent past has also seen the increasing recognition of the importance, complexities, and role of urban local bodies in the health sector, which received impetus from initiatives like National Urban Health Mission (now subsumed under the National Health Mission) and Smart

[3] https://fincomindia.nic.in/writereaddata/html_en_files/15thFcReportIndex.html
[4] https://www.panchayat.gov.in/whats-new-content/-/asset_publisher/4ySMdMHjzIhP/content/current-panchayati-raj-act

Cities Mission among others. The COVID-19 pandemic brought to forefront the state of urban health system(s) and factors unique to cities and urban settings, which impact urban preparedness for future health emergencies. Given the key role of municipal corporations and/or municipalities in creating healthy cities and urban spaces, initiatives by urban local bodies are gaining momentum.

Despite this, there has been limited evidence on role played by local government in health care, both in rural and urban settings. This conference sought to fill this policy to practice gap by bringing together policy makers, technical experts, elected representatives, practitioners, civil society, and researchers to:

- **Share insights and experiences on impact of decentralised governance in health sector in Kerala,** including the historical evolution of related policies and practice and to draw lessons for other states and low- and middle-income countries (LMICs), based on a research study by Health Systems Transformation Platform (HSTP) and Health Action by People (HAP)[5].
- **Examine the findings from a landscape study on role of urban local bodies** in managing primary health care in Bihar, including an analysis on models of urban primary health care in ensuring access to equitable health services in Bengaluru, Bhubaneshwar, Chennai and Pimpri Chinchwad based on research by Janaagraha Centre for Citizenship and Democracy.[6]

Key discussion points and insights that emerged during the two-day conference are collated and documented in this report. **For ease of presentation, the report is organised thematically, and not sequentially as per the agenda**. Given the inter-linkages between the themes, at times, varied aspects of the same theme may also flow into different sessions. A copy of the agenda is at Annexe-1 and list of participants is at Annexe-2.

This documentation is expected to contribute towards identifying potential areas for research, advocacy, policy, and programme intervention to strengthen the local health systems both in rural and urban context.

[5] http://hapkerala.org/
[6] https://www.janaagraha.org/

PRESIDENTIAL ADDRESS: THE JOURNEY OF DECENTRALISATION IN KERALA

In the Presidential Address, Dr. T.M. Thomas Issac, Former Finance Minister of Kerala, and a key architect of Kerala's People's Plan Campaign laid out the key dimensions of the journey of decentralisation in Kerala.

Key Takeaways

- Effective people's action is a powerful catalyst for change.
- Decentralisation creates the necessary conditions for good health.
- Decentralisation is essential for improving health outcomes.
- Decentralisation demonstrates the power of public health systems and local communities working together to address life-style diseases.
- Continuously address and learn from impediments.
- Balance Devolution and Centralisation in Health Planning.

Key Takeaways:

- **Effective people's action is a powerful catalyst for change.** Decentralisation plays a critical role in empowering local governments with the transfer of funds, functions, and functionaries, enabling concerned citizens to intervene more effectively in local decision-making processes. This intermediation of citizens is key to strengthening the impact of decentralisation and amplifying the voices of those who are most affected by policy decisions.
- **Decentralisation creates the necessary conditions for good health.** Kerala's experience demonstrates that while the final outcomes may vary across different regions and periods: by providing a democratic space for citizens to intervene, decentralisation paves the way for improvements in health outcomes.
- **Decentralisation is essential for improving health outcomes** as it follows the principle of subsidiarity, allowing for effective implementation of important sectors like water, sanitation, nutrition, fiscal culture, and education at the local level. Kerala's remarkable health outcomes are largely attributed to the continuous demand for health services from social movements and concerned citizens. The state's response to crises such as COVID-19, floods, and NIPAH outbreak have gained global recognition. The active participation of local government and communities has been a vital factor in the success of these responses.
- **Decentralisation demonstrates the power of public health systems and local communities working together to address life-style diseases.** The rise in lifestyle diseases has resulted in an increased emphasis on specialised hospital care. Kerala's successful community-based palliative care system for tackling lifestyle diseases like cancer demonstrates the power of public health systems and local communities working together. Similarly, innovative models have been developed for geriatric care and addressing the needs of differently-abled children, and these have been scaled up across the state.

- **Continuously address and learn from impediments.** Although devolving power to local governments is crucial, it's important to recognise that there are multiple obstacles that must be addressed during implementation. Despite the initial excitement surrounding the 73rd and 74th constitutional amendments, progress has been slow. Kerala is the only state to proactively celebrate the 25th anniversary of democratic decentralisation, highlighting the need for greater attention and effort towards fully realising the potential of decentralisation.
- **Balance devolution and centralisation in health planning.** Financial devolution by Union Finance Commission was not factored in during 1990s at the time of the 73rd and 74th Amendments. Today, the Union Finance Commission's allocation to local governments coupled with allocation for Centrally Sponsored Schemes and other programmes is substantial and assured to enable states to start planning. While this is a welcome initiative, it is critical to trust local government and not micro-manage from the Centre, or develop separate plans under various programmes rather than a comprehensive health plan thereby undermining the devolution practices and achievements that have been put in place by states like Kerala among others.

REFLECTIONS ON STRENGTHS AND WEAKNESSES OF 25 YEARS OF DECENTRALISATION IN KERALA

In his address, Mr. S.M. Vijayanand, former Chief Secretary, Kerala, and the architect of the administrative structure of Kerala's decentralisation reflected on strengths and weaknesses of 25 years of Kerala's experience in decentralisation.

Insights from Kerala's decentralisation experience relevant for other states and LMICs

- **Convergence of Constitutional, Political, and Intellectual factors.** Kerala's success in decentralisation can be attributed to the convergence of constitutional, political, and intellectual factors. Political consensus sets decentralisation going, but ongoing efforts are required to sustain it. Civil society, politicians, and bureaucrats actively worked together to create a system that cannot be rolled back.

- **Campaign for Planning and Putting Evidence into Action.** In the nineties Kerala carried out a total literacy campaign, with popular participation. The community mobilisation that accompanied the literacy movement was instrumental in galvanising public participation in Kerala's decentralisation process. Evidence-based policies informed by rigorous research and methodology were developed. This approach empowered people to take an active role in the planning process and make informed decisions.
- **Bringing the State to the Doorstep of the People – Moving from a Welfare State to a Caring State.** Effective planning was a crucial factor behind the success of decentralisation. Rather than diminishing the role of the state, the approach was to bring the state's services and resources closer to the people and address their specific needs.
- **Values-Driven Decentralisation.** Kerala's decentralisation process was founded on clearly articulated values and principles that prioritised participation, inclusivity, transparency, and accountability, with an emphasis on uplifting the poorest of the poor. This guided local policy-making and norm-setting and ensured that decision-making was grounded in the needs and perspectives of the communities affected by it.
- **Build Capacity Through Doing, Guide Without Directing, Enable Without Restraining.** Decentralisation process actively sought to build capacity by providing resources, responsibility, and trust to local communities. The government's role was to enable communities to take charge without imposing rigid direction or constraints, which was a formidable challenge. An innovative concept of 'voluntary technical core[7]' was introduced to address capacity gaps. However, this approach has not been fully utilised.
- **Equitable Decentralisation.** This approach aimed to guarantee that all communities (rural and urban) had equal access to resources and services, while allowing for local variations.

[7] The core comprises experts who volunteer their time and skills to assist local communities in their development efforts.

He further elaborated on the Ten Fs in Kerala's experience in Decentralisation

Reflections on Kerala's Decentralisation Experience: The Ten Fs

- Clarity in **F**unctions
- Institutionalise **F**unctionaries with a clear control
- Ensure adequate **F**inances
- **F**ungible Funds
- Validated and Successful **F**ramework
- **F**reedom and Accountability
- Active **F**acilitation
- **F**raternity
- **F**unctioning

1. **Clarity in Functions.** Ensuring clarity in functions of centre, state and local governments is essential. This helps to prioritise responsibility mapping over activity mapping. In Kerala, the human development institutions (e.g., health and education) are under the ambit of the local government. The Gram Panchayat is the most powerful with a focus on 'more to the bottom'.
2. **Institutionalise Functionaries with a clear line of control [Work and Worker Go Together].** In Kerala, a dual control system is in place – professional control by department and administrative control by gram panchayats. This allows for effective supervision by gram panchayats and penalties for non-performance.
3. **Ensure Adequate Finances.** Adequate resource allocation has been ensured in Kerala, with good level of own source revenue. A substantial part of the funds devolved to local governments is untied, thereby allowing greater autonomy and flexibility. Local Governments also have access to non-lapsable general corpus fund. Transparency is ensured through computerised allocation and formula with weightage.
4. **Fungible Funds.** Kerala's decentralised financial system is characterised by fungibility, which allows for freedom of use within a framework while ensuring equity and assuredness of resource, thereby facilitating planning and implementation.
5. **Validated and Successful Framework.** Kerala's People Plan Framework is an effective planning method which is emulated by Gram Panchayats across the country.
6. **Freedom and Accountability.** Local governments have the freedom to spend within a framework, but they cannot change priorities set by the state. Local GP decisions can only be cancelled if illegal, by an ombudsman after due process. Local governments cannot be dissolved, making Kerala unique in India in that there is independence of local governance.
7. **Active Facilitation.** The government must facilitate without interference.
8. **Fraternity** is necessary for decentralisation. The largest fraternity in Kerala is a formal partnership between SHGs and local government, which predates decentralisation.
9. **Functioning** is crucial, and Amartya Sen's idea of converting capability into functions is vital. While the initial focus of local governments was on infrastructure, evidence has shown that decentralisation has also contributed to improvements in service delivery, poverty reduction, and the creation of a new generation of political leadership that understands development. Decentralisation enables diffused economic stimulus as funds become available to all and are not restricted to regions with better absorptive capacity. With local government, the surface area of contact between people and governance (platforms) widens and distance closes.
10. The **Future** of decentralisation is evolving. Some challenges from Kerala experience are: constituency-based approach for spending of money; prioritisation of an annual plan over a five-year plan; negotiated priorities instead of evidence-based prioritisation; lack of comprehensive health plan; weak capacity for multi-level planning; Adivasi and traditional fishing communities not being able to fully harness the benefits of decentralisation, need for improvement in tax mobilisation and building managerial capacity for governance.

