EXPLORATION OF SOCIAL INNOVATION ECOSYSTEMS IN PRIMARY HEALTH CARE IN KERALA: AN APPLICATION OF INSTITUTIONAL ANALYSIS PARADIGM AND INCLUSIVENESS ASSESSMENT

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ABBREVIATIONS

AIDWA	All India Democratic Women's Association
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BJP	Bharatiya Janata Party
BP	Blood Pressure
BPL	Below Poverty Line
CD	Communicable Disease
CDA	Critical Discourse Analysis
CDI	Community Directed Interventions
CDS	Community Development Society
CPI(M)	Communist Party of India (Marxist)
CS	Case Study
CSR	Corporate Social Responsibility
DHS	Directorate of Health Services
DMO	District Medical Officer
DPC	District Planning Committee
DPM	District Program Manager
FGD	Focus Group Discussion
FHC	Family Health Centre
GPK	Grameena Padana Kendram
GRBS	General Random Blood Sugar
HH	Household
HI	Health Inspector
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Team
HSC	Health Standing Committee
HSR	Health Status Report

IAD	Institutional Analysis and Development
ICDS	Integrated Child Development Scheme
IDI	In-depth Interview
IEC	Institute Ethics Committee
IHDP	Integrated Housing Development Project
IITC	Integrated Information and Technology Centre
IKM	Information Kerala Mission
IP	In Patient
ISO	International Organisation for Standardisation
IT	Information Technology
JHI	Junior Health Inspector
JPHN	Junior Public Health Nurse
KGMOA	Kerala Government Medical Officers Association
KILA	Kerala Institute of Legal Administration
KSSP	Kerala Sasthra Sahithya Parishad
LASM	Latin American Social Movements
LDF	Left Democratic Front
LSGI	Local Self Government Institution
MO	Medical Officer
MP	Member of Parliament
NCD	Non-Communicable Disease
NDA	National Democratic Alliance
NHM	National Health Mission
NREG	National Rural Employment Guarantee
NRI	Non-Resident Indian
NSS	Nair Service Society
ODK	Open Data Kit
OECD	Organisation for Economic Co-operation and Development
OP	Out Patient

PDR	Panchayat Development Report
PHC	Primary Health Centre
PI	Principal Investigator
PPC	People's Plan Campaign
RRT	Rapid Response Team
SC	Sub Centre
SC	Scheduled Caste
SCP	Special Component Plan
SCTIMST	Sree Chitra Tirunal Institute for Medical Sciences and Technology
SDG	Sustainable Development Goals
SECC	Socio Economic and Caste Census
ST	Scheduled Tribe
TAC	Technical Advisory Committee
UDF	United Democratic Front
UHC	Universal Health Care
UNICEF	United Nations International Children's Emergency Fund
VP	Vice President
WHO	World Health Organisation

SYNOPSIS

The year 2021 marked the 25th year of decentralisation in Kerala, initiated under the banner of the People's Plan Campaign (PPC) in 1996. Through the campaign, the State initiated decentralisation with a heads-on approach which involved the devolution of 35-40% of the State's Plan fund to the LSGIs. A key aspect of the PPC model was also the delegation of responsibilities related to primary health care to the LSGIs in Kerala. The functioning of Primary Health Centres as well as the planning and delivery of primary health care fell directly under the prerogative of LSGIs. This has subsequently led to the formation of a unique primary health care project landscape in the State, planned and implemented by the LSGI leadership in collaboration with the primary health functionaries across the state. A key aspect of such locally developed health projects was also the element of community participation, where local communities were empowered to play the role of key partners in the planning and implementation of the projects at the grama panchayat level.

Given the unique context of decentralisation where LSGIs continues to play a significant role in the delivery of primary health care, the current study builds on the concept of 'social innovations' for primary health care. Social innovations are innovative activities that are initiated in partnership with communities in an attempt to address long-standing and unresolved health issues. Given the participation of local communities, these innovations are also largely seen as more sustainable and inclusive specifically in terms of serving the disadvantaged sections. The literature on social innovations points out that, they could be one of the crucial strategies to address the growing inequities within primary health care given the heightened role of community involvement. Besides, the conducive political context in the state in terms of the pivot on community partnership within the PPC in Kerala, the construct of social innovations specifically gathers relevance for the state in the effective implementation of primary health care activities at the grassroots.

However, a key area of concern across India as well as in Kerala is the issue of persisting caste-based health inequities, specifically among Dalits or Scheduled Castes in India. For, they have historically remained a community that is largely excluded

from the dominant paradigms of development and progress owing to the continued blindness within larger discourse to the stark oppression that Dalits face. Given their status as one of the most disadvantaged social groups, various policies are in existence that aim to improve their social status in the country. The key among them is the policy of affirmative action within LSGIs that mandates the allocation of a specific number of seats for Dalits to ensure their representative justice within local governance. However, studies suggest that despite this, the ability of Dalits to exercise complete autonomy as elected officials of LSGIs remains limited given the already existing social hierarchies within Indian contexts.

Though the existing landscape of decentralisation has over the years demonstrated multiple innovative models of primary health care, limited research has gone into their exploration. There is also a paucity in terms of the nature of community partnership within them as well on the aspect of Dalit inclusion and development within them. The current study, therefore, attempts to answer the various factors that could lead to the emergence of social innovations within various LSGIs in Kerala. The study also aims to explore the extent to which communities and in particular Dalit sections are included within these social innovation health care projects. To aid this enquiry, the study also attempts to explore the nature of policy discourses on primary health care innovations, community participation, as well as their ideas related to marginalisation and vulnerability related to health in the State.

The objectives of the study were:

1. To understand how the existing formal policies and key actors at different levels within the public health system and local self-government institutions conceive of innovations, social innovations, and inclusiveness.
2. To examine the various contextual factors that may shape and influence the emergence of social innovations within selected grama panchayats.
3. To examine the institutional ecosystem influencing the emergence of social innovations in selected grama panchayats in Kerala and understand the role of various actors and their interactions in conceptualising, implementing, and institutionalisation of social innovations.

4. To explore the extent of inclusiveness within the selected social innovations and to explore how these social innovations in village Panchayats facilitate the health needs of the marginalised community groups.

The permission to conduct the interviews with health department officials was sought from the Director of Health Services, Government of Kerala. The study was also cleared by IEC vide SCT/IEC-1355/FEBRUARY-2019.

The study applied a sequential approach for its enquiry and examination of social innovations in primary health care among LSGIs in Kerala. Phase-I endeavoured to examine the policy level discourses on primary health care innovations, ideas related to community partnership within primary health care innovations and marginalisation and vulnerability in terms of health. The key idea is, to explore how these discourses might also influence the social practices of primary health care projects and innovations at the level of grama panchayats. These explorations were guided by a qualitative paradigm and adopted the conceptual framework of Critical Discourse Analysis (CDA). Phase I exploration was carried out between May 2019 to November 2019 among senior-level bureaucrats within the Department of Health, Government of Kerala as well as among LSGI representatives in Kerala. In addition to qualitative in-depth interviews with policy level actors, the research also involved CDA of written down policies of Aardram which was introduced in 2016 by the Government of Kerala. This document was specifically used considering its novelty in terms of reforming the existing primary health care system in the State. The individuals for phase I interviews were purposively selected from the Directorate of Health, Thiruvananthapuram, District Medical Officers and District Program Managers (National Health Mission). Interviews were also conducted with senior LSGI representatives selected from Trivandrum District as the study was based in the same District. The policy level texts for critical discourse analysis were sourced from the office of Kerala State Health Systems Resource Centre, Thiruvananthapuram.

Phase II which followed after the CDA phase, specifically aimed at an in-depth exploration of social innovation cases from two specific grama panchayats in Kerala. An explanatory case study methodology was adapted to examine the local contexts,

actors, their interaction, as well as the examination of various 'institutional' factors all of which ultimately shaped the social innovations. Though decentralisation holds vast potential to strengthen democratic decision-making processes, the actual implementation of such formal rules/institutions is often found to be limited. Formal rules and mandates often fail in providing the needed incentives to achieve sustained adherence to them by the local actors. The result is wide variations in the degrees of success achieved by different local governments even under similar legal frameworks. The key to tackling this challenge may also lie in the exploration of informal institutions in terms of local conventions and rules that also dictate the interactions between various actors as well as local level decision-making. Given this emphasis on 'Institutions', the current study applied an adaptation of the Institutional Analysis and Development (IAD) Framework by Elinor Ostrom. This framework was adopted given its ability to explore the local health outcomes/projects vis-à-vis the nature of interactions between various actors influenced by various institutional dynamics. IAD also enables the researcher to locate these institutional dynamics within its larger physical, political, social and legal contexts that also shape local realities. The third and final phase integrated within the case studies attempted to explore the social innovations in terms of their inclusiveness for Dalits as well as in facilitating their health needs. This was explored using the analytical framework of Heek's Ladder of inclusiveness approach. The phase II and III case studies including the exploration of inclusiveness were conducted between November 2019 to March 2021. These involved in-depth interviews with LSGI, PHC as well as functionaries of other relevant departments, FGDs with community members and participant observations of grama sabha meetings.

The sampling of the LSGI cases was guided by the principle of theoretical sampling using the construct of social innovations. Primary health care projects within the LSGIs were explored for their fit with the construct of social innovation and based on the proportion of Dalit communities (at least 10% of the population). The researcher undertook a snowball method to collect information related to innovative LSGIs across Kerala. Key informant interviews (KII) were performed with senior Health Inspectors (HI) and Junior Health Inspectors (JHI) under the department of health in Kerala. The

information from the KIIs resulted in the compilation of a list of LSGIs in the state with innovative models of primary health care projects. From this initial list, two villages were selected based on their presence of health care projects that fitted with the definition of social innovation and a sufficient proportion of Dalit communities. The two social innovations for primary health care that were selected as part of the case study and the background information of the grama panchayats were;

1) Village A: An innovative community collaborated model for the prevention of communicable diseases called 'I care we care'. The project was initiated under the leadership of LSGI and as part of the project, around 2000 community volunteers were recruited and trained to provide house to house surveillance for sanitation and hygiene awareness in all 18000 households in the panchayat in three phases. The panchayat was closely located to an urban corporation and therefore had a partially urbanised nature and had 23 wards. The panchayat also had a larger geographical area and also had a relatively higher population of around 68,000 and a population density of 2100/sq.km. It had a Dalit demography of around 10%

2) Village B: An innovative model of health care for the elderly through the establishment of elderly care societies managed and run by local elderly members and supported by the LSGI and local primary health centre called 'Sayamprabha'. Through the elderly societies, the health needs of the elderly were mapped using community surveys by the elderly and required services were provided for them in collaboration with local health centre staff. In comparison to village A, the panchayat was located in a rural area and had 17 wards. The population in the village according to the census of 2011 was 24555 and had a population density of around 1317/sq.km. The proportion of Dalits in the panchayat was around 15%.

In terms of the political context, both the panchayats demonstrated similarities in terms of having a left leadership in the LSGI. However, the LSGI leadership in Village A have historically remained under the control of the Left Democratic Front (LDF) since 1996. This historical political trajectory was found to have influenced the formation of an affiliate organisation called Grameena Padana Kendram (GPK). GPK was comprised of individuals closely associated with CPI(M) to academically support the

project-related decision making for LSGI leadership in the village. Similarly, other structures like Kudumbasree, ASHAs, and MGNREGA were also found informally affiliated to the Left in the panchayat. In terms of the bio-physical and demographic contexts, the large geography of the village A, with a very large population and its proximity to an urban area was peculiar in terms of its challenges too. The panchayat has had a long-standing history of communicable diseases (CD) as a major health challenge in the region, owing to the issue of public waste dumbing along roads, river bodies and unattended lands. This combination of the history of left politics and the longstanding challenge of CD outbreaks in the panchayat was found to have also shaped a unique history of community collaborated initiatives. Over the years village A has demonstrated multiple community collaborated initiatives specifically to control and prevent CDs in the panchayat and has a very active community group called Health Promotion Team (HPT) who are called in action on a case-to-case basis. However, an external trigger that initiated the 'I care we care' project was the Covid related lockdown in early 2020 and the burdened health staff which limited them to be involved in routine CD prevention activities including pre-monsoon cleaning activities. These contexts did in fact force the LSGI to come up with the project which was collaborated and supported by HPT, Kudumbasree and ASHA volunteers.

In contrast village B had an unstable political context with fluctuating political leadership until 2010. However, a stable majority in 2010 for the CPI(M) had resulted in the emergence of an authoritative leadership at the LSGI with a unilateral decision-making style. This was found facilitated by the presence of a strongman style leader as the LSGI president with strong familial clout in the State and district level CPI(M) leadership. The result was an authoritarian style of decision-making by the president, who also had a penchant for unique and risky projects, evident in terms of the slew of innovative activities that made the panchayat famous as a 'model LSGI' across the State since 2010. Also relevant was the unique economic and demographic context in the panchayat with a relatively higher presence of non-residential Keralites. This has also resulted in a unique demographic challenge in terms of a higher number of elderly individuals with no younger family members for their support. The issue of elderly members was therefore found to be a major health-related challenge in the panchayat

specifically in terms of non-communicable diseases (NCDs). The ‘Sayamprabha’ project and its evolution demonstrate this combination of the elderly related challenges and facilitated by the unique authoritarian political leadership in the panchayat. However, a triggering factor for the project was the joining of an ICDS supervisor in late 2018 who championed the issues of the elderly in the panchayat which resulted in an innovative project in 2019.

Though both the projects had significant levels of community involvement, the nature of community partnership in both social innovation cases was largely seen as limited to the implementation of the projects. In the case of ‘I care we care’ the partnership of community volunteers was clearly limited in terms of house-to-house surveillance and cleaning drives. Within ‘Sayamprabha’ too, despite the presence of elderly societies, they were characterised by limited say within the decision-making related to the project. Similar limitations were also found reflected within the phase I CDA analysis of policy discourse too. These discourses were evident with their limitations in accommodating community members as active co-partners within primary health care innovation strategies. Policy discourse on innovative strategies for primary health care was largely seen as an expert-driven modality, which by extension relegated the role of communities at their receiving end. Yet another way community partnership within primary health care innovation strategies was discursively limited within policy narratives were the ways in which the ideas related to the partnership were equalised with community ‘utilisation’ and community level ‘support’ for implementation.

In addition, the social innovation projects were also found shaped by the larger policy discourse in terms of the very nature of their activities. The analysis of the policy discourse on primary health care innovations did allude to a dominance attributed to secondary prevention and curative strategies. Strategies like screening camps based on a need assessment of disease prevalence at the level of LSGIs were the most preferred within the discourse of policy actors. Given this bias towards a curative aspect of primary health care, infrastructural improvements of the Primary Health Care centres too remained the most repeated innovative strategies for primary health care among policy actors. The ‘Sayamprabha’ innovation in particular constituted of strategies like

screening camps for the elderly and distribution of medicines for NCDs. Yet another overlap between the policy discourse and the 'Sayamprabha' project was the emphasis within policy discourse on elderly care projects. The fact that elderly care societies were an already recognised and awarded model within some few Left run panchayats in Kerala also laid the context for the 'Sayamprabha' with its unique elderly run society structure.

Reading along with this bias towards secondary and curative care within the policy discourses on primary health care innovations was also the inherent bias on social determinants of health care within them. The policy perspectives on primary health care innovations did include strategies that could address the issues of social determinants of health, albeit from a superficial take on social determinants. For, the narratives on primary health care innovations frequently referred to strategies that tackled the aspects of the social determinants like issues related to water, sanitation and hygiene. However, these narratives failed to acknowledge the differential distribution of these determinants, something that ultimately qualifies them as 'social' determinants. The failure to bring in the narrative of the 'social' element inherent within the distribution of these elements, the discourse largely maintained a 'sanitised' view of social determinants of health perspective. Both the social innovation models examined within the phase II case studies too failed to move beyond the straitjacket of 'health determinants' and to have a social determinants view of them. The 'Sayamprabha' never within its project did involve any discourse on equity in terms of access to the project for any disadvantaged social groups within the elderly. 'I care we care' project too never had any prioritised action in terms of improving the hygiene and sanitation of the most deprived Dalit colonies within the panchayat.

The villages panchayats selected for the case study also revealed certain specific patterns in terms of their institutional context. Both the villages were formally headed by Dalit woman members as the LSGI president. However, the autonomy of these Dalit women leaders was rather limited given the power wielded by their non-Dalit male counterparts within the panchayat. The decision-making spaces were 'informally' controlled and managed by non-Dalit LSGI leaders. The incumbency of

Dalits and women representatives within formal positions of power within the LSGIs was found exclusively facilitated by the policies of affirmative action. However, what made the issue of differential power between Dalit and non-Dalit a moot issue was its clandestine manifestations within LSGI spaces in the study. The issue of caste and gender-based hierarchies of social actors was largely oblivious within the LSGI discourses. Both gender and caste were neither acknowledged as an axis of social advantage/disadvantage nor was considered as a source of power within decision-making spaces of LSGI by non-Dalit male leaders. This was contrasted by the socially conditioned attitude of their Dalit counterparts. Dalit leaders, specifically male leaders tended to accept the status quo as a taken for granted practice, failing to acknowledge caste as the deciding factor. Dalit women leaders were the most excluded and vulnerable social group who often found caste as an oppressive structure within LSGI spaces as well as within the larger society. However, their weaker position also meant that they had limited space to confront or rebel against it without facing consequences. Caste and gender-based hierarchies were also the norm within political parties, which also contributed to the further sidelining of Dalit and female leaders given the overarching power political parties wielded over the functioning of their members within LSGIs. The conflict between these informal power structures with the formal rules of LSGIs also resulted in the emergence of newer informal rules too. These included the informal convention of 'reserving' unreserved seats for non-Dalit and male party members since seats reserved for Dalits and women could not be allotted to non-Dalits and male candidates by political parties. This meant that never was any Dalit or woman party member allowed to contest in local elections from unreserved seats since they were almost always 'reserved' for non-Dalit male members by political parties.

Both the grama panchayats were evident with a strong consolidation of political power over the years. This by extension also meant that the dominance of non-Dalit male leaders of the LSGI and the unquestioned power were also equally strong and consolidated. This meant that the ideas these powerful actors conceive were also easily translatable as real projects without conflicts within LSGI spaces. This was also one of the key factors that evidently worked in favour of both the LSGI leadership in two

panchayats to come up with innovative health care projects without many conflicts. For, both the 'I care we care' and 'Sayamprabha' was conceived by the dominant non-Dalit male leadership in both the panchayats. 'I care we care' in Village A was championed and easily implemented by GPK which was a crucial player given both its political clout with CPI(M) and its exclusive non-Dalit male leadership nature. This was also supported by the LSGI leadership which was particularly constituted by a leadership which had a de facto weaker position owing to their social locations of gender and caste. The 'Sayamprabha' project too in a similar vein was championed at Village B, by an authoritarian non-Dalit male Vice-president of the LSGI who had unquestioned power within the LSGI.

Given this unique institutional structure, the projects devised by the structure too demonstrated characteristics that reflected the worldview of the dominant decision-makers within both LSGIs. Given the exclusion of Dalit members within decision-making spaces, the social innovations examined were also exclusive in nature for Dalits, except for 'coincidental' inclusions of Dalits. For, they have been key partners in terms of making the social innovations successful, as they were one of the most active groups in terms of implementing the projects within the panchayats facilitated by their larger proportion within the local population. However, the informal exclusion and sidelining of Dalit LSGI members from having a meaningful role in decision-making related to health projects were also reflected in terms of how the specific issues of Dalits, were problematised within the social innovations examined. Though the projects did not purposively aim at Dalit exclusion, were marked by their inherent lack of awareness about the realities of Dalits within the local communities. This by extension also meant that, despite any purposive exclusion, Dalits were excluded from achieving any equitable impact on their health needs given the design of the social innovations being exclusive by design.

Parallels to this were also evident within the phase I CDA of policy discourse on marginalised social groups which too failed to acknowledge Dalits as disadvantaged. A theme that emerged from the phase I policy analysis was the evident failure of the discourse on marginalisation to acknowledge the realities of Dalits in the State. The

policy discourse remained silent on the issues related to caste and Dalits were seldom considered a marginalised social group. Primary health care was largely seen from an equality perspective that saw health and illness as equal for all human beings despite their social locations. This could be read along with the narrow perspective on social determinants that failed to see the 'social' element inherent to it. The key groups that were considered marginalised in terms of having prioritised for primary health care innovations were the elderly, scheduled tribes and coastal communities. Dalits within this discourse were invisibilised around the narratives of a 'general' community, that does not really encounter any forms of vulnerability. The invisibilisation of Dalits and policy reluctance to acknowledge caste as an issue bore an uncanny resemblance to the social practice of untouchability being carried over to the discourse as unspeakability of Dalits or caste-based inequities.

The findings from the study suggest that any examination of decentralisation and its impact on the health of disadvantaged social groups should also focus on the informal institutional dynamics that dictate the local conventions. Particularly in shaping unequal power hierarchies between social groups. The findings from the study suggest that social innovations examined emerged due to the existence of strong yet exclusive informal institutions that privileged certain social groups over others. This meant that the nature of the social innovations and their impact were also dependent on the world views of the dominant actors within the LSGIs. Though decentralised systems of local governance hold the potential to further the goals of health equity and social justice, the realisation of these goals also depends on their ability to be comprehensively inclusive for all sections of the community. The nature of these health care projects at the panchayat level is also evidently influenced and shaped by the larger policy level discourses on primary health care, community partnership as well as their ideas on marginalisation. For, these dynamics also ultimately shape and decide how they decide on projects and who are ultimately prioritised within the grassroots level health initiatives in the state

INTRODUCTION

1.1 CONTEXT

The year 1978 marked a watershed moment in the history of healthcare across the globe. The International conference on primary health care at Alma Ata called for a paradigm shift in health care service delivery, with its clarion call towards a comprehensive approach on health through primary health care. The declaration launched the concept of health for all by the year 2000 and urged nation states to adopt health care policies that emphasised primary health care by making it accessible to all sections of the population. It demanded that the concept of primary health care shall adopt the ideas of equity, community participation, affordability, inter-sectoral approach, appropriate technology and to consider health as a right (*Declaration of Alma-Ata*, 1978). The declaration argued the need to materialise strong systems of Primary Health Care system across nations that is catered to the needs of communities it serves. It also argued for the application of health strategies that are socially acceptable and responsive to the needs of the communities. The notion of Primary Health Care that was conceptualised through the Alma-Ata declaration tried to encompass a health system that was capable of serving the health care needs of a community, based on the premise of social justice and which is sustainable over time through community ownership (Beard & Redmond, 1979; Gauld et al., 2012).

2022 marks the 44th year since the declaration, one that was made in the midst of an aggravating cold war in 1978. The declaration at its time had acknowledged the sweeping health inequalities that existed between and within countries and subsequent call for 'Health for All by 2000'. However, it is rather unfortunate to note that this rallying calls for 'health for all' has not really materialised even after such a long period of human progress. Multiple theories had emerged arguing the non-achievement of the vision; a lack of priority on Primary Health Care approach in many countries as well as due to emergence of various other global health threats like HIV amongst others. However given the current realities of growing burden of chronic and communicable diseases, weakening health systems in various countries due to the narrow focus on maternal and child health, the Primary Health Care approach is only

gaining momentum as a lifeline to emerge out of these global health woes (Lancet, 2008; Robert Beaglehole, JoAnne Epping-Jordan, Vikram Patel, Mickey Chopra, Shah Ebrahim, Michael Kidd, 2008). Primary Health Care is much more relevant today in the wake of a global pandemic like Covid-19, given its ability to achieve effective gatekeeping and timely medical response. It can play a key role at the grassroots level, in the face of Covid-19 prevention strategies like lockdowns, and non-functional outpatient departments within health care facilities. It is therefore increasingly argued that primary health care is a much more cost-effective strategy for pandemics like Covid-19 and one that can enhance the trust between communities and health-care functionaries (World Health Organization, 2020).

The Astana Declaration on Primary Health Care, 2018, reaffirmed its conviction in the principles of Alma Ata and comprehensive Primary Health Care approaches with emphasis across the spectrum of preventive, promotive, curative, rehabilitative and palliative care. Rooted in the idea of health as a fundamental human right, Astana declared the existing health inequities and differential health outcomes within communities as unacceptable, calling for strengthened efforts towards Primary Health Care (Walraven 2019). The current study, therefore, draws on the strengths of Primary Health Care as a crucial approach to improving health care and its outcomes in low and middle-income countries. Specifically in terms of its ability to engage with local communities within decision-making related to health, thereby, providing them with the autonomy to improve their own health outcomes. An idea of participation drawn from the perspective that communities have a better understanding of their situations and are better placed to be their own agents of change rather than just be the passive beneficiaries of health interventions implemented from above (Mishra et al., 2022; Sandy Smith-Nonini, 1997). This is particularly crucial in the context of Kerala, where structures of decentralisation have had strident progress in terms of community participation through approaches like People's Planning Campaign (PPC) (Balan et al., 2014a; Heller et al., 2007a). Given this context, the study specifically aims to examine the interface between Primary Health Care and the scope and extent of community engagement within it, in the context of PPC in Kerala. This is being explored through the concept of Social Innovations for Primary Health Care in Kerala

and also to examine the nature of community engagement in terms of inclusion of various underprivileged social groups like Dalits.

1.2 DECENTRALISATION AND PRIMARY HEALTH CARE

A major route to the implementation of effective primary health care approaches was envisaged through the strategies of decentralisation. The Alma Ata declaration through its emphasis on Primary Health Care has called out for decentralisation of health systems to achieve its goals of community participation within health care decision-making (Tsofa et al., 2017). The World Development Report: Investing in Health published in 1993 by the World Bank (*World Development Report: Investing in Health*, 1993), also reiterated the significance of decentralisation as a key strategy to improve health care delivery within countries. The report argued that decentralised systems owing to their very nature allows to improve the efficiency of health sector through better allocation of resources and management. Decentralisation can also improve better participation of communities which could have significant improvements in terms of utilisation of resources at the local level, that are better targeted to the health needs of the communities (Collins, 1989; Tsofa et al., 2017).

Besides, formulation of policies as well as implementation of Primary Health Care was often argued to be impossible exclusively from a conventional top-down approach. A significant degree of decentralisation was found to be inevitable along with some degree of centralisation in terms of development of policies with an orientation to equity within Primary Health Care. Given these, implementation of Primary Health Care initiatives across the globe has often attributed much significance to the strengthening of structures that remained closest to periphery to achieve stronger implementation. The key claims of decentralisation that often makes it the go to approach for Primary Health Care initiatives are its features of being responsive to the needs of local communities, empowerment and mobilisation of underprivileged sections of the communities, better participation of communities. The fact that decentralised systems are also able to better cater to the needs of poor and improve their access to public goods and services also makes it one of the best possible strategies to implement Primary Health Care (Collins & Green, 1994).

1.3 SERVICE DELIVERY INNOVATIONS FOR PRIMARY HEALTH CARE IN THE CONTEXT OF DECENTRALISATION

Innovations for service delivery are defined as, strategies that are aimed at improving outcomes of health, improving cost-effectiveness or enhancing the experiences of the end users, that are achieved through novel behaviours, routines or modes of working. These strategies are often implemented through actions that are also planned and coordinated (Greenhalgh et al., 2004). Given the larger goals of universal health coverage and resource constrained public health service provisioning, innovative strategies of health care delivery are going to be one of the most urgent and crucial pathway in addressing the existing health inequities (Dako-Gyeke et al., 2020). Evidences from across the globe also are increasingly suggestive of the relevance of innovative modes of primary health care that are more effective and accessible for all sections of communities. These therefore point to the significance of innovative primary health care service delivery in managing as well as preventing wide range of diseases as well as reaching to the most disadvantaged social groups within the grassroots. These were largely successful given their impetus on locally responsive strategies that are also partly driven by community participation, which are also inherent within the idea of primary health care (Doshi et al., 2020).

One of the key advantages that decentralisation adds to the discussions on primary health care and innovations is the conduciveness of decentralisation itself to be innovative. For, a key advantage of decentralised systems is its ability to devise strategies that are also innovative, relatively effective and that are much more responsive to the needs of communities. Literature on decentralisation too suggest the emergence of innovative models of health care delivery facilitated by decentralised governance systems that could achieve structural changes within health care systems that demonstrated better effectiveness and more prudent use of available resources. Innovations for health care were also found facilitated by the increased participation of communities through innovative models of participation of communities for health care delivery (Saltman et al., 2007). These therefore suggest to fit and alignment between the ideas of primary health care, decentralisation and the role of innovations

in improving the larger goals of both primary health care as well as decentralisation in general.

1.3.1 DECENTRALISATION IN INDIA

During the early part of 1990's nation states across the world had embarked on their mission towards decentralisation. According to a report by World Bank, by 1998 almost 12 of the 75 countries in the developing world and all countries with more than 5 million population which were in a transition from developing to developed had initiated political devolution (Crook & Manor, 1998). The decentralisation reforms in India were introduced through the 73rd amendment of its constitution in 1993 which legalised the formation of a three-tier system of local governments within village, block and district levels called Panchayati Raj (Johnson, 2003). Though the overall achievements and progress of decentralisation experiment in the country remained slow for various reasons (Peters et al., 2003), certain states like Kerala owing to a comprehensive approach to decentralisation have had a certain degree of success within its health care infrastructure and delivery (Seshadri et al., 2016).

1.3.1.1 People's Plan Campaign of Kerala

The decentralisation experiment of Kerala was ushered in under the popular banner of 'People's Plan Campaign' (PPC) of 1996. This was launched by the then ruling left coalition government in Kerala, following which 1214 local governments in Kerala including Local Self-Government Institutions (LSGIs) at the level of village, block, district and municipalities were devolved decision-making responsibilities. This was enabled through the allocation of 35-40% of the State's Plan expenditure funds to these LSGIs. The State's policy on decentralisation was perceived as strategy to deepen the democratic structures through the maximum possible level of community participation and devolution of administrative responsibilities. Given these unique features of decentralisation in Kerala, PPC represented one of the most ambitious efforts of decentralisation that was ever undertaken in the entire country (Heller et al., 2007b; Participedia, 2011).

The year 2021 was the 25th year of decentralised governance in Kerala. The PPC is largely seen as a milestone for the State in its journey towards an egalitarian society given its emphasis on local democracy, devolution of financial autonomy, functional autonomy as well as its authority over functionaries (3Fs) to the Local Self-Government Institutions (LSGIs). As part of the campaign, the State government initiated the practice of allocating a significant proportion of the Funds under the State's Plan outlay within the hands of its LSGIs. To achieve better implementation of decentralisation, through the PPC the state government encouraged massive social mobilisation for local level project planning and implementation. The State's achievements in terms of poverty reduction and the significant improvements in various sectors including health, education, improved access to various determinants of health including drinking water, housing, better sanitation and road infrastructure is often attributed as the impacts of PPC (Chathukulam, 2021).

1.3.2 INNOVATIVE PRIMARY HEALTH CARE PROJECTS UNDER PPC IN KERALA

One of the key advantages owing to the existence of strong LSGIs is the evolution of a pattern of novel health care and health care related projects at the grass roots level in Kerala. The financial freedom and autonomy that the LSGIs enjoy in terms of health decision-making as well as the existence of formal spaces of community participation has in fact paved a conducive environment for novel health projects (John, 2012). Health related planning at the local level with community members as participants remains one of the mainstays within local planning processes at the LSGI level. These planning process at the grass roots level in a way shape and influence the local primary health projects currently implemented across the state by various LSGIs. Evidently this has resulted in LSGIs across the State in taking up local projects that addressed issues of nutrition, water, sanitation, housing as well as improvements within local primary health care infrastructure. Several models of disease prevention projects were observed from various LSGIs in the state, that attempted to address specific local issues including vector control strategies to prevent communicable diseases as well as several other projects to improve local health (Elamon et al., 2004b).

Over the years multiple cases of innovative projects that address health directly or indirectly are evident within the realm of LSGIs in the State. These include widely appreciated LSGI projects that attempted to make child friendly panchayats, creation of herbal parks, attempts to involve children within decision-making processes ("Kilimanoor Panchayat to Come up with Innovative Initiatives," 2018). These also include LSGI driven innovations including Kidney patient welfare society, palliative care initiatives, HIV related treatment support projects. The state wide palliative care policy currently a mainstay in the health care of Kerala, was in fact initially initiated as a village panchayat level project in the late 2000s. Grass roots level health innovations by LSGI could also be seen extended to improvements in other areas of health including infrastructure, sanitation facilities as well as novel strategies within resource utilisation for health care activities, initiated by a various grama panchayats in Kerala (John, 2012).

1.4 SOCIAL INNOVATIONS FOR PRIMARY HEALTH CARE

Given the unique context of decentralisation and how the existing LSGIs in Kerala have a significant say in the delivery of primary health care, also of key relevance would be the concept of Social Innovations. Social innovations within health are defined as; "Inclusive solutions to address the health care delivery gap that meet the needs of end users through a multi-stakeholder, community-engaged process" (Social Innovation in Health Initiative, 2021a). They are considered advantageous since they are drawn from the expertise of multiple community-based stakeholders as well as local institutions. Given the participation of local communities these innovations are also largely seen as more sustainable and accountable from the perspective of communities (Halpaap et al., 2020a). The 2018 Declaration of Astana too calls for a renewed commitment to primary health care with greater participation and empowerment of communities as a key stakeholder. One of the strategies to ensure the objectives of greater role of communities and their empowerment is through the adoption of social innovation strategies within primary health care (Social Innovation in Health Initiative, 2021b).