SPECIAL ADDRESS

In his address, Mr. Manoj Joshi, Secretary, Ministry of Housing and Urban Affairs, Government of India highlighted that Kerala has a unique political and social context that allowed it to adopt decentralised planning effectively, resulting in remarkable improvements in healthcare and education, with a strong emphasis on PHCs and local bodies' funding. However, this model may not be applicable 'as is' to other states due to different political exigencies and the varying success of decentralisation in ULBs. While decentralisation has succeeded in rural local governments in Kerala the experience of ULBs has not been comparable.

Key Takeaways:

- **Emphasis on local government**. Legacy of strong public health systems and public health activities were further strengthened through decentralisation. Kerala's tradition of political decentralisation facilitated the adoption of decentralised planning. The movement of devolution of institutions was affected by political expediency.
- **Urban vs. Rural**. Effect of decentralisation was more emphatically seen in rural Gram Panchayats than in urban local bodies (ULBs). Zilla and Block Panchayats could not replicate what Gram Panchayats were able to do.
- **Institutional transfer challenges**. Difficulty in effectively transferring institutions at the district level.

- **Success in healthcare**. Decentralisation led to remarkable results in Primary Healthcare Centres and preventive healthcare among other.
- **Combined effect.** Increased (and sustained) state investments coupled with decentralisation contributed to system-wide improvements. Strong standard operating procedures and work culture were also evident during the COVID-19 pandemic.
- **Applicability of Kerala model**. Kerala's unique context may limit the direct application of its model to other states but there are elements which other states can learn and adapt to their context.

KEYNOTE ADDRESS

Mr. Hardeep Singh Puri, Hon'ble Minister of Housing and Urban Affairs, Government of India highlighted the importance of decentralisation journey of India especially in the *Amrit Kaal* period.

Key Takeaways:

- **Importance of development parameters.** Significance of sensitivity and quality of life in addition to GDP, as key components of a country's development, was emphasised, with education and healthcare identified as critical areas for qualitative advancement.
- **COVID-19 has re-ignited the debate on urban planning and development** around density versus urban sprawl.
- **Increased urban focus in policy making** was highlighted. Significant government funding is being allocated to programmes such as Swachh Bharat Mission 2.0 and National Health Infrastructure Mission. The XV Finance Commission's allocations to local self- government present an unprecedented opportunity to reform previously under-funded municipal health functions and improve urban service delivery.
- **Importance of research and evidence in urban planning to understand the impact of determinants of health** was emphasised**,** citing John Snow's work on cholera in London as an example. The importance of learning from successful healthcare models and practices within India was reiterated.
- **Academia and research institutions can act as catalysts and help demonstrate successful models** of decentralised health care, that can be scaled up nation-wide.

He concluded with the view that findings of the studies and deliberations of the conference can guide local decision making and health services planning in rural and urban areas.

INTERNATIONAL EXPERIENCE OF DECENTRALISATION IN HEALTH

In this session, Prof. Dina Balabanova, Professor of Health Systems and Policy in the Department of Global Health and Development, London School of Hygiene and Tropical Medicine, shared lessons and insights from international experiences from LMICs and high-income countries on decentralisation in health.

Key Takeaways:

- **Decentralisation takes various forms (e.g., de-concentration, devolution, delegation, or privatisation) and is often implemented as part of wider reforms.** Policy goals of decentralisation are to enhance governance, better reflect local needs and structures, improve service delivery, accountability, efficiency and optimise financing flows.
- **Difficult to untangle impact of decentralisation on health** as it often mirrors political structures. There may be mismatch between design and implementation and decentralisation may span multiple sectors making attribution difficult. Intention vs Outcome depends on institutional capacities, governance structures and political will. Success of Brazil's approach provides an encouraging example of how municipal bodies execute functions affecting health.
- **Success factors in LMICs and SSA.** Adequate mix of technical skills, effective decision-making, focus on processes, central government's will to make legislative/ administrative changes, and presence of mechanisms that enable responsiveness to local needs and values were identified as key success factors across 26 Low- and Middle-Income Countries (LMICs) and Sub-Saharan Africa (SSA). The case of Kenya illustrates the benefits as well as unintended consequences of decentralisation.
- **High-income countries' evidence** shows moderate decentralisation is associated with lower public healthcare spending and higher life expectancy. While decentralisation may help improve efficiency; excessive decentralisation may lead to fragmentation of healthcare services and reduce efficiency and hamper implementation of national strategies.
- **Actor-based approaches** may be more effective than technocratic solutions.
- **Clear roles, agreements, and supportive structures**. Beyond political will and alliances, clear roles and agreements on key decentralised tasks and identification of supportive structures is necessary.
- **Successful decentralisation focuses on process and not merely on technocratic solutions**. Decentralisation has mixed outcomes, and continually building technical and institutional capabilities is critical. Alongside, engaging with the political economy, building relationships, and considering socio-economic disparities and health system contexts are crucial for successful decentralisation as seen in successful examples in Brazil, Honduras among others. Strengthening overall governance remains a critical task.

Key Takeaways

- Decentralisation takes various forms and is part of wider reforms.
- Difficult to untangle impact of decentralisation on health.
- Success factors in LMICs and SSA: technical skills, effective decision-making, process focus, government support, and responsive governance.
- Moderate decentralisation in high-income countries is associated with lower spending and higher life expectancy.
- Actor-based approaches may be more effective than technocratic solutions.
- Clear roles, agreements, and supportive structures are necessary for successful decentralisation.
- Successful decentralisation focuses on process.

DEEP DIVE: DECENTRALISATION AND LOCAL DECISION MAKING IN HEALTH - THE KERALA EXPERIENCE

This section provides an overview of key findings and takeaways based on in-depth study and sub-studies on different aspects of decentralised governance in Kerala's health sector.

1. DECENTRALISATION AND PUBLIC HEALTH IN KERALA: INSIGHTS AND OVERARCHING RECOMMENDATIONS FROM FIELD RESEARCH

Dr. V Raman Kutty, Chairman, Health Action by People, Kerala, shared findings and recommendations from the field research on decentralisation and public health in Kerala.

Key findings:

(We have come a long way yet)…**True participatory democracy remains a distant dream**

- **Government-citizen interface had a positive impact.** Local governments came down to the people resulting in improved material conditions of people's lives.
- **The three-tier system of local government effectively intervened in local governance** and modified as necessary, the instruments of power, to make the system responsive to people's needs.
- **Mixed outcomes and importance of local factors.** Decentralisation interacted with local factors to improve people's lives with varying degrees of success across levels and regions.
- **Community participation improved health outcomes.** Overcoming initial resistance from traditional bureaucracy, younger medical professionals recognised the potential of working with local governments to improve the health status of their communities, leading to better health outcomes.
- **Improved health infrastructure across all three tiers.** Local governments enthusiastically supported demands from technical experts to improve health infrastructure at all three tiers, resulting in improved access to care and reduction in costs for local communities.
- **Effective use of opportunities offered by decentralisation were made by the Department of AYUSH** compared to the more dominant allopathic sector.
- **Decentralisation led to improvements in Primary Health Care** with local governments undertaking projects in nutrition, vector control, waste management, drinking water, and sanitation, which contributed to better health. National programmes for HIV/AIDS, TB, Vector Borne Diseases Control programmes were implemented with augmented funding and human resources at the local level.
- **Missed opportunity.** The National Health Mission, which was set up to promote decentralised decision making to support local needs and planning were not in synchrony, with health planning by both proceeding in parallel, leading to a lost opportunity for strengthening the decentralisation initiative.
- **Failure to truly empower marginalised communities.** Decentralisation process failed to truly empower marginalised communities (e.g., Dalits, Adivasis and coastal fishermen), leading to comparatively poor health outcomes for these communities. Women's health is another area that needs to be further strengthened.
- **Moving from representation to true participation.** There has been lack of participation in Gram Sabhas, except as claimants for benefits, thereby reflecting the stratified status of the larger society.

Key Recommendations

- **Enhance capacity of Health Working Groups** at the panchayat level with the help of local experts to ensure that health services are tailored to the needs of the local population.
- **Develop/strengthen health database** at the panchayat level, including electronically link all government data, to provide accurate and timely information on the health status of the population, which can inform the development of health policies and programmes.
- **Implement a 5-Year perspective instead of an annual plan to** enable a more comprehensive and long-term approach to health planning.
- **Incorporate social determinants in planning** to address the social determinants of health, and enable collaboration between different sectors (e.g., education, water, sanitation, and housing) to address underlying causes of poor health.
- **Adopt a multi-level planning approach and integrate health plans at central, state, and local level** to ensure health programmes are coordinated and aligned with national and state health policies and contribute towards achievement of common objectives.
- **Revamp the urban health system.** The urban health system is currently the weakest link in the local planning process. Bring Health and Wellness Centres (HWCs) under the overall supervision of the Gram Panchayat and utilise Self Help Groups more effectively.
- **Increase resource allocation** for health programmes for improved health outcomes.
- **Conduct capacity building programmes** for Panchayat members to enhance their skills and knowledge in health planning and management. Joint training of Panchayat members and health workforce improves collaboration and efficiency.
- **Implement participatory planning campaigns** to increase awareness and participation in health programmes, instead of planning being a routine government activity.

2. IMPACT OF DECENTRALISATION ON HEALTH SERVICE DELIVERY

Dr Rekha Raveendran, Executive Member, HAP & Sr. Research Officer, State Health System Resource Centre, Trivandrum, Kerala shared findings of a sub-study on the influence of decentralisation in the implementation of various national and state health programmes in Kerala (See Box for list of programmes covered).

Key takeaways:

- **Local government involvement has resulted in positive outcomes.** Successful models of community engagement (e.g., NCD control, Primary/Family Health Care) have been identified and can be replicated in other areas.
- **Decentralisation has led to several benefits.** Provision of augmented funding and human resources at the local level has resulted in improved health infrastructure, accessibility, quality of healthcare services, and better outcomes across different health programmes and initiatives (e.g., Nutrition, TB, HIV/AIDS, Vector Borne Disease Control, RMNCH+A etc) in Kerala.

List of national and state health programmes covered in the study

- National Health Mission
- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular disease and Stroke
- National Vector Borne Disease Control Program
- National Tuberculosis Elimination Programme
- National AIDS Control Programme
- Reproductive, Maternal, Newborn, Child Health + Adolescents
- Ardram Mission, a state government initiative to transform public health care

- **Local government involvement has consistently led to more effective community participation, locally appropriate solutions, improved access to services, and better outcomes across different health programmes.** Decentralisation has provided committed leaders and officers with the freedom, resources, and space to develop and implement healthcare programmes, making governance more accessible and fostering mobilisation of volunteers and local resources.
- **Challenges.** To fully realise the potential of local government involvement, challenges such as bureaucratic rigidity, power dynamics, uneven commitment among leaders and healthcare workers, lack of awareness among community leaders and health workers, lack of public health perspective in planning, funding shortages, inadequate monitoring and evaluation, and sustainability must be addressed. For example, a missed opportunity to align NHM activities with the existing decentralised framework, resulted in considerable gaps in integration.

3. IMPROVING ACCESS TO MARGINALISED POPULATION

Dr Biju Soman, Executive Member HAP & Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, shared insights on impact of decentralisation on the health of marginalised populations in Kerala. While decentralisation has contributed to improved health outcomes for the general population, the effect on marginalised groups within Kerala has been limited.

Key Takeaways

- Better health indicators for Scheduled Tribes and Scheduled Castes, but disparities remain.
- Budget allocations not translated into commensurate outcomes.
- Importance of valuing culture and addressing oppressive elements.
- Potential limitation of democratic decentralisation.

- **Improved health indicators for Scheduled Tribes and Scheduled Castes, yet disparities remain.** Decentralisation has led to noticeable improvements in infrastructure, staff patterns, and overall efficiency in Kerala's healthcare system. Scheduled Tribes (ST) and Scheduled Castes (SC) in Kerala have better health and development indicators than those in the rest of India, but significant disparity remains within Kerala, particularly among the ST population who experience higher levels of poverty and social exclusion.
- **Budget allocations not translated into commensurate outcomes**. Despite significant budget allocations towards the Tribal Sub Plan and local self-government initiatives, commensurate changes are not seen. Political activism is emerging among various communities, including SC and coastal communities.
- **Importance of culture and addressing oppressive elements**. Schemes are often imposed upon these communities without considering their priorities or aiming for their long-term benefit, highlighting the importance of valuing their culture and customs. Oppressive elements such as casteism and hierarchies need to be addressed to mainstream these communities and promote their long-term benefit.
- **Potential limitation of democratic decentralisation**. Dominant middle-class ethos can limit the inclusion of weaker sections, and the democratic decentralisation process, dominated by such ethos, may still have significant limitations.

4. COMMUNITY BASED INNOVATIONS – BUDS SCHOOL AND PALLIATIVE CARE

Dr. Ravi Prasad Varma P, Executive Member, HAP & Additional Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram presented on two community-based innovations, namely the BUDS School and Kerala's palliative care model.

BUDS is a collective venture that supports socio-economically disadvantaged families who have a child or adult person with developmental disorder. It brings together Kudumbashree, local governments, and various departments such as education, women and child development, social justice, and health to provide support to those in need. The success of BUDS demonstrates the impact of collective efforts in improving the lives of marginalised communities.

Key Features of BUDS:

- **'Home-grown' model in response to local needs.** BUDS initiative was launched in August 2004 after results of a socio-economic survey in Venganoor Gram Panchayat by Kudumbashree, which identified families with differently abled children living in poor and deprived conditions. In absence of any existing models to emulate, the gram panchayat leader and others established the first BUDS school. The success of the first BUDS school led to the establishment of more schools, followed later by BUDS rehabilitation centres (BRCs) for people in the adult age group. From 2004 to 2020, the number of BUDS Schools and BRCs have increased significantly. The number of registered beneficiaries has also increased from 41 in the age range of 2 to 20 years in 2004 to 9,001 in the age range of 5 to 45 years in 2020.
- **Critical role of Local Government** in supporting the BUDS initiative by providing infrastructure, remuneration for staff, equipment, support to beneficiaries, and transportation. Even during the COVID-19 pandemic, the BUDS institutions continued to function.
- **Challenges remain.** While BUDS has been successful in providing support to socio-economically disadvantaged families, there are areas for improvement in terms of standardisation and equity in support across different gram panchayats.

Kerala's Comprehensive Palliative Care Programme: A Model for India and Beyond

Kerala is known for having one of the most comprehensive community based palliative care programmes in India, which has become a model for other states and countries worldwide. Key features are:

> As a society, collective, or state, we have a responsibility to care for those who are suffering, and governance that is compassionate and focused on development and democratic deepening can help support this effort.

- **Community-based care model is possible.** The palliative program, a joint initiative between the government of Kerala, non-governmental organisations (NGOs), and the local community, is a testament to the power of community-based care and the importance of providing compassionate care to patients with advanced illnesses.
- **Emphasis on holistic care.** The programme focuses on providing relief from pain and other distressing symptoms, as well as improving the quality of life for patients and their

families. Trained palliative care nurses visit bedridden and homebound patients in every gram panchayat, municipality, and corporation, with transportation provided for home visits.

- **Pilot, iterate and scale.** The palliative care programme has evolved and expanded over time. The early developments of the programme were institution-centred, with pain clinics and palliative care societies established in different areas. The Neighbourhood Network in Palliative Care (NNPC) was piloted in 1996, with community participation. The involvement of local government was demonstrated in 2007 through the Pariraksha initiative in two panchayats and through the Santhwanam project of the Kudambashree.
- **Integration with the health system.** In 2008, the Kerala Pain and Palliative Care Policy was introduced with a focus on community participation through a three-tier governance system. The policy was implemented, through Aarogya Keralam Palliative Care Project under the National Rural Health Mission (now NHM) with the Directorate of Health Services providing guidelines and support. The programme was mandated in all Local Self-Government Institutions by a 2012 order, and by 2014, Kerala was the only state in India to have palliative care in all districts. The policy was revised in 2019. By 2019, there were 1,084 primary palliative care units with 151,454 registered patients in Kerala.
- **Financing and Ensuring Sustainability.** The programme is financed through a combination of earmarked funds and local resource mobilisation. The budget allocation for palliative care in Kerala has steadily increased over the years, with expenditures on palliative care increasing for all types of local bodies.
- **Challenges remain.** For instance, there is a need for effective implementation in urban areas of the Corporation (as compared to the Panchayat area) and for improvements in monitoring and evaluation system to assess the quality-of-service provision.

Key Takeaways

- **Models of compassionate governance can exist in public system**. Decentralised spaces have played a critical role in the initiation and expansion of compassionate governance initiatives such as BUDS and Palliative Care Model.
- **State government support is essential for the scale up and institutionalisation**, through initiatives like modification of fiscal structures, augmentation through policies and guidelines.
- **Need to address quality-of-service provision.** Concerns related to variations in quality-of-service provision need to be addressed in order to ensure continued success.
- **Develop robust information and monitoring systems** to capture technical inputs in order to improve the implementation and effectiveness of the programmes.

EXPERIENCE SHARING BY ELECTED REPRESENTATIVES – RURAL

Elected representatives shared examples of innovations and best practice initiatives undertaken through leadership of the local self-government in rural Kerala and Jhabua district of Madhya Pradesh.

The genesis and process followed for **development of the first BUDS school, a special school for children with developmental disorders which was started by a Gram Panchayat as part of its poverty reduction effort, its subsequent scale-up by the state** and the role of local governments was shared by Mr. Bhagat Rufus (District Panchayat Member, Venganoor Division, Kerala). He outlined in detail, the active role of the gram panchayat in identification of children with developmental delays through medical camps and special medical board meetings and efforts to get the BUDS school off the ground[8]. The BUDS school today forms an integral part of efforts to develop child friendly panchayats. The role of gram panchayat in preparation of detailed sectoral plans by consolidating the micro-plans prepared at the neighbourhood level was also shared.