This pivot on community participation is also owed to the introduction of the decentralisation that was crucial in terms of facilitating autonomy among local governments in developing health projects that were relevant to the local context and social needs. This was evident from the key mechanisms that were crucial within the concepts of decentralised governance. The key among this was the concept of autonomy which enabled the LSGI institutions to have greater freedom in terms of functional, financial and administrative autonomy. This therefore meant that the decisions related to local governance and reform were completely under the prerogative of the local self-governments in charge of the area. A second reform that enhanced this principle of autonomy was the introduction of the concept of people's participation. This gave the local people a greater say in the things that related to their governance and development. It thus laid the foundation for the empowerment of citizens in terms of their involvement in the administration of their region (Vijayanand, 2009).

1.4.1 INCLUSION OF DISADVANTAGED SECTIONS AS A CROSS CUTTING THEME

Given the strong pivot on the active participation of communities within the PPC mode of decentralisation in Kerala, these social innovations do gather relevance in the effective implementation of primary health care activities in Kerala. One that is responsive to the needs and demands of all sections of the communities. For a key cross cutting theme across the three constructs of primary health care, decentralisation as well as social innovation is also the idea of inclusion of disadvantaged social groups. The Astana declaration of Primary Health Care places inclusion of disadvantaged social groups as a key imperative within its vision. One that is responsive to the needs of the most disadvantaged social groups (WHO & UNICEF, 2018). Similarly, decentralisation too through its strategies of bringing governments closer to the local communities, primarily aims to redress the issues of social exclusion of disadvantaged social groups through inclusive processes (Durga Prasad Chhetri, 2013). The idea of social innovation too attributes significant emphasis on the aspect of inclusion. For inclusion of marginalised and neglected social groups have always remained a key

construct within the definitions of social innovations too (Howaldt & Schwarz, 2010; Marques et al., 2017; Moulaert et al., 2014; Neumeier, 2012; van Niekerk et al., 2021).

1.5 RATIONALE FOR THE STUDY

Kerala given its long history of democratic decentralisation and informed citizenry does hold the potential for community partnered models of innovative primary health care initiatives. The Kerala model of decentralization popularly called the People's Planning Campaign have in fact achieved significant strides in engaging with communities facilitated through multiple models of institutionalized mechanisms, all of which have in fact resulted in significant success in terms of community empowerment (Franke & Chasin, 2000; Shobha Raghuram, 2000). The state also stands as proof of the capabilities of democratic planning models evidenced by the significant progress in improving human development indicators as compared to the rest of India. Arguably also a product of decentralization and the active engagement of citizens facilitated through the consultative planning processes established through structures like LSGIs (Balan et al., 2014a; Heller et al., 2007a). Two aspects are of crucial significance in the context of the decentralisation and PPC in Kerala. One is the fiscal space enjoyed by the existing LSGIs and health functionaries to conceive and implement local projects for health (Nair and Naidu 2016). Second being the administrative space available for LSGIs to try out novel strategies for improving Primary Health Care with the support from primary health centre functionaries to tackle local health and related issues (Elamon, Franke and Ekbal 2004; Varatharajan, Thankappan and Jayapalan 2004).

The current structure of LSGI institutions in Kerala, therefore, has the right mix of ingredients to be conducive contexts for the emergence of community partnered and innovative models of primary health care strategies that can successfully address various health inequities in Kerala. However, even after close to quarter of a century after the implementation of PPC, little has been explored about the primary health care innovations that might have been undertaken by various LSGIs at the grass root level in Kerala. These primary health care innovations – community partnered models in particular - if explored can provide key insights into the diverse factors that may trigger

as well as lead to better participatory and equitable models of health care delivery at the grassroots in the State. Besides, there is limited empirical explorations undertaken that aims at exploring the nature and extent of community participation within the existing realm of primary health care innovations across grama panchayats in the State. Consequently, there is also little evidence regarding the extent to which such innovative health care projects implemented by LSGIs are inclusive of various disadvantaged and marginalised social groups. Hence the current study expects to bridge the existing gap in the literature on primary health care innovations in Kerala and thereby produce valuable evidence in improving the culture of social innovations that are participative as well as inclusive in terms of addressing the needs of the historically marginalised social groups in the state.

1.6 RESEARCH QUESTIONS

The key questions that guided the current study are;

1. **What are the various factors and circumstances that lead to the emergence of social innovations in the context of Primary Health Care in certain Panchayaths of Kerala?**
2. **How inclusive are these selected social innovations in terms of the participation of the marginalised sections of the population?**
3. **Are these social innovations in Primary Health Care, able to better facilitate the health care needs of the marginalised populations?**

1.7 OBJECTIVES

The objectives of the current study are:

1. To understand how the existing formal policies and key actors at different levels within the public health system and local self-government institutions conceive of innovations, social innovations, and inclusiveness.

2. To examine the various contextual factors that may shape and influence the emergence of social innovations within selected grama panchayats

3. To examine the institutional ecosystem influencing the emergence of social innovations in selected grama panchayats in Kerala, and understand the role of various actors and their interactions in conceptualising, implementation, and institutionalisation of social innovations

4. To explore the extent of inclusiveness within the selected social innovations and to explore how these social innovations in village Panchayats facilitate the health needs of the marginalised community groups.

2. REVIEW OF LITERATURE

The current section attempts to lay the ground in terms of the existing empirical evidence regarding three main concepts that the current study attempts to explore. 1) The idea of primary health care and its imperativeness in achieving the goals of equity and inclusiveness 2) the idea of decentralisation vis-à-vis primary health care and 3) The role of social innovations vis-à-vis primary health care and decentralisation. Further the review also attempts to discuss the existing literature on primary health care specifically from a Kerala context and how it is interlinked with the decentralised political context in the State. Further the review attempts to discuss the need for social innovations specifically in the context of a decentralised primary health care landscape in furthering the ideas of community participation as well as addressing the issues of marginalisation for Dalits.

2.1 PRIMARY HEALTHCARE

The World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) in 2018 adopted a definition of Primary Health Care that was much simpler and more suited to the diverse contexts into which it is implemented, and it goes like this

"Primary Health Care is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" ("A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals.," 2018)

The document reiterates the fact that now more than ever, the idea of Primary Health Care is increasingly gaining relevance given its larger fit and flexibility to effectively meet the complex needs of contemporary society, one that is characterised with its rapid evolution. In addition, the specific features of Primary Health Care including its emphasis on preventive and promotive care, addressing issues related to social

determinants and the significant role of communities gives it an edge over other systems of healthcare. Given these advantages, Primary Health Care as a modality of healthcare can effectively address the causative factors of ill health as well as meet any new and emerging healthcare challenges in the future. This also gives Primary Health Care a unique advantage of being the most appropriate paradigm of healthcare to achieve the global goals of Universal health coverage (UHC) and Sustainable Development Goals (SDG) ("A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals.," 2018)

2.1.1 Role of Primary Health Care in bridging health inequities

Empirical evidences from across the globe suggests widening gaps in the inequitable distribution of health outcomes are ample across countries (Gauld et al., 2012). Given these circumstances, one of the best possible strategies to bridge the existing inequities in health and to achieve the global health expectations would be through the adoption of the principles of Primary Health Care. The ability of primary health care approach has been proven by the fact that, among countries with similar economic development better health status were seen in those countries which adopted the strategies of primate health care. These evidences show consistent pattern across multiple settings including Low- and Middle-Income Countries as well as countries of the Organisation for Economic development (OECD) and also through multiple types of studies at various levels. This is possible because primary health care as a vision considers prevention as important as cure and has a balanced emphasis on both upstream and downstream determinants of health (Chan, 2009; Rao & Pilot, 2014; Starfield, 2012).

Often in the run up to the achievement of Universal Health Care (UHC) by various countries, the major pathways often incorporated are strategies on Health Systems reforms, restructuring and development. However, what goes missing within these discourses is a major fact that, such developments in Health Systems are never exclusively financial and human resource improvements. But what is more important is to embed such improvements within a framework that can acknowledge and serve the needs of people in an efficient manner. And Primary Health Care is one such framework that can act as a strong backbone for an effective Health system by

lowering inequities and reduce overall cost of health care. Primary Health Care with its key principles (First contact, continuous, comprehensive and coordinated care) has proved to be a stable system that can sustain over time. However a conspicuous absence of emphasis on Primary Health Care within the current narrative of UHC calls for urgent action to bring this issue to the surface (Stigler et al., 2016; Tsimtsiou, 2017).

2.2 DECENTRALISATION AND PRIMARY HEALTH CARE

For long health systems across the globe has been burdened by the issues of misalignment between the actual local needs and the nature of technical planning and budgets allocated. These challenges are also found extended in terms of inability of health systems to achieve sufficient participation of communities within planning of priorities. One of the core reasons for this gap has been the stark separation between the realm of planning and budgetary allocation. One of the key solution that is often touted as the go to strategy to bridge these aforementioned gaps between the allocation of resources and local level health needs as well as to improve community involvement in health care delivery is through decentralised mechanisms (Tsofa et al., 2017). Decentralisation was also one of the key strategies as envisioned through the Alma Ata Declaration on primary health care. For involving communities within local health care planning had implications in terms of enhancing equity in health given its emphasis on vulnerable and marginalised social groups (Beard & Redmond, 1979).

However, the empirical evidence on decentralisation and its impact on health outcomes including equity, efficiency of health systems as well as levels of community participation have remained widely varied. This is often attributed to the contextual variations of the settings where decentralisation is implemented. For, decentralization reforms when implemented may interact with previously centralised health systems in some settings, or they may interact with current forms of decentralisation in other settings, due to the fact that they are frequently implemented without considerations regarding their influence on the health system (Abimbola et al., 2019). Given this, there remain only limited evidence that causally link decentralisation with better health outcomes. Despite this, in general there is a larger acceptance that decentralisation

does tend to have some beneficial impacts on the health outcomes (Jim,nez & Smith, 2005). There are however, sufficient literature that suggest that strategies like increased discretionary control over local level health sector priority setting has resulted in better utilisation of primary health care spending in many countries (Jeppsson, 2001). Evidence also suggest better financial decision-making in terms of health at the local level has been one of the key outcomes drawn out of the better autonomy that decentralised systems provide for local communities (Bossert et al., 2003).

What is also crucial within discussions of decentralisation and its implications for primary health care are the role of larger discourses that may drive and shape decentralisation across settings. For, unlike the initial discourses of decentralisation that pivoted on promotion and participation of communities, the later discourses were largely driven from a 'new right' discourse. One that perceives decentralisation as a strategy for further consolidation of market forces through further weakening of state control at the lowermost levels of governance. This bore by extension serious implications on the larger goals of primary health care too including the likes of equity, inclusiveness and community participation (Collins & Green, 1993). Hence, the realisation of primary health care and its vision is very well contingent on the political nature of decentralisation too. For, decentralisation is a political process that entails not just distribution of political power, but also access for various social and political groups to decision-making as well as to public resources (Collins & Green, 1994). Hence any analysis of primary health care vis-à-vis their larger goals in the context of decentralisation shall also have to extend beyond the mere analysis of the technical realm of effectiveness and efficiency.

2.3 RELEVANCE OF SOCIAL INNOVATIONS WITHIN PRIMARY HEALTHCARE

A major demand that is emerging within the realm of health care delivery to tackle the challenges that entail within a market-oriented approach to health has been the participation of community within the processes of health care delivery. This shift demands the relocation of community as not just passive receivers of health care, but active participants through deliberative democracy within health care delivery. It

points towards the idea of co-production of public goods like health care through the establishment of institutions that enable the collaboration of citizens and state in the production of outcomes that are socially desirable (Dunston et al., 2009). It is in this context that the idea of social innovations gathers relevance, particularly in the area of primary health care. Social innovation strategies attribute significant emphasis on participatory modes of developing and implementing novel strategies for healthcare including health system actors, innovators, communities as well as other related actors. The approach of social innovations that way also attempts to be more inclusive, equitable and effective, through the heightened role of communities as a core partner in creation and sustenance of these strategies (*Social Innovation to Transform Health Care Delivery*, 2019).

The challenges faced by health systems in various low- and middle-income countries are manifold. These challenges range from lack of sufficient human resources, infrastructural gaps, access related issues, gaps within the capacity of various local actors and above all incidences of infectious diseases. Social innovation strategies attempted within local contexts marred by these aforementioned issues have in fact provided an effective means to overcome these through eliciting local responses encouraged by a host of other actors (Dako-Gyeke et al., 2020). Examples of successful social innovation initiatives are also emerging across the world, that has effectively managed to overcome various local challenges in healthcare delivery. These include examples like community-directed intervention (CDI), that was highly successful in achieving a mass drug administration strategy for various endemic tropical diseases (Amazigo et al., 2012). Development of a nurse managed primary healthcare posts example from Rwanda (Niekerk & Chater, 2016), Human Immunodeficiency Virus (HIV) testing centres in People's Republic of China that are community-led (Chater & Niekerk, 2016) and many others too (Reeder et al., 2019)

Literature on social innovations within health contexts therefore suggest to its relevance in furthering the goals of equity across various dimensions of health. These include enhancing equity within the realms of socio-economic participation and cohesions, women's health, physical activity amongst many other health related dimensions. Yet another feature within such service-related social innovations also

involved the development of interventions to enhance the delivery of existing welfare systems to address inequities in health that are also locally relevant. Thus, the literature on social innovations suggests to its growing relevance in achieving the larger goals of primary health care. Given its inclusive and democratic characteristics it qualifies as a crucial strategy to address the growing health inequities through fostering of community partnered innovations within health and primary health care in particular. And it is important that such innovations are fostered in such a way that it actively builds social relations and building networks, emphasis on political, social as well as financial resources and improving the motivation of the agents within the existing system (Mason et al., 2015; Sibthorpe et al., 2005).

2.3.1 SOCIAL INNOVATIONS IN THE CONTEXT OF DECENTRALISATION

The idea of social innovation is being approached from a two-sided argument. One it focusses on the changes and shifts in the larger political economy across the globe that reaffirms the need to emphasise ideas like social innovation models of rural governance. Two, the fit and alignment social innovation has with the existing frameworks of decentralisation in countries like India and specifically in Kerala. The first approach is to see how strategies like social innovation models within rural governance is vital in facilitating the abilities of communities to counter the larger fractural and oppressive narratives of neo-liberalism. For literature on social innovation continues to argue how the post 2008 austerity reforms under neoliberal regimes have accentuated socio-economic regressions within rural communities globally (Hadjimichalis, 2011). The evident marginalisation and segmentation of rural communities therefore argues for a 'neo-endogenous' forms of governance for rural communities. One that is pivoted on the addressing marginalisation by establishing connections between the endogenous dynamics with that of the exogenous one as well as through bottom-up models of governance (Smith & Teasdale, 2012). A key strategy that is being proposed within these models is the idea of social innovation given its ability to disrupt structures of marginalisation. Social innovation models are touted to have the ability to break away from conventional structures of governments through the shaping of self-dependent stakeholders as well as through their ability to institutionalise innovativeness within rural communities. This crucial given the need

to move away from the traditional ideas of 'government' to much more democratic idea of governance(Bock, 2016; Georgios & Barraí, 2021). Thus, these literature largely suggest to the felt need across various country context to embrace newer forms of governance at the grassroots level that is much more horizontal, collaborative and has the capacity to resolve new age issues (Georgios & Barraí, 2021; Neumeier & Heinrich Von Th, 2017)

The second theme here is the nature of fit that the concept of social innovation has with the already existing paradigms of decentralisation in an Indian context. For, the idea of decentralisation since its inception in India, through the 73rd constitutional amendment mandated local self-governments across the country to develop plans for economic development and social justice. Through the amendment, the constitution devolved the responsibility to respective State governments to endow the local self-governments all the needed powers and responsibilities to enable them function as 'institutions of self-government'. Through its emphasis on achieving the larger goals of social justice, the constitution requires local self-governments as spaces of governance where the masses, specifically deprived masses get to have a say in their own local decision-making processes (Bandyopadhyay, 1997). The decentralisation reforms thus initiated accrues significance also due to the repeated failures of various centralised schemes and projects aimed at community development in achieving their intended goals. These failures are largely owed to the disconnect between the projects and the intended beneficiaries of the project (N. D. G. Nair & Krishnakumar, 2004). All these suggest to how the idea of decentralisation or panchayati raj reforms the country initiated close to three decades back aligns with the basic tenets of social innovations too. Specifically with regards to the inclusion of communities within local level decision making to resolve local level issues. This natural fit between the two ideas therefore provides a conducive political context that mandates the need for further exploration of the concepts in tandem.

2.4 DECENTRALISATION AND HEALTHCARE IN KERALA

The 73rd constitutional amendment during 1992 was a landmark event in the history of India, which ushered in a decentralised governance model across India, with specific

emphasis on economic development and social justice. Though repeated efforts were made to strengthen local government since the 1950s, the most radical change in policies related to local self-government was only introduced through the amendment in 1992. However, unlike other states in the country, the devolution of powers to the local government representatives are much deeper in Kerala in terms of autonomy in power and resource use established through a proper legal framework to facilitate true democratic functioning of these agencies. Hence, it could be seen that, ever since the introduction of decentralised planning and governance, the state of Kerala has been at the forefront in promoting local democracy and citizens participation in local planning. (Oommen, 2004).