Adv. Saju Xavier (Panchayat President, Payyavoor Gram Panchayat, Kerala) discussed the **transformation of health centers in rural areas from Primary Health Centers (PHCs) to Family Health Centers (FHCs).** Local resources from the gram panchayat are used to complement and top-up what the government provides, including support for drugs, human resources (doctor, palliative care nurse and pharmacist), laboratory, x-ray facility, extension of OPD hours among others. The panchayat also provides palliative care[9] to about 200 patients.

Advocate Rajeev N (Former Panchayat President, Eraviperoor Gram Panchayat, Kerala) presented on **wide range of health-related activities and innovations undertaken by the gram panchayat.** Notably, these included, gram panchayat complementing state government resources in ensuring availability of human resources and drugs, fully equipped laboratory, pharmacy. The gram panchayat was the first to introduce Yoga over a decade ago, when no such direction was provided in the annual plans. The Primary Health Centre (subsequently upgraded as Family Health Centre) at the Panchayat is unique in having a quality circle and has also achieved ISO and NQAS certification. The Hospital Management Committee (HMC) acts as an implementing and monitoring agency and actively engaged in various activities. Innovative practices undertaken by the panchayat include, for example, organisation of Arogya Sabha in all 17 wards of the panchayat since 2014 and evaluation of health activities by the Gram Sabha on a six-monthly basis. The panchayat also runs a NCD fitness centre, medicine counselling centre, runs a club for elderly people amongst other. During COVID-19, the panchayat was the first to use robots to provide services at First Line Treatment centres where patients with mild symptoms were managed.

Mr. Radhu Singh Bhuria (Former President Block Panchayat, Block Rama, Jhabua, Madhya Pradesh) **a rural and remote block in Madhya Pradesh spoke of his efforts to improve health**

[8] Details about the BUDS school genesis and impact are covered in the session on community-based innovations in this report.

[9] Details about the palliative care model are covered in the session on community-based innovations in this report.

at the Janpad Panchayat (block) level during COVID-19 lockdown, including installing a digital x-ray machine. This was first such effort which considerably impacted people's access to basic diagnostic services. He also shared efforts at successfully establishing computer lab for children in rural areas, as well as the difficulties faced in implementing solar power systems due to a lack of civil engineers. Despite these challenges, he emphasised the importance of perseverance and innovation.

In subsequent discussions, one of the participants raised concerns about **women's representation at different levels of governance.** In response to a **query on planning and resource generation,** the planning process in Kerala, including the role of planning committee, working group and Gram Sabha was explained. The idea for a project is presented in the planning committee, followed by working group[10] (which acts as a technical support group) which examines the proposal based on various parameters. The final proposal is presented to the Gram Sabha for approval. In terms of resource allocation, nearly 30% of state plan budget is given to local governments. Of this, 70% of funds is allocated to the gram panchayat. Sector plans are thereafter developed based on local priority. Funds are also received from NHM. Gram Panchayats also generate own funds/revenue through licensing, etc. Local government fixes priority and decides the resource allocation. The process itself creates demand from below. The local government, if needed, undertakes local resource mobilisation.

The topic of resource generation through **user fees at health centres** was briefly touched upon. In contexts where utilisation rates for health services are low, the imposition of user fees can create barriers to access for economically disadvantaged populations. It was stated that basic services need to be provided by the state, Rogi Kalyan Samiti can only supplement it. SHGs can play a critical role in demand generation.

The **importance and role of awards such as Argram Arogya Puraskaram, how it led to allocation of funds by NHM to gram panchayats and helped move the focus from infrastructure to quality health service delivery was shared.** Such awards and incentives also initiated a competition amongst Gram Panchayats.

Across these initiatives, the speakers elaborated on the planning process, resource allocation, and the role of local self-governance in utilising funds for health initiatives. These experiences outline how decentralisation creates spaces for local leadership and innovation to emerge.

[10] Working Group comprises of five categories of members, including elected member who is usually chair of the Standing Committee, medical officer, non-government professional, CSO member and community representative

DEEP DIVE: DECENTRALISATION IN THE URBAN CONTEXT

1. DECENTRALISATION JOURNEY OF THREE CITIES – EXPERIENCES FROM BENGALURU, CHENNAI AND PIMPRI-CHINCHWAD

The 74th Constitutional Amendment established the overarching framework for urban governance in India. This discussion brought together senior representatives – Dr. K. V. Trilok, Special Commissioner- Health, Bruhat Bengaluru Mahanagara Palike Chandra (as Chair) and Dr. Balasundar A S, Chief Health Officer (Public Health), Bruhat Bengaluru Mahanagara Palike (BBMP), Dr. M. Jagadeesan,

City Health Officer (Public Health Department), Greater Chennai Corporation (GCC) and Dr. Laxman Gophane, Asst. Medical Officer of Health, Pimpri-Chinchwad Municipal Corporation (PCMC) who shared on-ground initiatives and challenges faced in the context of urban local bodies. Ms. Astha Joshi, Associate Manager, Janaagraha Centre for Citizenship and Democracy, in the opening presentation highlighted the key findings from Janaagraha's study focusing on three cities, namely - Bengaluru, Chennai and Pimpri Chinchwad – who are leading in service delivery and community engagement in urban primary health care.

Key highlights of the Janaagraha study are:

Bengaluru	Chennai	Pimpri Chinchwad
•Health is key agenda for Ward Level Committees. •Insitutionalisation through policy initiatives and prioritisation of public health delivery by administrative and elected representatives. •Futuristic planning for health infrastructure, services and human resources. •Well functioning Jan Arogya Samitis •List of services, drugs, diagnostics and equipment available in public domain. •Emphasis on delivery of Comprehensive Primary Health Care services in a phased manner. •Leveraging of state level robust supply chain mechanism for drugs, diagnostic consumable and medical equipment. •Financial Resources: BBMP corpus, NUHM resources for drugs in case of emergencies.	•Historical prioritisation of health by policy makers. •Larger share of resources allocated to health as compared to other ULBs. •Creation of a seperate cadre of human resources for health. • Active and engaged Standing Committee on Health at city level. •UPHC Lady Medical Officers trained to conduct ultrasonography. •DOTS Centres, Laboratories and NCD clinics operational at UPHCs and UCHCs and prioritised for population based screening and rendering of services. •Cadre of community volunteers trained to screen for NCDs. •Self help groups recognised as Mahila Arogya Samitis. •Financial Resources: GCC corpus, NUHM, State health schemes.	•Shift from focusing only on Maternal and Child Health and vector control services to provision of Comprehensive Primary Health Care through model UPHCs. •Facility based screeing for NCDs and primary level care for hypertension and diabetes. •Provision of laboratory services in PPP. •Household-based Population Emumeration underway. •Plan to digitize all health care records. •Financial Resources: NUHM, user fees.

The panel discussion covered various aspects of public health delivery in the context of Urban Local Bodies, with a focus on success stories, budget allocations, and organisation of health services, engagement between state government and ULBs, and level of citizen engagement in policy formulation.

Key themes from the panel discussion and subsequent interactions with participants

- **Urban health is gaining centre-stage, yet much remains to be done.** There is a growing emphasis on addressing the health needs of urban population and bolstering urban health services. Yet, only ten major municipal corporations in the country manage health systems. These cities have evolved systems within ULBs over a period of time and are able to deliver citizen-centric services including health.
- **Models of urban primary health care are emerging.** Corporations such as BBMP and PCMC are in the process of establishing/expanding urban primary health centres known as Namma Clinics and Jijao Clinics respectively, to provide comprehensive primary health care services. Corporations (e.g., PCMC, GCC) also support health service delivery (e.g., for cardiac care, MRI/CT scan, dialysis etc) through Public Private Partnership (PPP) mode or hub and spoke model for laboratories (e.g., BBMP).
- **Varied financing provisions.** Provision of financing and autonomy varies across ULBs. These include, own corpus (e.g., BBMP, GCC), NUHM/state scheme (e.g., BBMP, GCC, PCMC) and user charges (e.g., PCMC). For instance, during COVID-19, additional services (e.g., RTPCR labs) were undertaken through GCC funds based on policy direction from the state government/NHM or Directorate of Public Health.
- **Health system (re) organisation, human resource and governance models evolve over time.** For instance, GCC has a legacy of creating a health officer post through a legal provision dating back to 1880s. Independence in functioning also means that GCC recruits its own health human resources (after approval on number of posts is accorded by the state government). The BBMP established separate cadres for health department with a focus on delivering public health services. Presently, a proposal for creation of 'One Bangalore Health System' which brings all primary, secondary, and tertiary services under one administrative head is under consideration. In comparison, a relatively 'younger' Corporation like PCMC relies heavily on contractual employees for health service delivery.
- **Citizen engagement is largely through public representatives.** In case of GCC, for instance, local councillors as well as the Standing Committee are actively engaged in the planning and implementation of health programmes. All health and related programmes are intimated to local councillors through a WhatsApp Group. Ward committees (e.g., BBMP, GCC) play a critical role in policy formulation, budgeting, implementation, and oversight for health-related initiatives. GCC is making efforts to create local Area Sabhas (not exclusively for health) while in PCMC, Mahila Arogya Samitis (MAS) is regarded as mechanism for citizen engagement.