Kerala through its 'People's Planning Campaign' in 1996 undertook a rigorous and radical route to decentralisation. Under the reform, the State initiated decentralisation with a heads-on approach which involved devolution of 35-40% of the State's Plan fund to the local self-governments. Massive campaigns were implemented to assess local needs of the people through 'gramasabhas' or village level assemblies of people. Decisions from 'gramasabhas' were drafted as local projects, passed on to block level local self-governments and approved at the district level by a District level planning committee. The entire process of 'People's planning campaign' was rolled out in phases with the support of voluntary task forces in all villages. Local projects and plans were devised with the direction provided from an expert State level body called State Planning Board(Kannan, 2000).

The advent of People's planning campaign gave the needed impetus for health activists in the state to push health sector further through local self-governments including demands for further investment on health. A key mechanism within decentralisation that brought about notable change in the health sector was through the transfer of primary healthcare institutions and its control to the local self-governments (LSGIs). The LSGIs were also given the mandate to undertake healthcare projects on their own at the local level. LSGIs across the state undertook discussions on health-related needs of the communities through 'gramasabhas', community-based surveys, and preparation of project reports on health and health related activities. The campaign also resulted in large scale improvement in local health infrastructure since the health

institutions now came under the ambit of LSGIs. Over the years, the decentralisation reforms have clearly laid out the conditions for building an effective and efficient health system in the State that are locally relevant and equitable for all sections of the community(Elamon et al., 2004a).

2.4.1 PRIMARY HEALTH CARE IN THE CONTEXT OF PPC IN KERALA

The functioning of Primary Health Centres as well as planning and delivery of public and primary health care now falls directly under the prerogative of LSGIs. This was based on the principle that local level needs are best understood by the people at that level than a higher authority planning for them. Hence the various primary health care projects are now currently planned and implemented in collaboration with the PHC functionaries at the level of Village Panchayat and supervised by the LSGIs. This reform of decentralised governance has thus carved out a much-needed space for LSGIs and PHC staff to tackle the issues of communicable as well as non-communicable diseases at the local level, through various locally planned innovative service delivery strategies. A key aspect of such innovative and locally developed health projects was the participation of community members as key partners in the planning and implementation of the projects right from its initial stages. This was achieved through the Grama Sabha meetings where community members came together to discuss the local issues and gathering of locally available data. Once the gramasabha meetings are compiled, these reports are discussed among the people's representatives and officials to plan solutions that are suitable for the problems identified through the Gramasabhas, which are then compiled together as Panchayat Development Report (PDR). Once the PDR is prepared, a task force of experts and activists examine the report to arrive at locally relevant projects or schemes that are best suitable to implement the solutions based on the PDR. In the final phase these projects are prioritised for implementation based on their relative seriousness and relevance, for which funds are then released to the LSGI (Elamon et al., 2004c; Varatharajan et al., 2004b).

A major achievement of such a decentralised control over the PHCs and delivery of primary health care service delivery was also the introduction of a conducive

environment for attempting novel projects at the level of LSGIs and PHCs. Given the freedom and autonomy in local level governance resulted in the emergence of grass root level innovative primary health care strategies relevant to the local needs and culture. A major feature that strengthened decentralised health governance and delivery was also the establishment of institutions that facilitated community engagement within the realm of decision making for health and innovations in health. This to an extent has resulted in the emergence of primary health care innovations that were co-produced in collaboration with community members, LSGIs and PHC functionaries in Kerala (John, 2012).

2.4.2 SOCIAL INNOVATIONS IN THE CONTEXT OF PEOPLE'S PLAN CAMPAIGN IN KERALA

The constitutional amendment that brought in decentralisation and the institution of local self-governments in India did have two main features within the amendment. One was the mandatory requirements expected out of the newly instituted local self-governments across the country and second was the voluntary yet agentic changes expected out of the various State governments in the country. Though the tenet of maintaining the local governments as 'institutions of self-government' was non-negotiable, the powers and responsibilities to be devolved to these local governments remained the prerogative of the State legislatures. As a result, the implementation of decentralisation across various States in the country did have significant differences too. And a key State that adopted a radical approach to decentralisation within the country was Kerala, through its People's plan campaign initiative in 1996 (Bandyopadhyay, 1997).

As a result, one of the core tenets of decentralisation in Kerala have always been the idea of pro-active participation of communities through its LSGIs. One of the stated missions of the department of panchayats, government of Kerala is *'To develop mechanisms for community participation in decision making and sustainable development. To realise an equitable and caring society with special focus on marginalised and weak'* (Government of Kerala, 2023). Hence, the adoption of democratic decentralisation through the People's Plan Campaign (PPC) enabled Kerala to overcome one of the major challenges in the success of community

development projects at the grass roots level. This was primarily owed to the significant emphasis on participatory planning as being the core pillar of the PPC, with 'development from below' as its rightful slogan. Through the campaign the State completely devolved the responsibility and the choice of the nature of projects that was required, completely and exclusively to the local communities. The State's Panchayati Raj Act further empowered and mandated these elements of people's participation within conception, formulation, implementation and maintenance of local projects by LSGI to local communities (N. D. G. Nair & Krishnakumar, 2004).

These also meant that, the unique context of the existence of powerful decentralised governments and the authority they had over the primary health care provisioning, provides a conducive political atmosphere for the development of social innovations by implication. For, social innovations too by their very definition has community participation as a key pillar within itself (Dawson & Daniel, 2010). It is in this context, that the context of democratic and political decentralisation that currently exist in India as well as Kerala gathers relevance.

2.5 DALITS IN KERALA

One of the longstanding challenges, that India today face would be its deafening silence and blindness to the oppressive conditions of Dalit communities. The dominant paradigms of economic development and progress in India have largely remained mute to the stark poverty that Dalits face today (Raghavendra, 2020). Various studies on caste based inequalities suggest that Dalits constitute the most significant proportion of deprived section in India (Sundaram & Tendulkar, 2003). As per the 2011 census, Dalits constitute around 16.6% of the Indian population, a major proportion of which are engaged in agriculture sector or other low-income jobs and is a social group that has very minimal asset ownership compared to others in India. Dalits constitute the major section within bonded labourers in India and their literacy status remain at 66% lower than the national average of 73%. However, despite their lower social status and limited livelihood and living conditions, they continue to make significant contributions towards Indian economic growth today (*Census of India: Primary Census Abstract*, 2011; Pankaj, 2019). The oppression that has lasted since many decades on

many fronts have also translated as poor health indicators for Dalits in India today. In her Lancet lecture by Arundhati Roy in 2014, she argued that for India to develop as a healthier country can only do so by addressing the issue of caste and its influence on health in the country. She urged that, to achieve a healthier society, it was imperative that politicians across the country shall strive towards an equal society, that has equal opportunities and better investment in health and education (Lancet, 2014).

Compared to the rest of the country, the State of Kerala displays a starkly different picture in terms of its achievements within areas of human development across various sectors. The State is widely known among academia and policy-circles to have achieved remarkable progress in terms of health and education of its people. The State stands unique among other states in terms of its achievement as the most literate, where almost 90% of women are literate as compared to 54% in the country. In addition, the unique history of diverse socio-political movements that the region witnessed including the long history of communist movements also have had an impact on the health and educational sector in the State. This has enabled the State to largely curb rapid expansion of its population as well as achieve significant progress in reducing infant mortality rates, maternal mortality ratio and a general improvement in life expectancy of its population (Thresia, 2007). As mentioned before too, the state is also widely acknowledged for its achievements in health due to its strong commitment of community participation, through the People's Plan Campaign (PPC) in 1996. All of this has statedly enabled the state to have significant progress for women and disadvantaged sections (Ramakumar & Eapen, 2021).

However, recent literature that examines the situation of Dalits and their experiences in Kerala suggest to a picture that is contrary to the popular narrative of the State being a progressive one, that benefitted the disadvantaged. A narrative that was blind to the realities of Dalit exclusion and marginalisation including in aspects related to health, as well as those related to wider determinants of health (Thresia, 2007). Studies on caste in Kerala suggested that, inter-caste disparities are evident in various sectors including basic necessities of food, clothing, landholding, educational achievements in the State, despite its overall achievements (A. Deshpande, 2000). Though the State is endowed with a diverse range of favourable factors including its unique socio-

political trajectory, favourable climate and availability of natural resources, this has not really translated as an equitable and socially just health within its communities. The overall development paradigm of the state is evidently riddled with large structural inequities driven by caste, gender, ethnic status and economic class. All of this has invariably translated as persisting inequities in the distribution of health outcomes among various social groups, Dalits in particular (Thresia, 2014). This has been evidently reflected through studies that have examined the differences in various health related dimensions between different castes in Kerala. It was observed that, scheduled caste groups due to their low economic status, found it the most difficult to access the sufficient healthcare services that they required in comparison to various privileged caste groups. The scheduled caste groups also demonstrated the presence of a huge unmet need in terms of chronic healthcare in comparison to their privileged counterparts in Kerala (Mukherjee et al., 2011).

Studies on the impact on health outcomes by caste in its role as a social gradient in fact also alludes to its role in affecting the general well-being of Dalits in terms of increased incidences of morbidities, compared to their non-Dalit counterparts. In addition to this, the historical exclusions from land ownership by Dalits gathers significance in terms of how they are squeezed out of their ability to even access public healthcare facilities in the State. Exploration of caste influences does suggest to persisting inequalities in access to health care in the State, mostly among poor Dalits. These explorations also allude to the compounded role of differential distribution of literacy and education among Dalits in creating pathways of increased morbidity among Dalits in contemporary Kerala. It was found that among members with lower literacy, there was higher incidence of morbidity. These findings on caste and its relation to health outcomes in Kerala suggests that, Dalits continue to endure discrimination in areas related to healthcare (Scaria, 2017). These findings point to a larger need to explore the issue of caste and their role in shaping health, in the context of a rapidly changing demographic and environmental context of the State and thereby effectively address the changing healthcare needs.

3.METHODOLOGY

This section aims to deal with the various operational definitions crucial within the study as well as the different frameworks that it used in undertaking the research. This sections also deals with the specific methodologies as well as study methods that different phase of the study adopted in completing the research.

3.1 OPERATIONAL DEFINITIONS

1. **Innovation:** Definition of innovation for the current study taken as, *"a new or improved product or process (or combination thereof) that differs significantly from the unit's previous products or processes and that has been made available to potential users (product) or brought into use by the unit (process)"*(OECD & Eurostat, 2018). The current study specifically focusses on processes innovations within Primary Health Care delivery that are new or relatively new to the area.

2. **Social Innovations:** "social innovations in health are inclusive solutions to address the healthcare delivery gap that meet the needs of end users through a multi-stakeholder, community-engaged process" (Halpaap et al., 2020b)

3. **Marginalisation and Inclusiveness:** The third dimension that will be considered in the innovation discourse within the current study is the notion of inclusiveness. The study tries to include the considerations of inclusivity of marginalised sections of the community, within the innovation processes that are by design social. Though there are multiple axes of marginalisation, the key focus within marginalised in the current study would be Dalits. For, Dalits continues to remain a historically marginalised social groups within developmental discourse of contemporary Kerala (Devika, 2013). Hence inclusiveness in the current study will be considered as inclusion of Dalits being part of the innovations that are also social in design.

4. **Dalit:** A Sanskrit term that signifies the meaning of 'broken' or 'oppressed' and used as the political term to denote the untouchable caste groups in India. In

administrative parlance or in constitutional terms Dalits are termed as Scheduled Castes in India (Minority Rights Group International, 2023)

5. **Dalit Colony:** A special housing scheme initiated by the Government of Kerala in 1972 that aimed at providing housing for the landless class and below poverty line and aimed at the resettlement of Dalits and Adivasis in the State. These colonies are characterised by their congested housing with limited access to basic amenities including water and sanitation facilities today (Pramod, 2020).

6. **Primary Health Centre (PHC):** A government Health facility that provides primary health care services including preventive, curative, rehabilitative and palliative care at the grassroots in the State. Typically, a PHC provides services to a population of around 20,000 to 30,000 people within a village geography and will be led by one Medical officer who supervises both the clinical care services as well as the public health team consisting of a Health Inspector, Junior Health Inspectors, and Public Health Nurses (Ministry of Health and Family Welfare, 2020).

3.2 METHODOLOGICAL FRAMEWORKS IN THE STUDY

A key criterion of interest within the current study is the role of institutions and their influence within local self-government decision making. The current study on social innovations therefore intends to undertake the examination of social innovations using the concept institutions and application of relevant frameworks that could effectively guide in exploring them. Institutions are the rules, regulations, laws and organisational culture that often dictates the functioning of actors within the system. Hence institutions are passive factors which are often the ‘rules of the game’ that influence the innovative roles of the system functioning and can also in turn be influenced by the actors in the system (Van der Hilst, 2012). Institutions have been defined here as, various legally, socially and politically accepted conventions or “ways of doing things/rules of the game” within a given social context. These rules of the game dictate the interaction and coordination between two or more individuals/organisation through the creation of incentives within its structures to ensure sustained adherence by the

actors involved in in it (Milchram et al., 2019). It denotes the various beliefs, cultures, customs and routines, established practices at the local level as well as the broader policies and regulations at the policy level that will in turn influence the local practices related to innovations (Edquist, 1997).

Given the unique political context of Kerala, LSGIs remain a close collaborator and decision-maker in terms of conceptualising and implementing primary health care projects. People's Plan Campaign, therefore, laid out a politically conducive environment in Kerala that allowed the LSGIs to take a leadership role in the provisioning of primary health care services at the grassroots level that is responsive to the health needs of their community (Nair & Naidu, 2016). Though decentralisation holds vast potential to strengthen democratic decision-making processes, the actual implementation of formal or legal rules tends to be limited in its ability to achieve complete adherence specifically in the context of developing countries (Bardhan, 2002). Formal rules and regulations often fail in providing the needed incentives to achieve sustained adherence to them by the local actors. The result is wide variations in the degrees of success achieved by different local governments even under similar conditions and common legal frameworks. The key to tackle this challenge may lie in the exploration of informal institutions/rules and to understand how they interact with various formal institutions (Horowitz & Palaniswamy, 2010). Though much of the literature has focussed on the formalised aspects of decentralisation including legal rules and devolution of powers, little priority has been attributed to the role of informal institutions and their roles. The significance of informal rules in bringing out large variations within the landscape of decentralisation in India suggests that a limited perspective on just the formal structures and rules are at best a partial explanation of the existing policy outcomes (Ban & Rao, 2009; Horowitz & Palaniswamy, 2010; Palaniswamy & Krishnan, 2008).

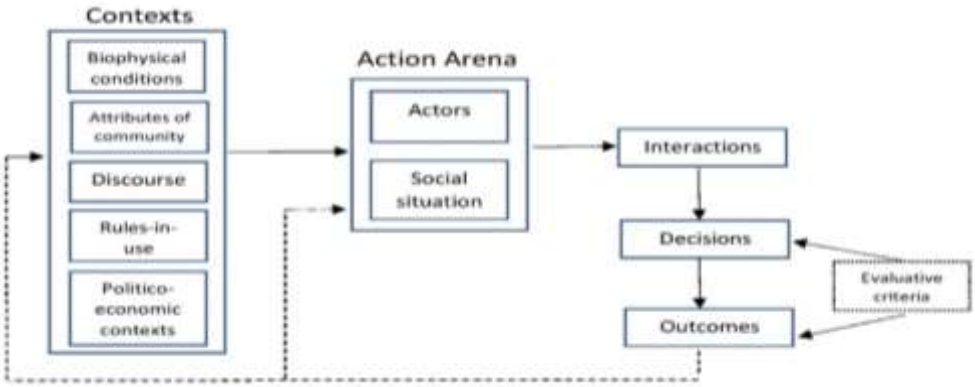
3.2.1 APPLICATION OF POLITICISED INSTITUTIONAL ANALYSIS AND DEVELOPMENT (IAD) FRAMEWORK

The Politicised IAD framework is an iteration of the much-applied IAD framework developed by Elinor Ostrom in 2005 (Clement, 2010; Indiana University, 2005). The IAD

framework has been one of the most commonly applied frameworks specifically in the context of analysing institutions and their multi-level dynamics specifically in the context of natural resources and its governance (Clement, 2010). A key advantage IAD framework offers researchers is this ability to unpack institutional dynamics and how actors within a given situation interact with each other governed by various institutions to create a specific outcome. The framework also locates institutions and the interactions among actors shaped by them within a broader context with its physical, social, political and legal characteristics which influence the local realities (Polski & Ostrom, 1999).

The focal level of IAD (Fig.1) analysis hence pivots around the concept called 'action arena', or space where multiple actors come together and interact to resolve a given situation at hand. This action arena is embedded within a specific socio-politico-cultural context or a set of external variables influencing the action arena. These external variables have been categorised primarily as three major categories; 1) Biophysical conditions or the actual physical attributes of the environment where the actors are located. These in turn can dictate and influence the action arena based on the available environmental resources, their abundance and uncertainties involved with these resources (Ostrom, 2007; J. Wilson, 2002) 2) The community attributes influencing the action arena, involves the specific cultural and demographic attributes specific to a given community (Cleaver, 1998; Klooster, 2000) 3) The rules-in-use are the shared rules, norms and values that are mutually shared among the actors involved in the action arena. They will include both the formal and informal rules and conventions that dictate decision-making within a specific community context (Sabatier, 2007).

Figure 3. 1 Politicised IAD (Clement, 2010)



3.2.1.1 Advantages of Politicised Institutional Analysis and Development Framework

The politicised IAD enrich the conventional IAD framework through its analysis of power as well as the embeddedness of local decision-making within a larger politico-economical context. The framework also discusses how power and institutions are produced, sustained and recreated through discourses or the social construction of realities by actors at different levels.

Analysis of power within the Politicised IAD framework

Drawing from the concepts of Critical Realism, Clement's Politicised IAD framework attempts to fill the lacuna of power and the complex embeddedness of institutions within the Ostrom's framework. What makes it flexible in the context of research on decentralisation is also its mindfulness of the idea of institutions being embedded in the larger narratives of politico-economic contexts (Clement, 2010). This is key within the realm of decentralised governance in particular, where evidence suggests that the provision of public goods through democratic decentralisation is significantly shaped by political narratives at higher levels of government. The result is significant links between priorities of national politics and their influence on the motivation and effectiveness of local governments (Ponce-Rodríguez et al., 2018). In addition to the influence of larger political contexts, the local governments also operate within the context of larger economic forces whose intent and objective are often different to that of the local communities and their needs. Global economic forces of neo-liberal order are more often than not in conflict with the local needs of the people and hence heavily

influence or limit the relative autonomy of LSGs in shaping the desired projects (Bhuyan, 2012).

Application of social construction of narratives and priority settings

A key advantage politicised IAD brings to the table is its introduction of discourse as an analytical criterion within IAD framework. This is particularly relevant in the context of analysing LSGIs in Kerala. Though Kerala is largely hailed as a model for development, it too obscures within this narrative the developmental plights of women, Dalits, coastal communities and tribal sections (Devika, 2010). For, not all candidates of social problems are prioritised as mutually agreed social problems and subjected to policy programs. Many social problems are never acted upon due to issues of poor problem definition or lack of understanding related to the connectedness of multiple variables leading to a problem (Dyckman, 2007). Herein lies the idea of discourse and the way they shape individual social realities. Discourse is defined here as a set of ideas, concepts and categories which are created, recreated and transformed, through which a specific world view is attributed to the social as well as physical realities (Hajer, 1995). Viewed from a Marxist perspective discourse can be powerful systems of ideology that could effectively obscure and normalise disparities in power and resource distribution (Howarth, 2000). Seen along with the concept of power, discourses are powerful ways of mediating institutions, creation of newer institutional practices as well as sustaining existing power relations. They have a significant role in decision-making spaces, where discourses of the powerful mediate priority setting as well as shape local policies based on these dominant narratives. Given this, discourse analysis proves to be a valid and effective way to initiate research on concepts like decentralised governance reforms. This could enable research on decentralisation to explain why policies assume a specific direction as well as why certain issues remain dominant over others (Foucault, 1977a).

3.2.1.2 Social justice and equity as the evaluative criteria within the Politicised IAD framework

A key value premise adopted within the framework is to approach local governments as instruments of self-governance and not just ‘delivery mechanism’. Unless local

governance structures develop the capacity to fully internalise the relationship between civil society and government as equal partners, the system cannot realise the vision of improving people's lives (United Nations Development Programme, 2000; R. H. Wilson, 2000). The relationship between communities and local governments can necessarily be categorised under three key areas, the election of local representatives, local decision-making processes and implementation of these decisions (Coleman, 1994). Though there are arguments that the role of communities shall be limited to the election of representatives, it is now broadly recognised that communities shall be an invariable part of all three processes for effective decentralisation (Sujarwoto, 2017; R. H. Wilson, 2000).

The idea of community here is conceived from a broader view that has an equitable and real representation of members from the marginalised groups like Dalits, Adivasis, coastal communities and women within LSGs. This is assumed to be relevant given the social context of deep-rooted casteism and male-dominated decision-making spaces in India. Substantial evidence on decentralisation points to the fact that constitutional provisioning of representation for Dalit communities has not been translated as real autonomy within the LSG decision-making processes in India (Inbanathan & Sivanna, 2010; Sukumar et al., 2019). Decentralisation as a political experiment can only be deemed effective when marginalised sections of society too have received their fair share of representation and treatment through the processes of LSG. Hence a key evaluative criterion to explore the various processes and outputs of decentralisation would be the concept of Social Justice. Social justice in the sense that the historically weaker sections too have the space to exercise real autonomy within decision-making structures of LSGs in Kerala. This broadens the idea of social justice beyond the de jure structures available for legal representation within LSGs to also include the de facto opportunities in decision-making. The freedom available for the historically marginalised sections for an equal and fair chance to hold a stake in the local decisions that can influence the health of the community.

As a corollary, equity becomes a prominent concept within this narrative. Equity in terms of the extent to which implementation of local projects are mindful of the historical realities and special needs of marginalised, Dalits in this case. The extent to which

weakest and marginalised are prioritised within the delivery of local health projects and services. For, the existence of informal institutions that proscribe meaningful participation by the marginalised sections in LSG decision-making also translate as local projects that are blind to the realities of marginalised communities. Hence, there exists a symbiotic relationship between equitable sharing of public goods and fair participation of the marginalised within the local governments (Bhuyan, 2012).

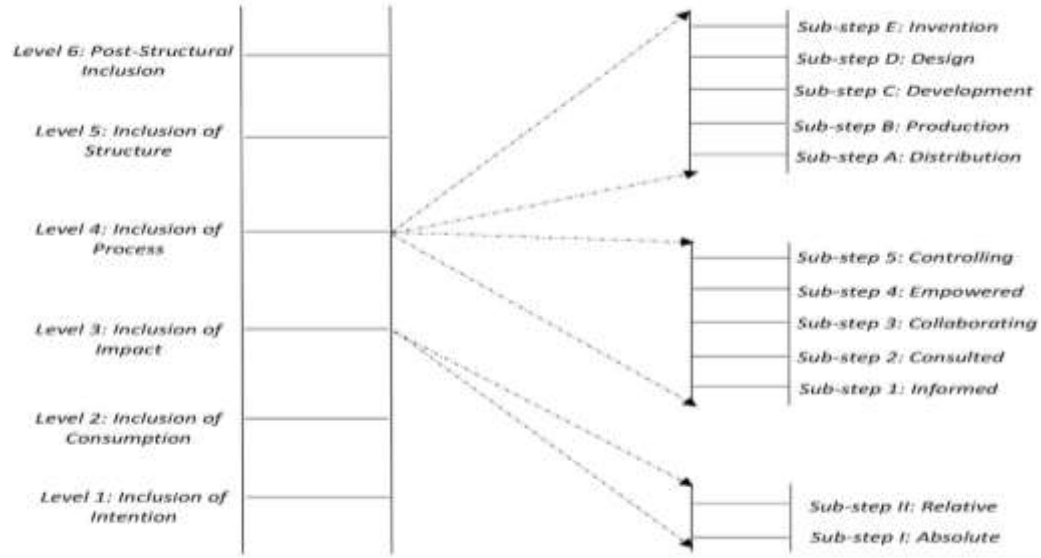
3.2.2 INCLUSIVE INNOVATIONS

Often a major concern within the realm of innovations and specifically in the case of social innovations, lies in the question of who are they ultimately serving and who are the key agents which decides the paths of the innovation itself. A closer analysis quite evidently reveals that, innovation systems are often dominated by large organisations who are driven exclusively by profit motives through manufacture and exports of goods which are ultimately serving the high-income consumers. Hence innovations that drive such a sector are obviously associated and often lead to stark inequalities and little are these innovation systems bothered about the basic needs of the low-income consumers (Richard Heeks, Mirta Amalia, Robert Kintu, 2013). Hence inclusive innovations try to take a different path in approaching innovations per se and is defined as:

"Conventional views of innovation (often implicitly) understand development as generalised economic growth. By contrast, inclusive innovation explicitly conceives development in terms of active inclusion of those who are excluded from the mainstream of development. Differing in its foundational view of development, inclusive innovation therefore refers to the inclusion within some aspects of innovation of groups who are currently marginalised" (Foster & Heeks, 2013)

To better understand the nature of inclusive innovation in terms of its level or depth of inclusion, it is important to know how inclusive they are for the groups it is untended for. To understand this, the study applies the "ladder of Inclusive Innovation" framework which categorises inclusive innovations as a step wise approach, with higher degrees of inclusiveness as the steps progress.

Figure 3. 2 Ladder of Inclusive Innovations Framework



Level 1: Inclusion of Intention

An innovation could be considered as inclusive at the level of intent, if its basic objective is to try and address the needs of the excluded sections - Dalits - within the community. This may not always lead to concrete real life actions, but the motivation for the innovative activity will be inclusive (Richard Heeks, Mirta Amalia, Robert Kintu, 2013).

Level 2: Inclusion of Consumption

Innovations would be considered as inclusive if the intended innovation is being utilised by excluded sections - Dalits - within the society, who have been historically excluded in some way or the other. For an innovation to be inclusive at the level of consumption, it needs to be translated to real life processes or goods that are accessible and affordable to the Dalits (Richard Heeks, Mirta Amalia, Robert Kintu, 2013).

Level 3: Inclusion of Impact

The innovation could be considered inclusive at the level of impact if it is ultimately impacting positively on the lives of the excluded sections, Dalits in the current stduy. However, the assessment of impacts achieved from the innovation could be examined

from different perspectives. One may see these impacts as improvements from a quantitative perspective that involves improvements in the productivity/welfare/utility of the excluded groups. Impacts may also be seen as improvements in the well-being, capabilities of such groups. From an equality perspective, impacts may mean, the higher availability of benefits to the excluded sections as compared to well-off or 'included' groups. Hence the impacts may be seen as either absolute improvements or relative to other sections (Richard Heeks, Mirta Amalia, Robert Kintu, 2013).

Level 4: Inclusion of Process

Innovations that are process inclusive are those which actually includes the excluded sections - Dalits - within the actual processes of the innovation itself. However, such involvement could be examined at multiple layers of involvement that ranges from; involvement in the distribution of the innovation to being part of its production, development, designing and crucial role in the initial invention of the innovation itself. It is also important to see the depth of such involvement in terms of whether the Dalits were only informed at these multiple stages, were they consulted, did they collaborate, were they empowered and did they took on controlling roles. All these levels could be seen as sub-steps within the broad level of inclusion within the processes (Richard Heeks, Mirta Amalia, Robert Kintu, 2013).

Level 5: Inclusion of Structure

Innovations could only be seen as structurally innovative, if the innovation is emerging out of structures and systems that themselves are inclusive in its nature. The argument being that often a system that is not inclusive can only breed innovations that are only temporarily inclusive. Hence to develop structurally inclusive innovations, it is also important that the core organisations, their relations and culture that constitute an innovation system are inclusive in their outlook. To achieve such a level of inclusion, it might require structural reforms that favour such shifts in perspectives or will have to develop alternative systems of innovations (Richard Heeks, Mirta Amalia, Robert Kintu, 2013). In the current study, this would be examined by the perspectives on

Dalits among key LSGI and health official's world views and narratives, as well as their inclusion within LSGI decision-making spaces.

Level 6: Post-Structural Innovations

Post-Structural levels of inclusiveness are achieved when the inclusive structures of innovation system are existing within a knowledge system and discourse that is also inclusive. It is important that the underlying knowledge systems and power structures need to conceive inclusiveness as a key feature, and to achieve such levels of inclusiveness, it is important that the excluded sections too are part of such power structures as a necessary condition (Richard Heeks, Mirta Amalia, Robert Kintu, 2013). In the current study this would be achieved through the CDA of the narratives of health and LSGI officials undertaken through the Phase I of the research.

3.3 STUDY DESIGN & DATA COLLECTION

3.3.1 PHASES OF THE STUDY

The current study on primary health care social innovations and exploration of inclusiveness of Dalits within them conducted over three phases between May 2019 till March 2021.

Table 3. 1 Phases involved in the study

Phases	**Study design**	**Objectives covered**
Phase I	Thematic analysis and CDA	To understand how the existing formal policies and key actors at different levels within the public health system and local self-government institutions conceive of innovations, social

		innovations, and inclusiveness
Phase II	Case studies	To examine the various contextual factors that may shape and influence the emergence of social innovations within selected grama panchayats To examine the institutional ecosystem influencing the emergence of social innovations in selected grama panchayats in Kerala, and understand the role of various actors and their interactions in conceptualising, implementation, and institutionalisation of social innovations
Phase III	Case studies	To explore the extent of inclusiveness within the selected social innovations and to explore how these social innovations in village Panchayats facilitate the

		health needs of the marginalised community groups.

3.3.1.1 Phase I: Thematic analysis of innovations, perceptions on marginalisation and Critical Discourse Analysis of Primary Health Care discourses and community partnership in Kerala and their influence in social practices of innovations

The phase I of the study attempted to explore how the policy actors as well as policy level documents on primary health care in Kerala perceived and shaped the grass roots level innovations on primary health care as well as marginalisation. This phase therefore attempted to explore two main aspects. One to examine the various themes of innovations as perceived by actors from health and LSGI as well as their perspectives on marginalisation and vulnerability. Secondly, using CDA we explored the implications for primary health care given the existing perceptions on primary health care innovations and role of communities within them. In this phase we applied both a thematic analysis of qualitative interviews as well as a critical discourse analysis of these interviews and existing policies.

Thematic analysis is a qualitative data analysis methodology, that primarily aims to unravel themes and patterns within data. Through shedding light on the emerging themes and patterns thematic analysis brings out interesting underlying implications hidden within the data (Maguire & Delahunt, 2017). Given these advantages, thematic analysis was considered for phase I exploration. Since, it aimed at unravelling the key patterns within primary health care innovations and perspectives on marginalisation within narratives of health and LSGI actors in Kerala.

Critical Discourse Analysis is a way of research that stems from the idea that language is often a form of social practice and hence is a major construct to be examined critically (Wall et al., 2015). Hence it is a specific approach to the study of texts and talks, that has its root in critical linguistics and semiotics and which try and see discourse from a socio-political standpoint by the way language and speech is constructed. The basic premise being, socially dominant groups often sustain their

power through exercising their control over the minds and actions of those who are less powerful or powerless. This is achieved through the dominance over the control of texts and resulting discourses, more so at the realm of formal policies and rules, where these texts are often controlled and manipulated by the elite and powerful sections. This includes, the control politicians and bureaucrats have over the policy and legislative discourses emanating from governmental and parliamentary bodies (Dijk, 1995).

Though there seems to be a fair bit of difference in the way one can frame the meaning and definition of what constitutes a discourse, the two major categories of discourse tend to be structural and functional. The structuralist school perceives discourse as the basic construction of language that involves the forms of language, the grammatical construction. In contrast functionalists are interested in the way in which language is used to express what one intends to express (Deborah Schiffrin, 1994). Drawing from the functional school of discourse, the definition of discourse conceived within the current study is the one adopted by Norman Fairclough, where he views discourse as, the way in which language is used in speech and texts, the meanings that are socially made out of such a language use and the resultant social actions are all constitutive of the idea of discourse (Fairclough, 2010; Hidalgo Tenorio, 2011)

3.3.1.2 Phase II & III: Case study of social innovation cases & Exploration of inclusiveness for Dalits within the social innovations

Phase II, aimed at an in-depth exploration of social innovation cases from two specific grama panchayats in Kerala. Case study methodology was adapted to examine the local contexts, actors, their interaction, examining institutional factors all of which ultimately shaped the social innovations. The methodology was also used to understand the nature of inclusivity of these social innovation in terms of Dalit participation within the various phases of social innovations examined.

Case studies are one of the best approaches to understand processes that are complex and enable to have a holistic understanding of the same situated within a social context. It enables to answer the ‘why’s and how’s’ of a complex phenomenon in question and when the researcher is unable to manipulate the behaviour of the actors involved in the

study. It enables the researcher to have a deeper understanding of a specific phenomenon, when it is largely unclear what the exact boundary between the phenomenon in question and the context in which it is located (Yin, 2009) Given these qualities and attributes that case study approach brings to the table, it has been widely used in health policy and systems research.

The conceptual framework of IAD, used for analysis of the social innovations too is underpinned by the idea of complex interactions of multiple actors embedded within a specific socio-cultural and geographic context. This neatly aligns with the premise of a methodology like case study. For, case studies too are premised on the understanding that health policies as well as system functioning is deeply embedded and influenced by the context in which it is placed. For instance, the behaviour of a health staff is largely influenced by a range of factors that includes his or her interactions, organisational and societal factors surrounding the actor well as the policy factors dictating his actions. Yet another factor to be taken into consideration being the multiple interpretations of a single experience by a range of actors within a single system which has implications on the function of the system itself. Since case study approach enables the researcher to explore and understand such complex interactions and influences that guides various actors, it was found to be the best method to be adopted for the current research (Gilson, 2012). Given this fit between the framework adopted with the case study ideology, an explanatory case study using multiple cases was chosen for the current study on innovations. Two grama panchayats that had innovative primary health care projects that had the characteristics of social innovations was selected for the conduction of the case study methodology.