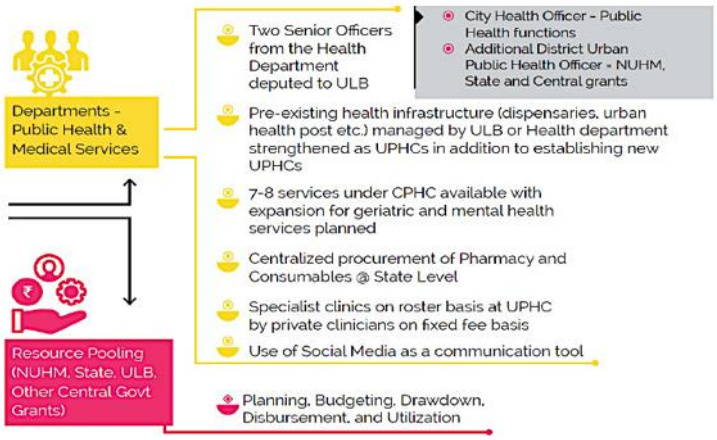
2. DECENTRALISATION JOURNEY OF EMERGING CITIES – BHUBANESHWAR, BIHAR, AND URBAN KERALA

This session chaired by Ms. Urvashi Prasad, Director, Office of Vice Chairman, Niti Aayog comprised of a mix of presentations and panel discussion. Mr. Shoumik Guha, Head - Public Health & Development, Janaagraha Centre for Citizenship and Democracy shared the findings

of studies conducted in Bhubaneshwar and Bihar on efforts made to bring about improvement in health by the Urban Local Bodies (ULBs). Dr. Kamala Rammohan, Executive Member HAP & Assistant Professor, Dept. of Pulmonary Medicine, Govt. Medical College, Trivandrum, Kerala shared findings from the study on role of local government institutions in Kerala's urban health sector. This was followed by a panel discussion comprising of Ms. Akhila Sivadas (Executive Director, Centre for Advocacy and Research), Dr. A Sasikumar (Corporation Health Officer, Kozhikode Municipal Corporation) and Mr. Sumit Kumar (Senior State Programme Manager, CARE India) who shared on-ground initiatives and challenges faced in the context of urban local bodies.

Key takeaways from the operating model in Bhubaneshwar

- **Clear State Government Mandate** for the involvement of ULBs in public health has been provided.
- **Strong Convergence** between Bhubaneshwar Municipal Corporation (BMC) and the Health Department.
- **Elected Representatives' engagement institutionalised** upto the ward level.
- **Upgrading of Healthcare Institutions to Urban Primary Health Centres (UPHCs**) with support from the National Urban Health Mission (NUHM).
- **Specialist Clinics operational in UPHCs**, with doctors hired on a contractual basis from the private sector.
- **Use of Social Media Communication** to communicate about available services.



Key takeaways from landscape study in Bihar

- **Expand Coverage and Improve Quality of NUHM services**. Improvements have occurred in infrastructure, maintenance, drugs, and diagnostic availability. However, coverage and quality of services need to be improved and shortage of drugs and consumables addressed.
- **Human Resource Challenges**. Availability of full-time health human resources dedicated to UPHCs is huge challenge.
- **Expansion of services to NCDs, yet larger focus continues to be on MCH and FP.** Patients visiting UPHCs are screened for diabetes and hypertension. However, larger focus

continues to be on Family Planning and MCH services. Special immunisation corners set up in UPHCs.

- **Limited role of ULBs in health,** primarily limited to vector control measures, WASH related activities and community mobilisation.
- **Limited capacity and engagement of Jan Arogya Samitis (JAS).** Though JAS have been formed, meetings are irregular. Participation of Local Councillors in JAS is limited.
- **Limited awareness among Elected Representatives** about their roles and responsibilities in health.

Key takeaways on role of local government institutions in Kerala's urban health sector

- **Weak Governance.** Decentralised governance in the urban health sector is weaker compared to rural local governments.
- **Priority to micro-sectors**: ULBs accord priority to micro-sectors like drinking water, nutrition, sanitation, and waste management.
- **Focus on service delivery.** Some ULBs have collaborated with health facilities and stakeholders to implement innovative, need-based health projects (e.g., out-sourcing of laboratory investigations to private clinics to reduce out of pocket expenditure, support for elderly and palliative care, running a dialysis project, implementation of green protocol in waste management).
- **Low fund utilisation.** Only 50% of funds allocated for health and health- related projects in ULBs were utilised between 2014 and 2020, with the highest utilisation (and priority) given to nutrition (75%).
- **Resource allocation is disproportionate to the expenditure**, for instance, highest fund allocation is for infrastructure development for allopathic urban health facilities which is not able to expend the entire quantum of allocated resources vis-a-vis for instance, human resource component which receive less quantum of funds but are able to expend the same. Similarly, the AYUSH institutions were seen to be better able to expend allocated funds as compared to allopathic institutions.
- Needs of **minority, vulnerable groups and women's health** require more attention.
- **Challenges** faced by ULBs include low autonomy, conflicts of ideas among stakeholders, lack of awareness/capacity, lack of proper co-ordination leading to delays in fund disbursal, confusion in identifying beneficiaries of certain programmes, duplication in project implementation and lack of resources and innovative initiatives to name a few.

The panel discussion revolved around the experiences and challenges in urban governance.

Key themes from the panel discussion and subsequent interactions with participants were:

- **Decentralisation remains a daunting challenge especially in urban settings**. COVID-19 pandemic has renewed the discussion on health and urban settings.
- **The urban context is largely untapped - we don't know enough of what works and what doesn't work** - be it in terms of - getting community structures to work, or building capacities, or ensuring community voices are represented.
- **Examples from Bhubaneshwar, Bihar, and Kozhikode, showcase efforts in leveraging community structures in urban settings.** For instance, in Bhubaneshwar, community structures at slum level, have been leveraged through creation of single window mechanism for WASH and help desks which helped communities/MAS to access/activate

their entitlements. Expansion of SHG platform and efforts at facility mapping to improve health infrastructure planning, augmentation of human resources and bringing service delivery improvements have been undertaken in Bihar. The local body in Kozhikode directly runs six Urban Health Centres with own resources. Additionally, it is also involved in running of FHC/CHC/ UPHC, primary prevention activities, vital registration, solid and liquid waste management, licensing, and secondary care. The local body has invested its resources in infrastructure development, support for health workforce contractual staff, purchase of drugs, elderly care, screening for NCDs, de-addition centre among others. Challenges include short time available for actual implementation of approved project and lack of multi-disciplinary support.

- The need to build social capital beyond existing schemes, ensuring that communities are empowered and have access to the benefits of these programmes was emphasised. As also civil society's role in facilitating the capacity building of ULBs and enabling community participation.
- Participants enquired about whether the study findings (e.g., community preference on health seeking) were triangulated with the community. And the other, was whether there was difference in women's engagement in ULBs.

Key Takeaways on Decentralisation in the urban context[11]:

- **Differing priority accorded to health across Urban Local Bodies.** Though ULBs are largely empowered by Municipal Acts to handle primary healthcare, and community health is a core function; preventive and promotive aspects are classified as 'additional functions' leading to nuanced implementation. In most states/cities, role of ULBs is primarily limited to community mobilisation and vector control. Public health is largely interpreted to focus on solid waste management and WASH.
- **Variance in role of health officer across settings**. Though the health officer finds mention in Municipal Acts, the actual role varies across municipalities. It is often restricted to registration of vital statistics and prevention of infectious diseases.
- **Financial devolution is key.** The 74th amendment provides a framework for devolving power to ULBs. However, in absence of full devolution of power, ULBs dependence on state resources curbs innovation necessary for public health delivery.
- **Urban health demands a distinct approach as compared to rural health care systems.** Urban health has tended to largely be a replica of rural health model. The XV Finance Commission provides an opportunity to examine the needs and challenges in urban settings and take a leap forward by developing fit for purpose urban health models.
- **Balance between centralised control and decentralised execution is needed to ensure uniformity in execution, especially in urban settings.** Guidelines should be given to ground-level people for effective utilisation of resources and to maintain consistency.
- **Need for a holistic yet layered, segregated and context-specific approach for addressing health in urban settings**. Provide states and ULBs, a menu of options that can be adopted/adapted based on typology of municipal body, city tiers (e.g., metro, tier I and II cities, census towns) and requirements rather than one-size fits all approach. Also, need to align population norms with urban governance infrastructure, streamline processes and coordination between ULBs and other stakeholders to reduce delays, duplication, and confusion in programme implementation.

[11] This summary combines the key points that emerged in both the sessions.

- **Create institutional arrangements at national level for systematic capacity building on urban health**, including for ULBs.
- **Review/Strengthen communitisation structures and processes for urban health**. To begin with, need to provide practical insight to ULBs on urban health, based on what is possible within current policy and programme framework.
- **Mechanism for referral audits**. In large urban settings, such as Mumbai, audit of referrals is essential to promote self-sufficiency in local health institutions and reduce the burden on larger facilities.
- **Create sustainable HR systems.** Health service delivery infrastructure expansion is primarily staffed by contractual staff. The state government needs to support urban local governments in creating cadre positions to ensure sustainability of human resources.
- **Public Participation.** Important to go beyond creating efficient government systems at urban level and get people to directly participate in programme making or implementation.
- **Private sector engagement, including with informal providers in urban settings needs to be part of** policies and programme and new knowledge and models (e.g., municipal surveillance, community surveillance models) generated on potential pathways for private sector engagement.

ROLE OF URBAN LOCAL BODIES IN PRIMARY HEALTH CARE: OVERARCHING RECOMMENDATIONS

Mr. Srikanth Viswanathan, Chief Executive Officer, Janaagraha Centre for Citizenship and Democracy, Bangalore highlighted the key takeaways from Janaagraha's work on role of urban local bodies in primary health care, focusing on the interactions between the city system and health systems. Overall, he emphasised the need for a more integrated approach to public health in urban planning and design, as well as improved capacity and resources such as municipal financing and leadership development programmes. Citizen participation is a key factor in promoting healthy cities.