The case study phase also included the exploration of the social innovations in terms of their inclusiveness for the marginalised sections of the community. Through this the research primarily explored the ability of the social innovations in facilitating better access to health care service by the LSGIs within the various phases of social innovation phases from the initial conceptualisation till the level of being benefitted from the social innovations by Dalit sections in the panchayats. The element of

inclusiveness was explored using the analytical framework of Heek's Ladder of inclusiveness approach

3.3.2 SAMPLE SELECTION & DATA COLLECTION

3.3.2.1 Phase I (Thematic analysis & CDA): Sample selection

The primary approach for selecting samples for phase I analysis were through strategic selection of individuals from health system as well as LSGI in the State. Hence, the selection of actors was done such that when undertaken it has adequate representation of the health and LSGI realm in the State. Hence, the individuals for phase I analysis under Department of Health were purposively selected from Directorate of Health, Thiruvananthapuram, selected District Medical Officers, District Program Managers (National Health Mission), Medical Officers (MOs) and public health functionaries including Health Inspectors (HI), Health supervisors (HS). Those under LSGI including panchayat presidents, vice presidents and health Standing Committee Chairpersons were selected based on their experience in being an LSGI representatives (at least one term of experience). Also, they were selected specifically from LSGIs that had at least 10% Dalit proportion and hence included members from Palakkad, Thiruvananthapuram and Pathanamthitta Districts. The information needed for CDA were also collected from these in-depth interviews as well as document analysis of policy level texts and documents. This enabled the researcher to collect the perspectives of various policy level actors on Primary Health Care innovations, community participation as well as inclusiveness. To maintain confidentiality of individuals who were part of the IDIs in this phase, we feel that it is important to limit further information of the exact participants. For, revealing the position of the interviewee will invariably facilitate in identifying the exact person, as often these are singular and key positions within health department.

The policy level text that was subjected to CDA was the document on 'Aardram' policy, by Department of Health, Government of Kerala. This was specifically selected given the policy's stated intent of being a novel guideline for a revised path for primary health care for Kerala. It therefore represents itself as an innovative reform to revamp the existing primary health care delivery in the state. This analysis was also aided by

supporting documents for 'Aardram' policy available in the Department of Health website, website of National Health Mission-Kerala. Aardram policy document was sourced from the office of Kerala State Health Systems Resource Centre, Thiruvananthapuram.

Table 3. 2 List of documents reviewed

Sl.No	Document name	Source
1	Comprehensive Primary Health Care through Family Health Centres	State Health Systems Resource Centre-Kerala, Department of Health, Government of Kerala (https://shsrc.kerala.gov.in/pdf/CompPrimaryHealthFHC.pdf)
2	Aardram overview	The Website of National Health Mission, Government of Kerala https://arogyakeralam.gov.in/2020/04/01/aardram/
3	Kerala Development Report: Initiatives, Achievements, And Challenges	Kerala State Planning Board https://spb.kerala.gov.in/sites/default/files/inline-files/Kerala-Development-Report-2021.pdf

3.3.2.2 Phase I (Thematic analysis & CDA): Data collection

In-depth interviews

In-depth interviews were the primary method of data collection that was adopted for phase-I of the research. These involved IDIs with various health and LSGI actors in the state.

Document analysis

Document analysis was used to parse details available within the Aardram policy document.

3.3.2.3 Phase II (Case studies) & III (Dalit inclusion): Sample selection

Phase II selection of panchayats for case studies

The sampling for the case studies of innovations was guided by the principle of theoretical sampling. Villages for the case studies were selected based on the theoretical constructs of social innovation and inclusiveness of Dalits. An initial attempt was made to collect information from the Information Kerala Mission (IKM) department through their proprietary software Sulekha for LSG projects. The Sulekha portal is a large database related to LSG projects for the entire State and contains the details of all projects undertaken by every single LSG in Kerala. However, the information available through Sulekha was vast and was impossible for a single individual to completely and effectively scan the entire database of projects just by their name and then decide on the innovative nature of projects. This was the case since the Sulekha portal contains only the names of the projects and a brief detail regarding the projects and details on their budget.

Hence, as a second method the researcher undertook a snowball method for collecting information related to innovative panchayats and the details of the innovative projects for health. As part of this process the researcher contacted a few senior Health Inspectors (HI) and Junior Health Inspectors (JHI) under the department of health in Kerala, seeking support to create a list of innovative health care projects in Kerala. As part of this, support was sought from the public health staff across Kerala through their social network groups and forums. Following this an initial round of information was collected from public health staff who were willing to share the information they knew. As part of this an initial list of innovative panchayats were selected by the researcher and they were;

Table 3. 3 List of innovative projects compiled during the initial stage

Sl. No	**Project name**	**Proportion of Dalits**	**Community partnered**	**Year initiated**
1	I care we care	10%	Yes	2020

2	'Sayamprabha'	15.36%	Yes	2019
3	Athijeevanam	4.74%	No	2016
4	Punarjani	4.92%	No	2015
5	Low-cost laboratory project	18.19%	No	2013
6	Innovative mode of NCD care	3.53%	No	2010
7	Student health inspector	0.34%	Yes	2015
8	Samagra gothra Arogya pariraksha	3.10%	Yes	2017
9	Gothrasparsham	3.10%	No	2016
10	NCD society	10.78%	Yes	2001

From this initial mapping of the village LSGs and their innovative projects, the researcher selected two possible cases for the current PhD research based on three criteria;

1. Innovations that are community partnered (social innovations)
2. Villages that have at least 10% Dalit population
3. Projects within the last 5 years (when the research started in 2019)

Based on these selection criteria, village panchayats with the projects 'I care we care' and ''Sayamprabha'' were selected as two cases.

Selection of individuals from within the panchayats

The selection of the individuals from the selected panchayats was based on the information made available by the LSGI leadership regarding the social innovations selected for case studies. Based on the available information all functionaries directly involved in the social innovation were choses for IDIs and/or FGDs. This involved people from PHC, LSGI as well as within related transferred institutions like ICDS, Kudumbasree, SC department staff.

Selection of individuals for exploration of inclusiveness of Dalit community members within the social innovations

Once Phase II case studies of social innovations were completed, these innovations were further explored for their inclusiveness of Dalit communities. This is primarily intended to explore the ability of the selected social innovations to better facilitate the health needs of Dalit sections in particular within the two panchayats. Hence, the sampling for phase III exploration of Dalit inclusion was embedded within the panchayats selected for phase II case studies of social innovations. Hence the Dalit members including LSGI representatives and community members were drawn from the panchayats that had the social innovations examined under the study. However, the selection of Dalit community members was done from randomly selected Dalit neighbourhoods, commonly called Dalit colonies within the panchayats. This was aided through the investigator's interaction with kudumbasree leadership at LSGI who provided needed information about Dalit colonies. From the list of colonies, the investigator randomly selected one or two colonies from both the pachayats. The information about Dalit individuals from within these colonies were also then sought from LSGI or kudumbasree leadership. These individuals were then either met personally at their household or through telephone to seek their consent to be part of the study.

The samples primarily were Dalit community members from the 2 case study villages in the study. The members included Dalit representatives in the panchayat. Dalit kudumbasree members as well as Dalit members who played active role within the innovations examined in the study were also included. A total of 10 members were

selected in Village A and 8 from Village B. They were strategically selected so as to ensure sufficient mix of individuals based on the sub-axes of marginalisation including gender, age as well as geographical locations.

Table 3. 4 Details of Interviewees involved in phase II & Phase III

Sl. No	Organisation	Village A	Village B
1	FHC	- Medical Officer - Health inspector - 2 JHIs and - 1 JPHN - 3 ASHAs	- Medical Officer - Health inspector - 2 JHIs and - 1 JPHN
2	LSGI	- President - Vice president - Health Standing committee chairperson - Development Standing committee chairperson - Scheduled Caste ward member	- President - Vice president - Health Standing committee chairperson - Scheduled Caste ward member
3	Kudumbasree	Kudumbasree Community Development Society (CDS) chairperson - Kudumbasree CDS secretary - Kudumbasree members	- Kudumbasree Community Development Society (CDS) chairperson - Kudumbasree CDS chairperson (previous)

			- Kudumbasree members
4	ICDS	2 Anganwadi workers	Anganwadi worker ICDS supervisor
5	SC development department	SC promoter	SC promoter
6	Dalit individuals from community (for inclusivity analysis)	10 individuals	8 individuals
		- GPK president, GPK secretary	

3.3.2.4 Phase II (case studies) & III (Dalit inclusion): Data collection

In-depth interviews

Due to the specific pandemic situation, the primary mode of data collection within the case studies remained in-depth interviews. Group methods like rich picture was avoided and FGDs were limited to very few, due to the need to adhere to hygiene protocols during the conduction of the study. IDIs with various key actors who were part of the process to elicit their responses on the various aspects of innovation, to explore the key underlying dimensions related to institutions that might have facilitated or hindered the innovation process as well as on inclusiveness of Dalits.

Focus group discussions (FGD) with Dalit community members in the case studies

Village A

To explore the experiences of Dalit community members in relation to the 'I care we care' project, one round of FGD was conducted in Village A. The participants for the FGD were primarily members from Dalit colonies within the panchayat and included both males and female members. The details of the participants are.

The female members between the age group of 40-60 were primarily involved in domestic labour and associated with kudumbasree activities too. They had a maximum education till 10^{th} level. The 3 female members between 20-30 were educated till graduation and worked in private organisations. The 2 male members aged below 50 were daily wage workers and one male member was without any jobs. All of them only had school level education.

Village B

The study performed two rounds of FGDs with selected group of community members to ascertain their experiences with the 'Sayamprabha' innovation in Village B. The first round of focus group discussion aimed to explore the experiences of historically marginalised communities (Dalits in the case of current study) within local self-governments. The participants for the first FGD were selected from a Dalit colony and involved around 8 individuals. The researcher had asked for the willingness of members to be part of such a discussion prior to the FGD. Subsequently all members who willingly came to the discussion were included at the time of the FGD. Following were the age category of the FGD participants;

All the participants in the first round of FGD were residents of a Dalit colony and came from a low socio-economic background. Except one member with an under-graduate degree all the participant had education below higher secondary. The FGD was conducted at the residence of one of the participants and the lasted for around 1.5 hours.

The second FGD was conducted to explore the experiences of Dalit 'Sayamprabha' members to explore their inclusiveness within the project. Hence willingness was

sought from ‘Sayamprabha’ members from a Dalit colony and all those who were willing were included in the FGD and was conducted at the residence of a participant. However, since the researcher had initially liaised with a male member most of the participants who turned up to the FGD were males except for one female participant who came in towards the end of the discussion. All the participants were ‘Sayamprabha’ members and were above 60 years old and all of them belonged to poor or very poor socio-economic status.

All the interviews, FGDs and participant observation were conducted by the principal investigator (PI) and was completed over a period of 3-4 weeks. To facilitate the conduction of the study PI stayed in the panchayat during the period of the research. The interviews with LSG actors were scheduled through prior meetings with the individuals, The venue and time was also chosen by the interviewee based on their convenience. Based on this the interviewer had either visited the interviewees at the LSG office or their homes. The focus group discussions with Dalit community members were conducted at their neighbourhood itself and the date, time and venue were chosen by the member with which the interviewer had liaised through telephone.

Table 3. 5 FGD participants and their details

Village A			
	Men	Women	Age
FGD 1	3	6	3 women - between 40-60 years 3 women - between 20-30 2 men - between 30-50 1 man - above 60
Village B			
	Men	women	Age
FGD 1		8	4 women between 30-40 years

			2 women between 40-50 2 women above 50 years
FGD 2	6	1	Above 60

Document reviews

To gather further information related to the social innovations and Dalit inclusion the study also employed analysis of available documents from the panchayats. These documents involved development reports of the LSGIs, available documents related to innovations examined, secondary data on health available from the FHCs.

Non-Participant observations

Non-participant observation methods were adopted during the course of the case study specifically to examine the nature of interactions between various LSGI staff. Relevant observations and patterns observed during the presence of the researcher within LSGI and within FHC during the course of the case studies were recorded through notes and verbal recordings. This was particularly employed to gather information in terms of the hierarchies of actors manifested within interactions between various actors based on their gender and caste status. These were used as supplementary materials to aid the analysis of the qualitative findings emerged from IDIs of various actors at LSGI and other organisations. Participant observations were also conducted within gramasabha meetings in one panchayat. Since there were pandemic related restrictions, the researcher was unable to observe any gramasabha meetings in one panchayat as there was a restriction to conduct them. Total 3 gramasabha meetings were observed by the researcher in Village B. The observations from the gramasabhas were recorded as voice notes and written notes by the researcher, which were then included as part of the analysis, as well as to triangulate the information made available through IDIs.

3.3.3 STUDY SETTING

All the three phases of the study were based in Kerala. The study setting for the phase-I CDA given its specific objective of a policy level analysis meant that it explored the views of policy level actors within Department of Health and LSG functionaries who have a say in policy framing, within Local Self Government. The study setting for case studies under phase II and III were selected Panchayats from Kerala, based on their presence of Dalit communities as well as the presence of a social innovations. Hence the two innovation cases were selected from across Kerala.

3.4 DATA MANAGEMENT AND ANALYSIS

3.4.1 PHASE-I: THEMATIC ANALYSIS AND CRITICAL DISCOURSE ANALYSIS

Data collected from the phase-I in-depth interviews were analysed for three major aspects.

1. To explore the perspectives on primary health care innovations expressed by health and LSGI actors
2. To explore the nature of community's role within primary health care innovations
3. The ideas related to marginalisation and the extent of inclusiveness of Dalits within these ideas on marginalisation

These three aspects were examined using two major approaches. One, a thematic analysis of the interview and using the theoretical concept of critical discourse analysis. Thematic analysis was specifically employed to identify the nature of primary health care innovation and the ideas related to marginalisation. CDA was specifically employed to examine the nature of primary health care within the discourse on innovations as well as the nature of community's role within primary health care innovations.

Thematic Analysis

Thematic analysis method followed Braun and Clarke's (Braun & Clarke, 2006) six staged approach to conducting a thematic analysis. This began with the first stage of familiarising with the interview transcripts. The researcher went through the set of transcripts multiple times to have a deep familiarity with the narratives of actors and the specific contexts to which they belonged. The second stage of coding largely used a theoretical approach to find codes related to innovations and perspectives on marginalisation. For, the initial codes were generated based on the specific question of the nature of primary health care innovation and for the theme on marginalisation. Therefore, only those areas that spoke about these specific aspects were captured as part of the coding. An open coding was used during this stage and therefore did not use any pre-set codes for the purpose. Codes were developed and modified on the go. The codes were developed from digital transcripts using the Microsoft word software. Once the codes were developed, these codes were categorised based on various themes. These themes were derived using the codes relation in terms of various disease groups or aspects of primary health care that the codes represented. These themes were further re-reviewed and later written up as results (Maguire & Delahunt, 2017).

CDA

The process of the CDA was guided by the 3-Dimensional model of analysis suggested by Fairclough. Hence the analysis of the documents selected for the study followed examination of the realm of 1) Text and its linguistic features 2) Discursive practices that relates to the production and consumption of the text 3) and implications within wider social practices (Jorgensen & Phillips, 2002). The conduct the CDA, the study extracted the ideas related to primary health care, within the narratives on primary health care initiatives as well as innovations by policy level actors as well as by policy documents. The texts for the analysis were prepared through the process of transcribing recorded interviews with the policy level health staff and LSGI representatives and importing them to NVivo^{TM}. In addition, the formal texts and policy documents on primary health care including the Aardram document as well as details on Aardram mission by the Department of Health were also imported to

NVivo^{TM}. The compiled body of text were then analysed based on the thematic codes drawn the analytical framework of Primary Health Care. The sections within the interviews and policy documents that narrated about primary health care strategies and/or innovations were subjected to detailed analysis for their nature of representation of the construct of primary health care.

Though CDA was used as a larger conceptual framework to explore and analyse the spoken words and written texts, the analytical framework that guided the CDA was that of the idea of Primary Health Care established through the Alma Ata as well as the recent Astana declarations. These two declarations by WHO through the idea of primary health care attributes much prominence to the idea of primary health care as a preventive, protective and promotive approach to healthcare in addition to their curative and rehabilitative element. Both these declarations emphasise communities as the cornerstone of health care through their active participation in health-related decision-making. A holistic approach to primary healthcare that includes preventive, promotive, curative and rehabilitative care with full participation of communities. A third key attribute within this discussion is the idea of inclusion of the marginalised and vulnerable as a key feature of primary health care strategies (Beard & Redmond, 1979; WHO, 2018). Hence a key underpinning ideology that guided the CDA was to explore how 'genres of governance' on primary healthcare in Kerala is in agreement with the ideas on primary healthcare put forward by these declarations. The representations of constructs related to primary healthcare, community participation and marginalisation in the study were discerned from the interviews and written texts of policies using the techniques suggested by Fairclough in conducting textual analysis. These included exploring the texts for themes of *Collocation, legitimation, intertextuality, assumptions* as well as for the techniques of *exclusion, inclusion and prominence* (Fairclough, 2010).

3.4.2 PHASE-II & III: CASE STUDY ANALYSIS AND QUALITATIVE EXPLORATION INTO INCLUSIVENESS AND FACILITATION OF EQUITY

The case study the data were collected in the forms of IDIs, FGDs, field and voice notes. The interviews were recorded and later transcribed for further analysis. IDIs and

FGDs remained the primary materials of analysis within the case studies. The findings from the interviews were aided and supplemented by supporting materials available from field and voice notes created from non-participant observations conducted during the course of case study period. The analysis plan followed the four stages of qualitative data analysis suggested by Morse, 1994 (Morse, 1994) for the analysis of case study data as well as the exploration on inclusiveness of Dalit communities. The four phases involved: Comprehending, Synthesising, Theorising and Reconceptualising.

Comprehending stage: The comprehending stage started with the broad coding linked to the objectives of the research. The coding process for the analysis of innovations and institutional analysis of LSGIs used a deductive strategy based on the themes derived from the politicised IAD framework. Hence, the broad themes related to the contextual factors included political, geographical, biological, demographic elements within the LSGIs. This also included themes related to actors involved, decision-making processes including initial conceptualisation, planning, development and implementation. Themes related to gender and caste too were included as coding guides to facilitate examinations related to social location and power within decision-making spaces. Separate coding was done for perspectives obtained from PHC staff, LSGI staff as well as those from the members of the community.

To explore the social innovations for Dalit inclusivity, the study primarily used the Richard Heeks ladder of inclusivity framework. Interview transcripts of Dalit LSGI representatives and Dalit community members were the primary materials used for analysing the social innovations in terms of inclusion. However, the analysis of Dalit inclusion was also supplemented by the specific observations made from gramasabha meetings which suggested to the nature of Dalit participation within such public spaces. The codes for analysing inclusivity were primarily designed to explore Dalit inclusion at different phases of the social innovations. These included inclusion at the level of objectives/intent, utilisation of innovations, impact on Dalits, Dalit presence within processes of innovations, Dalit presence within discourses of marginalisation by LSGI and PHC actors, Dalit inclusion within discourses of marginalisation by

policy level actors (explored during the CDA phase). In addition to the pre-established codes, emerging codes were also explored at this stage to aid finetuning of the frameworks used.

Synthesising stage: The synthesising stage involved reassembling the data that were decontextualized during the broad coding and identify the pattern of coding. At this stage, the researcher started writing memos for the identified pattern coding for the multiple perspectives and the experiences of the PHC staff, LSGI staff, community members and the other stake holders interviewed in the study. During this phase the researcher also coded the non-participant observation field and voice notes and created an explanatory pattern for the emergence of social innovations and Dalit inclusiveness within primary health care at the LSGIs.

Theorizing stage & reconceptualising: At this stage, in the light of the themes emerging from the analysis of the information, the researcher explored for the connections between various themes for further theorisation. This was achieved by making comparisons between the selected cases, and also making comparisons between the perspectives of PHC and LSG staff as well as community members within each case. Both the synthesizing and reconceptualization of social innovation cases and the various pathways of their emergence were guided by the theoretical framework of 'Institutions' and how they are associated with social innovations. The theorisation of social innovations within the current study was compared and contrasted with the available theories of social innovations to develop a coherent theory applicable for the current study. The inclusion of Dalits were aided by theories of social inclusion and exclusion in particular. These theoretical frameworks enabled the study to also propose a new theoretical understanding of Dalit inclusion/exclusion within the current study. Finally, a coherent set of explanations on the factors associated with the emergence of social innovations and their ability to facilitate inclusion and exclusion of Dalits within LSGI level primary health care innovations have been proposed.

3.5 Ethical considerations

The proposed study was conducted keeping the ethical principles of research. The study was undertaken after getting the approval and clearance from the Technical Advisory Committee (TAC) as well as Institutional Ethics Committee (IEC) of Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST). The ethical clearance for the study was provided during February 2019 by IEC vide SCT/IEC/1355/FEBRUARY-2019

Written informed consent were obtained from all the participants after explaining the objectives and purpose of the study and potential benefits and risk of participating in the study prior to data collection. Confidentiality and participants' right to withdraw from the study were maintained throughout the study. The participants were informed that their decision to participate in the study was completely voluntary and they had the right to withdraw from the study at any point. Privacy was maintained in all interactions with the respondents and the confidentiality of the information were protected under all circumstances.

4. RESULTS

The results section is primarily divided into two major sections. Section-I deals with objective 1 in the study, which primarily endeavours to throw light on three key aspects within primary health care innovation discourse in Kerala. One, to explore the nature of innovations as perceived by various actors within health and LSGI. Two, to examine how primary health care innovation locates the role of communities within them and three the perspectives on vulnerability and marginalisation within primary health care in the state. Section II deals with the case study findings from two panchayats in the state. This section deals with the various factors as well as pathways that results in social innovations for primary health care as well as the extent to which Dalits are included within these social innovations. This section also examines the ways in which these social innovations facilitate the health care needs of Dalits in the panchayats examined.

4.1 PRIMARY HEALTH CARE INNOVATION THEMES

This specific section tries to examine two key aspects within primary health care innovation discourse in the State. One, the various shades of primary health care innovations as expressed by the health system actors as well as by the LSGI representatives. Two, the perspectives of these actors regarding who constitutes the vulnerable and marginalised social groups in terms of primary health care in the state. However, the nature of community partnership within primary health care innovations will be examined in detail within the section that discuss the findings from Critical Discourse Analysis. The examination of the diverse nature of primary health care innovations and perspectives of vulnerable and marginalised groups were specifically undertaken through a thematic analysis of the interviews with staff at different levels of health system as well as LSGI.

4.1.1 TYPES OF PRIMARY HEALTH CARE INNOVATIONS

The innovation themes panned across the board and touched different aspects of health at the level of village panchayats in Kerala. However, depending upon the interviewees location within health system as well as LSGI, the emphasis on the innovation areas

too differed. Some of the common patterns within the thematic analysis of the innovations were

4.1.1.1 Innovations for NCD prevention

NCD prevention was one of the most emphasised aspects that stood out within the analysis of the innovation discourse among health as well as LSGI level actors. Nevertheless, the nature of strategies involved within NCD prevention also was found to be varied within these discourses. Some of the most prominent themes of innovative NCD prevention strategies in were

Community level need assessment and screening for common NCDs like hypertension, diabetes mellitus and cancer

Need assessment of various diseases as well as screening were the two most prominent innovation themes within the health and LSGI discourse. However, this was seen to be valued the most by the most senior level health system staff at the State level. Almost all actors at a policy level within Department of Health attributed much emphasis on strategies that prevented NCDs at a primary health care level in the State. Within the various innovative strategies for NCD prevention, the most sought after was early detection strategies that included either targeted NCD screening camps or through need assessment at a community level.

"First thing that needs to be done is to do a basic need assessment, so we will have to have a health status report. Those panchayats that has done this well can implement good innovative projects. So, first thing that is needed is health status report, what really happens there in terms of people's health. Try and see where there is a deficiency and based on that they can act" (Directorate of Health service 1)

"For instance, when I was a DMO we had initiated an innovative project some 10 years back. We trained a number of volunteers and developed a checklist. There were around 82-83 panchayats and we did it in a phased manner. Each year we would cover 20-30 panchayats. These volunteers would visit every household and using the checklist and based on symptomatology they would score people for their probability for cancer. Then people who have received a high score would be called for a common

camp and based on the screening there, we would provide them free treatment (Directorate of Health service 2)

These strategies largely point to innovative strategies that are aimed at early detection of NCDs including cancer amongst others and provision of treatment at a primary care level.

Physical activity and healthy diet promotion

Though sparsely mentioned, a theme that appeared under NCD prevention as innovation were strategies that aimed at physical activity promotion and dietary modification. These strategies were largely mentioned by PHC level Health Inspectors and Medical Officers.

"Since NCDs are higher, we have strategies that aim to improve awareness on that. Because unless we act early it's not really useful. So, we have to build those habits early on from childhood itself. It is important to raise awareness on physical activity. So, to achieve that we have developed a play area here for children. And for adolescent age group and for adults we are building a footsal turf" (Medical Officer 1)

Similarly, strategies to modify unhealthy diet through the promotion of use of vegetables as well strategies like yoga were also some of the commonly mentioned themes. However, unlike policy level staff, medical camps as a strategy to detect NCDs were rarely mentioned by health functionaries at a primary health centre level in the State. Similar strategies were also found to be a priority among LSGI representatives, who also repeatedly mentioned about projects that aimed at NCD prevention, early detection and treatment. These included strategies like screening camps, free BP and blood sugar examination as well as free provision medicines for NCD.

4.1.1.2 Infrastructure and service improvement of PHCs and Sub centres as innovations

Strategies to improve existing infrastructure at the primary health centre as well as sub centres were also one of the most common themes under primary health care

innovation discourse in the State. These were mostly narrated by senior level doctors as well as medical officers in the State

Improving patient amenities at PHCs and quality accreditation strategies

A major priority within primary health care innovation discourse revolved around strategies that strengthened PHC and Sub Centre (SC) infrastructure. Projects that would improve the patient amenities at the PHC that it could attract more people.

"Sometimes to achieve something new we will also have to think new. For instance, for a hospital to be functional it is enough we have a sufficient number of tables and chairs. But at the same time, we can also provide health care with a good a painting installation, comfortable chairs for the patients to wait and for the staff and if we create a good atmosphere like a garden. However, what would be ideal for both the health care provider and for the patient would be the innovative…uh, the latter one I just said" (Medical Officer 2)

Most of the PHC level MOs as well as senior health functionaries did suggest to projects that could strengthen the PHC infrastructure as innovative. This included provision of additional manpower using ASHAs, token system for better patient management as innovative strategies. Also were projects that aimed at quality accreditation including National Quality Accreditation Scheme (NQAS), ISO certification, Kayakalpa accreditation. A common pattern that fell under the strengthening of PHC services were also strategies that improved better utilisation of existing services by communities. These included strategies that attracted communities including specialty services at PHC by training existing Medical Officers (MOs) on speciality care. Also, strategies like flexible Out Patient timings to better meet the needs of communities were some of the innovations within this category.

Extending existing primary care services to remote areas

A theme that was expressed exclusively by a few public health functionaries was improving access to primary care. Provisioning of primary care services closer to

community using innovative strategies including mobile medical units was a theme that was mentioned by a few health inspectors.

"We have an area here that is almost 12-13 kms away from the PHC. So, for a person there to even just check their BP or to consult the doctor they have to travel all this way. But if we go to them and provide services at their area would be much helpful for them. So, they will not have to travel every month to consult the doctor. The doctor will go to them, provide medicines, checks their BP and provide recommendations. The public health staff will do all the required follow-up activities along with their routine palliative care activities" (Health Inspector 5)

Sub centre strengthening

Yet another theme within infrastructure strengthening were also strategies that aimed at strengthening existing services provided through sub centre. Within subcentre strengthening included purchase of newer equipment for better maternal care. Equipment like foetal heart monitor for pregnancy care, provision of computer and internet facilities were some of the commonly mentioned strategies.

"At sub centres even before aardram was launched we had initiated some innovative activities. Because we had purchased foetal heart doppler at all sub centres. Also, a common issue we face at subcentres is related to HMIS. Tabs were introduced only recently, but we had in 2016-17 installed laptop and internet connection at sub centres" (Directorate of Health service 6)

4.1.1.3 Strategies for prevention and control of communicable diseases

Though not as dominant as non-communicable diseases, prevention of communicable diseases was also a repeated theme within primary health care innovation discourse. More so by senior level health staff and LSGI representatives than PHC level MOs and public health staff.

Vector control strategies

"Back in 2005-08 when I was an MO along with the support of LSGI and health inspectors we had done an effective mosquito control project. In 2003 we had a dengue

outbreak and in 2006 there was a chikun gunya outbreak. That was when I joined there as an MO and we had done an effective mosquito control project and we had even received awards" (Directorate of Health service 8)

"When I was MO our panchayat at a point in time, we used to have high rates of chikungunya and dengue. It was a hilly area. So, with the help of panchayat we had selected 10 volunteers for every 25 houses from the community. The benefit we had was that, as soon as there is an incident of a disease, I will get the report. We have ASHAs for every 1000 houses, but with this its much faster and effectively. Also, through the help of these volunteers I was able to achieve effective source reduction activities too." (Medical officer 2)

Strategies that specifically addresses vector control were perceived as innovative by policy level actors in particular. However, the low priority attributed to the same by much younger MOs and HIs at the grassroots level suggest to the reduced burden of CDs as a general trend in the State and reduced priority for the same within innovation discourse. In addition, strategies that addressed drinking water within water scarce areas were also seen as innovative in terms of reducing vector breeding within the narratives of medical officers as well as public health staff.

Waste management strategies for hygiene promotion

One of the most prominent strategies often mentioned by LSGI representatives as well as health staff was the dominance attributed to strategies that addressed the emerging issue of waste. Specifically, among health functionaries at the level of Primary health centre often mentioned about strategies that addressed effective management of plastic and other household waste as innovative

"In our panchayat we have been undertaking multiple projects that are really good. One is related to plastic disposal and activities that aimed at reducing the use of plastic. As part of that we had done a project called 'athijeevanam'. Through this we had done household collection of waste, a first of its kind in the district and we also had conducted a mass awareness campaign as part of it" (Health inspector 4)

Similar instances of panchayat projects that also aimed at recycling of plastic as well as providing alternate sources of plastic materials including non-plastic carry bags were also some of the innovations that emerged from the interviews. Hygiene management strategies using 'Arogya jaagratha' volunteers were also a priority within innovation discourse among LSGI representatives.

4.1.1.4 Palliative care strategies

A prominent theme that stood out within innovation discourse were the frequent repetition of strategies around palliative care in the state. Innovative palliative care strategies were a priority for stakeholders at all levels of health system as well as among LSGI representatives. These included perceiving the existing model of palliative care in the state as an innovation in itself. In addition, strategies that strengthened this model were also seen as innovative.

"Recently during the term of our old MP using his MP fund he had provided ambulance for all PHCs in his constituency, exclusively for palliative care field visits. So, there have been multiple such good models within the primary health care level in the state" (Medical officer 5)

Provision of ambulance and vehicle facility was a key theme within innovative strategies for palliative care among the interviewees. Strategies those utilised support for palliative care provisioning from community-based groups including youth volunteers were also some of the innovative strategies that stood out. Besides, strategies that looked at extending the existing palliative care services through strategies that aims at emotional wellbeing of individuals under palliative care were also seen as innovative. These included activities like outdoor trips and frequent meet up of patients under palliative care as innovative.

4.1.2 PERSPECTIVES ON VULNERABLE AND MARGINALISED GROUPS

A key area of exploration within innovation narratives was to identify the key social groups that were prioritised within them. The thematic analysis of the interviews identified four major axes used by actors within health systems and LSGI in drawing their ideas on vulnerable or marginalised social groups. These were 1) Age related

vulnerabilities 2) Geographical vulnerabilities and 3) Disease/disability based vulnerable groups and 4) economic class as an axis of vulnerability.

4.1.2.1 Age related vulnerable groups

Elderly care strategies

One of the most accepted axes of vulnerability within the primary health care innovation discourse was that of the elderly age group. Strategies that aimed at elderly welfare were considered as innovative by all levels of actors interviewed within the current study.

"Beyond the conventional activities that are conducted every year using the plan funds for elderly, there have been innovations in the state in terms of activities that are aimed at emotional wellbeing of the elderly as well as those to resolve their issue of loneliness like 'karanavarkoottam' projects" (LSGI 6)

"For senior citizens we have like an innovation, but I don't think it's a totally new idea because most panchayats have this, an activity to control lifestyle diseases among them. We do health education for them, so we conduct awareness classes along with a medical camp to check their GRBS and BP etc." (Health inspector 4)

Elderly care strategies that extend beyond routine health care to that of emotional wellbeing were often considered as innovations by various actors. Also, strategies that aims at reduction and control of NCD rates among elderly too were considered innovative by most of the actors. Elderly was also a priority group among LSGI representatives, who felt that activities like 'pakal veedu' or provision of welfare benefits like free cots or medicines were innovative. Medical camps for elderly were a key innovative strategy by many LSGI representatives in the study.

Women and children

A prominent category within age based vulnerable was the priority attributed to women and children. Almost all actors within health systems mentioned about women and children within their ideas on vulnerable groups in the state.

"If I say about social vulnerabilities, I guess all are socially vulnerable and I can't say that there is anyone who are not vulnerable. Suppose if we consider children, they are also vulnerable, specifically during times of communicable diseases and all, like nippah and all. So, when we say about vulnerable groups, normally we consider children below 1-year, pregnant women and people above 65 years" (Health inspector 7)

4.1.2.2 Disease/disability based vulnerable groups

A common axis of vulnerability among health system actors were people with various diseases or disabilities.