Key Recommendations classified under the four catalytic 'City-Systems':

1. **Urban Planning and Design**

- **Prioritise public health in current town and country planning act(s).** With rise of non-communicable diseases, look at intersection between city systems and health systems, spatial design of cities itself becomes important (e.g., design streets and transportation systems that promote physical activity, address air pollution and other challenges). Mere co-ordination between different functions such as water, sanitation, and public health is not enough, adopting a whole system approach is needed.

2. **Urban Capacities and Resources**

- **Municipal Financing is a challenge.** Improve public finance systems by institutionalising reforms in financial accountability and transparency and build capacities for better management of state health budget to ensure that health allocations are well-utilised.
- **New Staffing Models.** Examine opportunities for innovative staffing arrangements, such as in Bhubaneshwar wherein health specialists are deputed to work along with and under supervision of overall city management. Or, the approach of building shared capacity through a cluster-based model for creation of a shared municipal services.

3. **Empowered and legitimate political representation**

- **Systematic Leadership Development Programmes**. Undertake systematic leadership development programmes to mainstream urban healthcare at the ward and block level, including proactive investments in women's leadership. Address the latent demand for councillor leadership programmes, which can also promote decentralisation.

4. **Transparency, accountability, and participation**

- **Citizen Participation**. Empower and build capacities of Standing Committees. Also, support the development of integrated local and hyper-local citizen engagement platform rather than development of fragmented sectoral platforms to ensure integration of different sectors.

EXPERIENCE SHARING BY ELECTED REPRESENTATIVES - URBAN

Former elected representatives/mayor namely, Mr. Abdul Wajid, Former Councillor, Leader of Opposition, Bruhat Bengaluru Mahanagara Palike, Dr Pandurang Patil, Former Mayor Hubli Dharwad Municipal Corporation, Ms. Meher Haider, Former Councillor, Brihanmumbai Municipal Corporation and Mr. Ibrahim Babu, Former Mayor, Ballary Municipal Corporation spoke about the importance of proper implementation of the 74th amendment, in its true spirit, which would enable Urban Local Bodies (ULBs) to address local health issues.

Key Takeaways:

- **Decentralisation is crucial but the 74th amendment has not been fully implemented, leaving Urban Local Bodies (ULBs) weak.** Last mile delivery can only be assured through decentralisation. At the minimum, regular elections need to be held to ensure that local councillors are in place so that local governance systems are functional.
- **Only when there is devolution of funds, functions, and power transfer then the potential of decentralisation in urban context can be fully realised**. In present scenario, ULBs have no power or role in health. Local councillor funds are primarily used for drainage, roads, and health is largely seen as being limited to solid waste management.
- **COVID-19 clearly showed the importance of decentralisation.** For instance, Mumbai was able to manage the COVID-19 crisis effectively due to the decentralised approach in ward management. However, post the pandemic, the system has returned to centralisation, causing challenges in HR resource management, logistics supply and service delivery. In other corporations (e.g., Bellary City Corporation, BBMP) the local councillors played a proactive role in COVID-19 Response. These learnings, especially from community engagement, should be used for strengthening health programmes and health system.
- **Build on the gains from COVID-19 and strengthen capacity amongst people's representatives,** ward level committee and other fora for addressing health issues.
- **Dynamics between local government and state/centre affects the extent of decentralisation.** There is a need for better coordination between state and local bodies, as well as more effective allocation of funds for healthcare, which is crucial for improving public health outcomes. Central government should issue overarching advisory/guidance so that local bodies are uniformly given powers for addressing health issues.
- **Leverage digital technology** to create awareness among people, provide information about available services, entitlements, improve access to health services and ensure better resource management.

SHARING DECENTRALISATION EXPERIENCES OF STATES

The panel discussion, chaired by Mr. Anirban Ghose, Co-founder, Transforming Rural India Foundation focused on reflections and learnings of decentralisation experiences from the states of Karnataka (Mr. Mohan H.L, CEO, Karnataka Health Promotion Trust) and Haryana (Dr. Shailendra Kumar Hooda, Associate Professor, Institute for Studies in Industrial Development) in the rural context and from Delhi (Dr. Tarun Seem, Indian Revenue Services, Health Systems Expert) in the urban context.

Highlights from State Experiences

- **Moving from centralisation to nuanced decentralisation in Delhi.** In Delhi, Mohalla Clinics initiative started primarily as a state driven model to provide assured basic curative services free of charge through neighbourhood clinics. The clinics disrupted existing protocols for recruitment, payment, stock movement, laboratory support, reporting and management. As the basic model evolved and stabilised, based on implementation experience, various elements were decentralised.

Decentralisation elements in Delhi's Mohalla Clinics: Reflections

What may be decentralised: Activities for which relevant local intel, capacity and funding exists (e.g., site, workforce, security, janitorial, utilities and oversight)

What may NOT be decentralised: Overall design and organisation; Information system and management through information system; Financing, SoPs, Annual maintenance contracts

What may be optimally decentralised: Ownership, Communication and Signages, Medicine supply, laboratory work, innovations

- **Leveraging learnings from COVID-19 to improve health system at the village level in Karnataka by taking the system closer to the people.** The Gram Panchayat Arogya Amruta Abhiyaana (GPAAA), aims to imbibe the positive learnings from COVID-19 and institutionalise decentralised convergence between health department functionaries, community structure and mandated committees to build healthy villages. This model primarily envisages the Gram Panchayat Task Force members, Health and Wellness Centres and Jan Arogya Samitis and functionaries working together to reach the community at village level. The GPAAA focuses on addressing promotion and implementation of testing, screening, and awareness programmes for infectious disease (e.g., TB), NCDs (e.g., Diabetes and Hypertension), under-nutrition/anaemia, menstrual hygiene, and mental health amongst its other activities. This initiative has now been scaled across all 6,000 gram panchayats in the state of Karnataka.
- Using select data from District Level Household Survey (DLHS-4) the **inter-relation between different dimensions of decentralisation, degree of community participation and health outcomes (e.g., maternal and child health) in the state of Haryana was examined.** Research showed that extent of decentralisation (high or low) coupled with degree of community participation and awareness plays a crucial role in ensuring equitable access to healthcare facilities across different socio-economic groups. Overall, high level of decentralisation and community participation shows a positive association with improvements in health service utilisation (e.g., MCH services, institutional delivery etc.) and reduction in out-of-pocket expenses. When dominant class/caste/male capture most of the decentralisation powers, it resulted in low community participation and reduction in service utilisation.

Key Takeaways

- **Mere passing of responsibility to ULBs is not decentralisation, it is a millimetre away from abdication.** True decentralisation occurs when a central/state government(s) shares responsibility and contributes to capacity building to raise funds, operationalise, implement and monitor and depends on the extent of community participation. For true decentralisation to occur, all parts of the government need to reform. What is implemented on the ground is important rather than a formal policy.
- **Decentralisation is about power.** Constant vigilance is needed to keep decentralisation agenda active, safeguard community participation in its true sense and ensure there is no roll-back.
- **Leverage spaces for communities to play active role in moving needle on health indicators at local level** in areas of nutrition, drinking water and sanitation and NCDs, which we have not effectively addressed. In rural areas, the Gram Sabha is a critical platform to foster community engagement and leadership.
- **The XV Finance Commission provides new space for communities to go beyond gram panchayat and develop block and district specific plans**. Community awareness about their entitlements coupled with capacity building can influence the extent of engagement (e.g., local gap identification for Health and Wellness Centres at panchayat level or provision of oversight over Village Health and Nutrition Days using digital applications in Jharkhand).
- **Fit for purpose hyper local strategies and guidance are needed to truly address urban health issues.** The approach of one-size fits all strategy (e.g., MAS) is not effective. To be truly effective, urban health services planning, community needs assessment and structures need to be 'locality specific', only then true convergence is possible.
- **Document and learn from state experiences.** For instance, extent to which mandates of health and urban development are aligned; oversight and co-ordination between department of health and ULBs, capacity building of ULBs etc.
- **Need for research and documentation on role of ULBs in engaging with private sector and extent of complementarity with public system, especially with emergence of health start-ups** (e.g., experiences from Rajasthan, Delhi)

AGENDA FOR THE FUTURE

The two-day conference provided a unique opportunity for policy makers, implementers, experts, researchers, elected representatives, and civil society to collectively reflect on the role of decentralisation in health in India. The group identified successes and best practices, challenges, and unaddressed issues to truly implement decentralisation in the health sector. A summary of proposed actions and the way forward is below.

- **Revive community-based planning for health, undertake responsibility mapping, implement a multi-level planning approach,** and integrate health plans at central, state, and local level.
- **Advocate for creation of institutional mechanisms/platforms for the National Health Mission (NRHM/NUHM) to consult with rural and urban local bodies.** The NUHM framework is in the process of being revised. Importance of convergence, platforms for institutional mechanism, definition of role and responsibilities of ULBs, creation of uniform structure for ULBs are some issues under consideration.
- **Nurture, mentor and work with gram panchayats and ULBs to create successful models of decentralisation** (e.g., demonstration of how a comprehensive health plan can be developed and implemented; models of urban health care).
- **Design, implement and institutionalise systematic leadership development programmes for Gram Panchayats and Urban Local Bodies while incorporating a dedicated focus on fostering women's leadership.** This approach would enable them to prioritise health issues, strengthen their skills and expertise in health planning, and contribute towards effective implementation of the XV Finance Commission grants.
- **Leverage new spaces and financial levers offered by the XV Finance Commission, to go beyond the gram panchayat, and develop block and district specific plans.** Community awareness about their entitlements coupled with capacity building can influence the extent of engagement.
- **Develop a methodology** for use of State Finance Commission (SFC) grants by Gram Panchayats, intermediate Panchayats and ULBs, which is adapted to state/city context.
- **Begin to collate empirical data to prepare a Memorandum for the XVI Union Finance Commission on Health Grants.**
- **Invest in systems of governance, adopt a holistic 'city systems' lens with a layered, segregated and context-specific approach for addressing health in urban settings**. Provide states and ULBs, a menu of options that can be adopted/adapted based on local needs, typology of municipal bodies, city tiers (e.g., metro, tier I and II cities, census towns) rather than one-size fits all approach.
- **Provide practical insights and guidance to ULBs on urban health**, based on what is possible within current policy and programme framework(s).
- **Learning from state and city experiences: Best Practice documentation and Research Agenda**
    - Examine the extent of decentralisation ('as is where is decentralisation') and compile exemplary state-level practices around decentralised health sector governance for knowledge-sharing and replication (e.g., Meghalaya, Nagaland, etc). Based on this, provide states a menu of options rather than using a one-size fits all approach.
    - Critically assess the role of local governments in responding to COVID-19 pandemic across rural and urban settings and lessons learnt.

- Critically examine decentralisation in health - from national to local level- to identify which functions can be decentralised and what should remain centralised.
- Examine the extent and role of ULBs in engaging with private sector (including informal providers) in select cities/states and recommend options on potential models and pathways for private sector engagement.

- **Leverage digital technology** to create awareness among people, provide information about available services, improve access to health services and ensure better resource management.
- **Leverage the opportunity** for communitisation of SDGs to improve demand at local level. Also, leverage the SHG platform in rural and urban areas to promote decentralisation.
- **Develop and implement pro-active strategies, to ensure health needs of minority groups, tribal population, migrants, and women** are addressed and equitable access to healthcare services is ensured.
- **Health Rights Charter.** Develop and advocate for a health rights framework for citizens, especially the poor, homeless, and informal workers.
- **Monitoring, evaluation, and data-driven decision-making.** Establish/strengthen data systems and mechanisms to track the progress and effectiveness of decentralisation initiatives and health programmes, using data to inform policy and resource allocation.

Health Systems Transformation Platform, Health Action by People and Janaagraha Centre for Citizenship and Democracy in collaboration with other partners, will actively pursue and take forward the insights, recommendations that have emerged to advance the agenda of decentralisation in health within the Indian context.

ANNEXE-1: AGENDA

Conference: Role of Decentralisation in Health

Date: 27 – 28 February 2023

Location: Friendship Lounge, Third Floor, Hotel Ashok, Chanakyapuri, New Delhi

Agenda

Time	Session	Speaker
Day 1: 27 February 2023		
9:30 – 12 noon	**Inaugural Session**	
9.30 - 9.40 am	Welcome Address	Mr. Rajeev Sadanandan, Chief Executive Officer, Health Systems Transformation Platform (HSTP), New Delhi
9.40 - 10.00 am	Presidential Address	Dr. T. M. Thomas Isaac, Former Minister of Finance, Government of Kerala
10.00 - 10.45 am	25 years of Decentralisation in Kerala: Strengths and Weaknesses Chair: Mr. Manoj Joshi, Secretary, Ministry of Housing and Urban Affairs, Government of India	Mr. S.M. Vijayanand, Former Chief Secretary, Government of Kerala
10.45 – 11.10 am	*Coffee Break*	
	Chair: Dr. T. M. Thomas Isaac, Former Minister of Finance, Government of Kerala	
11.10 - 11.20 am	Key Recommendations of the Study: *Role of urban local bodies in primary health care*	Mr. Srikanth Viswanathan, Chief Executive Officer, Janaagraha Centre for Citizenship and Democracy, Bangalore
11.20-11.30 am	Key Recommendations of the Study: *Decentralisation and Local Decision Making in Health-the Kerala Experience*	Dr. V Raman Kutty, Chairman, Health Action by People, Kerala
11.30-11.35 am		
11.35 - 11.55 am	Release of the two Study Reports	
11.55 – 12 noon	Keynote Address	

	Vote of Thanks	Mr. Hardeep Singh Puri, Hon'ble Minister of Housing and Urban Affairs, Government of India Dr. Sudha Chandrashekar, Advisor, HSTP
12.00 – 1.00 pm	Decentralisation Journey of 3 Cities: Bengaluru, Chennai, and Pimpri-Chinchwad	
Chair: Dr. K. V. Trilok Chandra, Special Commissioner- Health, Bruhat Bengaluru Mahanagara Palike		
12.00-12.15 pm	Decentralisation Journey of 3 Cities	Ms. Astha Joshi, Associate Manager, Janaagraha Centre for Citizenship and Democracy
12.15-1.00 pm	Panel Discussion	Dr. Laxman Pandurang Gophane, Asst. Medical Officer of Health, Pimpri-Chinchwad Municipal Corporation Dr. Balasundar A S, Chief Health Officer (Public Health), Bruhat Bengaluru Mahanagara Palike Dr. M Jagadeesan, City Health Officer (Public Health Department), Greater Chennai Corporation
1:00 – 2:00 pm	*Lunch*	
2.00-3.20 pm	Decentralisation of Health in Kerala	
Chair: Dr. T. M. Thomas Isaac, Former Minister of Finance, Government of Kerala		
2:00-2:20 pm	Decentralisation & Public Health in Kerala (insights from field research)	Dr. V. Raman Kutty, Chairman, HAP
2:20-2:35 pm	Impact on health service delivery	Dr. Rekha Raveendran, Executive Member, HAP & Sr. Research Officer, State Health System Resource Centre, Trivandrum, Kerala
2.35-2.50 pm	Improving access to marginalised population	Dr. Biju Soman, Executive Member HAP & Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerala
2.50-3.20 pm	Discussion + Q&A	
3.20-3.30 pm	Preparation for virtual session	
3.30-4.00 pm	International experience of decentralisation in health (10.00am UK time)	Prof. Dina Balabanova, Health Systems and Policy, Department of Global Health and Development, London School of Hygiene & Tropical Medicine
4:00–4.30 pm	*Coffee Break*	
4:30 – 5:30 pm	**Experience sharing by Elected Representatives – Rural**	
	Chair: Mr. S.M Vijayanand, Former Chief Secretary, Government of Kerala	Mr Bhagath Rufus, District Panchayat Member, Venganoor Division, Kerala

	Panel Discussion	Adv Saju Xavier, Panchayat President, Payyavoor Gram Panchayat, Kerala Adv Rajeev N, Former Panchayat President, Eraviperoor Gram Panchayat, Kerala Mr. Radhu Singh Bhuria, Former President Block Panchayat, Block Rama, Jhabua, Madhya Pradesh
Day 2: 28 February 2023		
9:30 – 9:45 am	Recap	
9:45- 10:15 am	**Community based innovations: Buds School & Palliative Care**	
	Chair: Dr. Vijayakumar K, Honorary Secretary, Health Action by People, Kerala	Dr. Ravi Prasad Varma P, Executive Member, HAP & Additional Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerala
10:15 -11:15 am	Decentralisation Journey of Emerging cities: Bhubaneswar, Bihar, Urban Kerala	
Moderator: Ms. Urvashi Prasad, Director, Office of Vice Chairman, Niti Aayog		
10.15-10.30 am	Bhubaneshwar & Bihar	Mr. Shoumik Guha, Head - Public Health & Development, Janaagraha Centre for Citizenship and Democracy
10.30-10.45 am	Urban Kerala	Dr. Kamala Rammohan, Executive Member HAP & Assistant Professor, Dept. of Pulmonary Medicine, Govt. Medical College, Trivandrum, Kerala
10.45-11.15 am	Panel Discussion	Mr. Sumit Kumar, Senior State Program Manager, CARE India Ms. Akhila Sivadas, Executive Director, Centre for Advocacy and Research Dr Sasi Kumar, Corporation Health Officer, Kozhikode Municipal Corporation
11:15 – 11-30 am	*Coffee Break*	
11:30- 12:15 pm	**Sharing Decentralisation Experience of States**	
	Moderator: Mr. Anirban Ghose, Co-founder, Transforming Rural India Foundation Sustaining Health for all at Grassroots through decentralisation Delhi Mohalla Clinic	Mr. Mohan H.L., CEO, Karnataka Health Promotion Trust

	Decentralisation in Haryana	Dr. Tarun Seem, Indian Revenue Services, Health Systems Expert Dr. Shailendra Kumar Hooda, Associate Professor, Institute for Studies in Industrial Development
12:15- 1:00 pm	**Experience sharing by Elected Representatives – Urban**	
12:15-1:00 pm	Moderator: Mr. Abdul Wajid, Former Councilor (Leader of Opposition) - Bruhat Bengaluru Mahanagara Palike Panel Discussion	Dr. Pandurang Patil, Former Mayor, Hubli Dharwad Municipal Corporation Mr. Cirivelu Ibrahim Babu, Former Mayor, Ballary City Corporation Ms. Meher Haider, Former Councilor, Bruhanmumbai Municipal Corporation Mr. Mattummal Saleem, Chairman, Nilambur Municipality, Malappuram, Kerala
1:00-2:00 pm	*Lunch*	
2:00-3:30 pm	**Recommendations & Advocacy Objectives** Chair: Mr. S.M Vijayanand Former Chief Secretary, Government of Kerala Concluding Session	Mr. Rajeev Sadanandan, CEO, HSTP Mr. Srikanth Viswanathan, CEO, Janaagraha Centre for Citizenship and Democracy Dr. V Raman Kutty, Chairman, HAP

ANNEXE-2: LIST OF PARTICIPANTS

S. No.	Name	Designation	Organisation
1.	A Sasikumar	Corporation Health Officer	Kozhikode Municipal Corporation
2.	Aaliyah Ali Khan	Program Associate - PMU	Health Systems Transformation Platform
3.	Abdul Wajid	Former Councilor (Leader of Opposition)	Bruhat Bengaluru Mahanagara Palike
4.	Abhiman Rajguru	Fellow, HCF	National Health Systems Resource Centre
5.	Aditi	Consultant, PHA	National Health Systems Resource Centre
6.	Akhila Sivadas	Executive Director	Centre for Advocacy and Research
7.	Amarjeet Mohanty	Ph.D Scholar	IITD
8.	Anagha Khot	Independent Consultant	
9.	Anirban Ghose	Co-Founder	Transforming Rural India Foundation
10.	Anjaney	Senior Consultant, HCT	National Health Systems Resource Centre
11.	Astha Joshi	Associate Manager	Janaagraha Centre for Citizenship and Democracy
12.	Baiju Paul	Technical Support System Links	Health Systems Transformation Platform
13.	Balasundar A S	Chief Health Officer	Bruhat Bengaluru Mahanagara Palike
14.	Bhagath Rufus	District Panchayat Member	Venganoor Division, Kerala
15.	Bhur Singh Rawat	Additional Program Officer (APO)	Zila Panchayat, Jhabhua, Madhya Pradesh
16.	Biju Soman	Executive Member Professor	HAP Achutha Menon Centre for Health Science Studies
17.	Cirivelu Ibrahim Babu	Former Mayor	Ballary City Corporation
18.	Daman Ahuja	Senior Manager, Community Action and Capacity Building	Population Foundation of India
19.	Devajit Bora	Senior Consultant, CP-CPHC, NERRC	National Health Systems Resource Centre
20.	Dhvani Mehta	Co-Founder and Lead, Health	Vidhi Centre for Legal Policy
21.	Diwakar Gautam	Finance Officer	Health Systems Transformation Platform
22.	Hardeep Singh Puri	Minister of Housing and Urban Affairs	Government of India
23.	Jatin Dhingra	Specialist Urban Health	PATH India

24.	K. Madan Gopal	Sr. Consultant (Health)	NITI Aayog
25.	K.V. Trilok Chandra	Special Commissioner - Health	Bruhat Bengaluru Mahanagara Palike
26.	Kamala Rammohan	Executive Member Assistant Professor	HAP Govt. Medical College, Trivandrum
27.	Kumaravel Ilangovan	Specialist - Primary Healthcare and PMJAY Linkages	Health Systems Transformation Platform
28.	Kuthirakulam Jayan	Panchayat President	Manickal Gram Panchayat, Kerala
29.	Laxman Pandurang Gophane	Asst. Medical Officer of Health	Pimpri Chinchwad Municipal Corporation
30.	M Jagadeesan	City Health Officer	Greater Chennai Corporation
31.	Madhura Kapdi	Fundraising, Media & Communication Expert	
32.	Manjunatha H L	Program Manager - Civic Participation	Janaagraha Centre for Citizenship and Democracy
33.	Manoj Joshi	Secretary, Ministry of Housing and Urban Affairs	Government of India
34.	Mattummal Saleem	Chairman	Nilambur Municipality, Malappuram, Kerala
35.	Meher Mohsin Haider	Former Councilor	Brihanmumbai Municipal Corporation
36.	Mohan H.L.	Chief Executive Officer	Karnataka Health Promotion Trust
37.	Monika	Consultant, HRH/HPIP	National Health Systems Resource Centre
38.	Mythrey Mugundan	Senior Associate	Janaagraha Centre for Citizenship and Democracy
39.	Navdeep Gautam	Sr Technical Officer, Urban Health	PATH India
40.	Navneet Manchanda	Health Economist	World Bank
41.	P S Prasobha	Panchayat President	Kareepra Gram Panchayat, Kerala
42.	Padmaja Keskar	Senior Advisor	SNEHA, Mumbai
43.	Pallavi Gupta	Specialist - Health Systems Governance	Health Systems Transformation Platform
44.	Pandurang Patil	Former Mayor	Hubli Dharwad Municipal Corporation
45.	Peter Parekattil	Operations Officer	Health Systems Transformation Platform
46.	Prabhat Kumar	Senior Manager, Municipal Finance	Janaagraha Centre for Citizenship and Democracy
47.	Pradeep H B	Panchayat President	Edavaka Gram Panchayat, Kerala
48.	Pranay Lal	Independent Consultant	

49.	Pratheeba J	Technical Specialist - Health Financing	Health Systems Transformation Platform
50.	Prince Mediratta	IT Support - India HPSR Fellowship Program	Health Systems Transformation Platform
51.	Radhu Singh Bhuriya	Former President, Block Panchayat, Block Rama	Jhabhua, Madhya Pradesh
52.	Raghu Sunaraneedi	Chief Executive Officer	JVMaRKiS Private Limited
53.	Rahul Reddy	National Coordinator	Health Systems Transformation Platform
54.	Rajeev N	Former Panchayat President	Eraviperoor Gram Panchayat, Kerala
55.	Rajeev Sadanandan	Chief Executive Officer	Health Systems Transformation Platform
56.	Rajnesh Kumar	Consultant, KMD	National Health Systems Resource Centre
57.	Ravi Prasad Varma P	Executive Member Additional Professor	HAP Achutha Menon Centre for Health Science Studies
58.	Rekha Raveendran	Executive Member Sr. Research Officer	HAP SHSRC, Kerala
59.	Renuka Singh	Ph.D Scholar	IITD
60.	Ruchi Verma	Specialist - Health Operations	Health Systems Transformation Platform
61.	Rugma M	Program Assistant - PMU	Health Systems Transformation Platform
62.	S. M. Vijayanand	Former Chief Secretary	Government of Kerala
63.	Saju Xavier	Panchayat President	Payyavoor Gram Panchayat, Kerala
64.	Sakshi Khemani	Research Associate	Health Systems Transformation Platform
65.	Sanjeev Kumar	Specialist - Research	Health Systems Transformation Platform
66.	Shailendra Kumar Hooda	Associate Professor	Institute for Studies in Industrial Development
67.	Shama Karkal	Chief Executive Officer	Swasti-The Health Catalyst
68.	Shilpa John	Specialist - India HPSR Fellowship Program	Health Systems Transformation Platform
69.	Shivaji Trimbakrao Dhage	Senior Medical Officer	Pimpri Chinchwad Municipal Corporation
70.	Shoumik Guha	Head - Public Health & Development	Janaagraha Centre for Citizenship and Democracy
71.	Shraddha Upadhayay	Associate, Public Health	Janaagraha Centre for Citizenship and Democracy
72.	Siddharth Maurya	Consultant, PHP&E, NERRC	National Health Systems Resource Centre
73.	Smita Srivastava	Senior Consultant, PHA	National Health Systems Resource Centre
74.	Sonali Randhawa	Research Associate	Health Systems Transformation Platform
75.	Sonu Pandey	Research Fellow	Azim Premji University

76.	Sridhar Guduthur	Chief Finance Officer	Health Systems Transformation Platform
77.	Srikanth Viswanathan	Chief Executive Officer	Janaagraha Centre for Citizenship and Democracy
78.	Srilatha S	Member	Health Action by People, Kerala
79.	Sudheer Kumar Shukla	Specialist - Resource Planning for Health	Health Systems Transformation Platform
80.	Sumit Kumar	Senior State Program Manager	CARE India
81.	Sunil Nandraj	Advisor	Health Systems Transformation Platform
82.	Suresh Kumar K	Chairman, Health & Education Standing Committee	Manickal Gram Panchayat, Kerala
83.	Swati Sukriti	Associate, Public Health	Janaagraha Centre for Citizenship and Democracy
84.	T. M. Thomas Issac	Former Minister of Finance	Government of Kerala
85.	Tarun Seem	Health Systems Expert	Indian Revenue Services
86.	Tejal R Varekar	External Consultant, HCF	National Health Systems Resource Centre
87.	Umesh	Support Staff	Health Systems Transformation Platform
88.	Urvashi Prasad	Director	Office of Vice Chairman, Niti Aayog
89.	Usha A P	Panchayat President	Delampady Gram Panchayat, Kerala
90.	V R Raman	National Convener	Public Health Resource Network
91.	V R Vachana	Manager, Advocacy and Reforms	Janaagraha Centre for Citizenship and Democracy
92.	V Raman Kutty	Chairman	Health Action by People, Kerala
93.	Vaishnavi N	Consultant HRH/HPIH	National Health Systems Resource Centre
94.	Veenapani Rajeev Verma	Junior Specialist	Health Systems Transformation Platform
95.	Vibhu Tomar	Admin. Executive	Health Systems Transformation Platform
96.	Vijayakumar K	Secretary	Health Action by People, Kerala
97.	Viplav Aleti		JVMaRKiS Private Limited