"There are people below 60 years who are afflicted with issues like stroke. So, this means that lifestyle diseases are also a factor. Factors like smoking or alcoholism might be the reasons for stroke, we don't know for sure. Similarly, asthma, that is also high here" (Medical officer 6)

"Surely, when we talk about vulnerable groups normally from a health perspective, we talk about ladies in vulnerable age groups or who are in reproductive age group, children below 5 years. We also talk about old age or people who are 60 plus. Then people who are suffering from chronic diseases and unable to go for a livelihood. People with mental health issues" (Health inspector 5)

Health system actors mostly tended to categorise people with chronic diseases like stroke, cancer, chronic kidney diseases as vulnerable social groups. Similarly, individuals who are mentally challenges or people living with disabilities were also considered as priority groups by the health system as well as LSGI actors.

4.1.2.3 Geographically vulnerable social groups

Strategies for tribal communities

Yet another priority group specifically among actors from health was health care strategies for tribal community. Most of the actors from health department perceived strategies that aimed at improving health status of tribals as innovative.

"If I were to tell about something which I feel is innovative is, something that has been undertaken in a tribal area, where there is around 10 or 15 tribal hamlets distributed in different areas. The number of home deliveries in that area was really low. One of the reasons for this, though there are multiple factors, but the main reason is that even if they have labor pain, specifically for 2nd or 3rd delivery, to arrange for a vehicle from there to transfer them to the hospital is challenging. At the same time if we have an ambulance from health department located in their area it will be much easier and we can transfer them to the hospital quickly, reduce complications and reduce maternal mortality rate" (Directorate of Health service 7)

Strategies such as above which attempts to improve utilisation of health care facilities among tribals and thereby reduce adverse events were found innovative by health actors. Similarly, strategies that aimed at improving breast feeding practices among tribal mothers as well as strategies that addressed nutritional deficiencies were also some of the themes within this category. Also, improvement within the Government Tribal Specilaty Hospital at Kottathara, Wayanad were seen as innovative by many actors. Mostly the themes around innovation for tribal community revolved around strategies that aimed at improving maternal and child health indicators as well as nutritional status among them.

Coastal community as a vulnerable social group

A third prominent social group within the narratives of health system actors were coastal community.

"I feel coastal community are a vulnerable group. The only thing they possess is fish and some money. Other than that, their lifestyle or their health care they are purely served…what I fell is that, they are not receiving the kind of education that others receive. They have a tendency to prioritise their vocation. So even if we arrange some activities, they are focussed more on their job, going to the sea, make money. So, in terms of health care or within other social activities they are absent" (Directorate of Health service 8)

Most of the policy level actors from health department felt that coastal community has historically remained a vulnerable group in terms of health outcomes. Most of them believed that low educational status of the community and their sea going vocation has been a bottle neck in terms of providing optimum level of health services to the community.

Migrants

A third group within the geographically vulnerable were individuals who belong to the category of migrants. Migrants were a commonly prioritised social group both by health and LSGI actors in the study.

"Migrant communities in the state, we have been working towards providing them the needed health care services. Now, since Aardram has been launched government has been attributing special priority for their service. However, when these are implemented, there might be certain bottlenecks and to resolve them the local government need to intervene effectively. Specifically, their housing condition, routine medical check-ups and follow up are key factors. So, we need to make sure that such marginalised groups are taken care of" (Medical officer 6)

Health care services for the migrants was a key area that health system as well as LSGI functionaries seemed to prioritise within their narratives on vulnerability and marginalisation within primary health care.

4.1.2.4 Economic class as an axis of vulnerability

A fourth category or axis of vulnerability or marginalisation within health among health system and LSGI actors was economic class. Perceived mostly by actors from LSGI than health system actors. A key narrative around vulnerability in terms of health outcomes and health care was the priority attributed to economically poor individuals within societies

"One project that deserves to be mentioned as far I am concerned is the one called 'padheyam'. It's a project initiated by district panchayat and people from low economic status are its beneficiaries and it's an innovative project…its given to people

who doesn't have anybody to support them. There are people who does not have the means to even buy a onetime meal, people without children to support, or without the money to buy food" (LSGI 6)

Projects such as above that prioritise the welfare of economically poor were often considered as an innovative activity among the interviewees.

"…there is this issue of poverty in urban areas, I feel it's a major issue now. It's a kind of relative poverty and there are people like that. In such areas there is a gap in primary care. When I say primary care, it means one should be able to seek immediate whenever necessary or medicines. So, there are such groups who have such difficulties in Kerala now" (Directorate of Health service 7)

Economically poor were also seen as a class who have been deprived of basic primary care services. These included seeing them as a class of 'urban poor' as well as narratives that alluded to members of 'urban slums' as vulnerable. Yet another way economic class figured within the narratives was the way in which they overlapped with other groups like palliative and poor patients with chronic diseases. As a result strategies like provision of free medicines, economic support for dialysis care or travel support for poor patients were often found innovative within the interviews.

4.2 CRITICAL DISCOURSE ANALYSIS OF INNOVATIONS, COMMUNITY PARTICIPATION AND MARGINALISATION

One of the key objectives of the CDA was to identify how larger discourses perceive and thereby structure the idea of innovations for primary health care at the level of LSGIs in Kerala. The specific aim of the research to embark upon a CDA analysis was to seek out the implications underlying within the existing views on innovations. Specifically, within the social practices of primary health care innovations at the level of panchayats and how they are reflective of these larger discourses on primary health care.

The CDA analysis revealed certain key inherent biases that were evidently reflected in the language used by both policy actors as well as policy texts in representing their ideas related to primary health care and innovations for it. They reflected certain

inherent contradictions that continue to persist within the larger level discourses on primary health care in the State. For, these contradictions point to the unconscious biases that continue to remain and could pose detrimental effects in achieving the larger goals of equity and social justice as envisaged under the ideals of primary health care. The analysis of the texts points to four major interrelated themes that dominate within the discourses related to primary health care in Kerala: 1) Dominance of secondary prevention and curative strategies within discourses on primary health care innovations 2) Dominance of a sanitised discourse of social determinants 3) A shallow idea of community partnership and 4) Exclusion of Dalits as a marginalised social group

4.2.1 THE DOMINANCE OF SECONDARY PREVENTION AND CURATIVE STRATEGIES WITHIN DISCOURSES ON PRIMARY HEALTH CARE INNOVATIONS

Although the policy level discourse acknowledged the relevance of innovations within primary health care, a key finding that emerged from the thematic analysis of innovations was indeed the priority on secondary prevention and curative care. These were primarily evidences through specific narratives like 'need assessment'

"Only if we know where is the deficiency can we give the right intervention. So, to correctly identify non-communicable diseases, communicable diseases or other issues within health like those of pregnant women, the elderly, palliative project needs or some specific and rare diseases we need a health status report. So, these are data that are already available at the PHC and the element of success lies in the way this is utilised." (Directorate of Health service 1)

Need assessment was a key phrase that repeatedly collocated with the narratives on innovations within policy level discourses. However, the examination of the nature of the need assessment discourse suggested to an exercise that largely aims at capturing disease-specific information of a community. These included the collection of data regarding the prevalence of CDs, NCDs as well as information related to others including pregnant women for instance. The dominance of disease-specific information within ideas of need assessment and the exclusion of references to the

need for data on other factors including those on distribution and access to social determinants - water, sanitation, etc. - alludes to a certain bias within them. That only health-specific information is required for need assessment for primary health care innovations suggest the dominance of secondary prevention and curative bias within the discourses related to primary health care among policy level actors in Kerala.

The narrative on need assessment is of relevance in the context of primary health care in Kerala, as it is also one of the core strategies of the 2016 Aardram mission. One the key activities envisaged within the Aardram mission was to encourage LSGIs to prepare the Health Status Report (HSR) of their communities (*Aardram – National Health Mission*, 2020). The use of an exact terminology from the state's Aardram policy to signify the individual's idea of need assessment - that excluded the social determinants aspects – also alludes to the attempt to legitimise their version of primary health care innovation discourse. What is also crucial is the parallel between the notion of need assessment narrated by policy actors and the HSR strategy adopted within the Aardram policy. The HSR preparation within Aardram too largely deals with the collection and compilation of disease-related information on the community from already existing data available at the FHC as well as from various institutions under LSGIs.

"Ideally through HSR what we are expecting is to have the health status of all individuals in a panchayat based on already available data without employing any special survey for the purpose. So, the idea is to use secondary data to infer the health status of a given community. For mortality there are registries within panchayats, we already have OP and IP related data at the PHC, there are also data available at the Anganwadi, published literature, data from regular monthly reports for various national programs. So, we are using these sources for HSR" (Directorate of Health service 8)

Though the mission envisages a primary health care delivery strategy based on local needs through HSR, it, however, fails to emphasise or institute in practice a relevant mechanism of gathering information on key social determinants to aid them. However, what is also of relevance within this aforementioned approach on need assessment is

its emphasis on collecting data that as a policy actor within department of health deems important. For compilation of data on CDs or NCDs or data on OP and IP are not always what ideally a community would prefer as relevant. The direction of need in that sense is more top down than a bottom-up need assessment, one that is reminiscent of the strategies of managerialism embedded within the neoliberal ideology of new public management. One that is relevant for the management and assessment of primary health centre and its performance by higher level bureaucrats within department of health. This by implication has limited priority on information from the grassroots that affect health of communities in more complex ways including that on social determinants of health. By such exclusion, the idea of need assessment within policy discourse posits itself further away from the elements of primary prevention crucial within primary health care approaches.

To be read along with this pattern is also the way in which ideas related to screening camps are equalised with ideas of innovative primary health care strategies, as evidenced from the thematic analysis.

"If I have to talk about an innovative project when I was a District Medical Officer, we had undertaken a big innovative project. As part of it, we recruited volunteers and we trained them on the application of a checklist. We had around 82-83 village panchayats, so in a phased manner volunteers went to individual households and identified people at risk of cancer using a symptomatology approach. And those individuals with a high score were further called for a detailed screening camp. Those who were confirmed for the disease were then provided with free treatment. So, that was a very good innovative project" (Directorate of Health service 2)

The narratives on innovations across the interviews almost often were replete with ideas and anecdotes on screening camps for NCDs. Again, within the above quote, there is also the repeating theme of community need assessment and these are then linked to the ideas of screening camps as innovative. The modality used within the narrative is suggestive of the speaker's greater affinity to assert their statement on innovations through the use of words like 'big innovation', 'very good innovation'. This is indicative of the emphasized commitment that is being made on the part of the

individual to assert that the idea of screening camps after a need assessment is in fact a primary health care innovation. The narrative also figures modalities that are 'truths', for instance the last statement 'that was a very good innovative project' asserts a factual statement about innovation, one that is incontrovertible. Evidently, the larger ideology that seems to guide such a discourse on primary health care innovations however remains limited within the previously discussed themes of secondary prevention strategies.

"A good example of innovation would be the upcoming Aardram mission. Our PHCs will be upgraded to FHCs, so in a way, they are becoming speciality clinics. So, now to run a speciality clinic we no more need the presence of a specialist doctor. Now, these speciality clinics could be run easily by training a normal medical officer and those in need will be given that service. So, this is a revolutionary project in Kerala health sector and these are innovations" (Directorate of Health service 9)

The aspiration towards the establishment of speciality clinics within existing primary health centres (PHC) as an innovation too suggests to the growing curative bias within primary health care discourses in Kerala. Instances of 'good example' and the truth statements like 'these are innovations' are again suggestive of a greater affinity and the categorical assertions evident within the tone of the narrator. Through such assertions the narrator is establishing the prominence of idea that every local PHC in Kerala shall have speciality services. An idea of primary health care that has emphasis mostly on first-contact curative care services. The ideas on innovations for primary health care too are therefore driven by the felt need to upgrade the existing PHCs into a more specialised curative service. Hence, strategies like the training of medical officers in providing speciality care at the PHC level achieves significance as innovative strategies. The overt reference made to the Aardram policy and its own emphasis on infrastructural and provision of specialist services through the Family Health Centres are also in a way being used as a justification of such a view on primary health care.

4.2.2 INFRASTRUCTURAL PROJECTS AS PRIMARY HEALTH CARE INNOVATIONS

The discourses on innovation among senior policy level health leadership also often tended to link and equate the ideas of infrastructural improvements with the ideas of innovation for primary health care.

"Even before state-level policy recommendations, by utilising the scope of decentralised planning many panchayats have attempted to strengthen the entire infrastructure of health facilities in Kerala. These are also innovations at various levels. Not only that, at the level of individual programs like NCD, palliative care there are such innovations. Recently at some institutions, they have projects to purchase foetal heart monitors, foetal doppler. Because previously pregnant women were reluctant to be checked by a JPHN, but due to such new components they turn to be innovations" (Directorate of Health service 4)

One can again discern the clear dominance and emphasis on secondary prevention and curative aspects of primary health care within the discourse. Infrastructural improvements of health facilities were increasingly portrayed as innovations within primary health care. Hence, improving the existing facilities of primary health centres (PHCs) as well as sub-centres were largely preferred by the health system and seen as positive and innovative. For, infrastructural improvements as being innovative were pivoted on their ability to enhance the existing facility-based disease-specific services. The decision made by many PHCs to procure newer devices as part of the existing non-communicable disease and palliative care programs alludes to this idea of innovations as improvements in provision of facility-based care.

"Yet another area important as far as we are concerned is the up-gradation of basic amenities in a PHC for a visiting patient. Now, that is also a priority within Aardram, but even before Aardram, many panchayats as their own self-initiative have implemented such projects. For instance, the PHC where I used to work, was one of the first PHC in Kerala to have an AC waiting area. It was implemented as an initiative of the panchayat and also by pooling multiple sources of funds. And that was a very big change in fact and imitating our project many other areas instituted similar

measures including patient queue management system." (Directorate of Health service 7)

The idea that primary health care innovations can also be infrastructural improvement ranged from the provision of newer health devices at the grassroots level sub centres to the idea of provisioning modern amenities at the PHC level. However, the idea that primary health care as a health care modality could also extend beyond facility-based care were largely lost within these notions on primary health care innovations. All too evident was also the crucial dialectic relation between the individual level narratives and the formal policy in these contexts. For, the individual level narratives often invoked their similarities with the policies' stand on infrastructural improvements as a means to accomplish legitimacy. The examination of the government's Aardram mission document similarly attributes significant priority on infrastructural improvement as a key strategy to strengthen primary health care in the State. The key aim of the mission is to re-engineer the existing PHCs to Family Health Centres with a specific focus on infrastructural improvements.

"*The main focus on the PHC to FHC transformation aspect of Mission Aardram, which is a phased series of infrastructural and administrative changes. With the strong emergence of the profit-oriented private health care sector in Kerala that seemed to have been gaining increasing popularity among all sections of society, people began to lose faith in the public health care system. A stronger curative focus gave the private hospitals an upper hand and forced PHCs across the state to compete along the same lines to merely stay afloat*." (Aardram Mission)

The above excerpt from Aardram mission points to the most dominant strategy that it adopts in moving towards the idea of comprehensive primary health care. This is pivoted on the mission's objective to overcome the challenges posed by the private health sector in the State by upgrading the existing PHCs. The policy could be discerned to have adopted a moralistic stance that legitimise its intent to adopt infrastructural improvement as its 'main' strategy. Through the foregrounding of the private health sector and its for-profit stance the policy attributes a negative value judgement on private sector as solely profit-oriented. By extension it presumes to

vindicate its own stance on the urgent need to strengthen the existing public health facilities infrastructure wise as 'the main' strategy. The mission therefore attempts to drastically change the existing realm of PHCs in the State through improvements in infrastructure and manpower so as to stay relevant. The dominant approach within the policy could be seen as this attempt to convert existing PHC infrastructure as a viable alternative to private health care facilities in the state in terms of quality of care and services. This is also reflected across the state in terms of the current FHC infrastructure in Kerala. FHCs today are marked by their attractive paint schemes, air-conditioned patient-waiting areas, modern furniture, television and internet connectivity (National Health Mission, 2022). Albeit in an attempt to present itself as an alternative to the private health sector, the mission's strategies themselves risk being largely an imitation of the private facilities.

The larger emphasis on infrastructural improvement could also be seen as translated as reduced priority on other aspects of the mission. An analysis of the Aardram mission document and its vision for the Family Health Centre (FHC) concept points to this bias towards infrastructural improvements and towards secondary prevention and curative care. The key strategies of the FHC concept as laid out by the policy documents are

1. Strengthening Primary health care
2. Improving quality of services
3. Addressing social determinants of health
4. Community participation

However, further analysis of the strategies reveals the rather muted priority on social determinants strategy within the FHC concept. Though the document speaks about social determinants, the two points mentioned under this strategy remains rather generic

1. Implementation of LSGI projects addressing social determinants of health
2. Convergence with other departments and other national/state/Panchayat programmes

Whereas sub-strategies under strengthening of primary health care and improving quality of services were relatively clearer within the policy document. Besides, analysis of the whole policy document also suggests the relatively low priority attributed on social determinants aspects of primary health care with a page real estate of less than 3 out of the 140-page policy document on Aardram and Family Health Centre concept. Though the argument here is not in any way to contest the significance of secondary prevention and curative elements within primary health care and infrastructural improvements. But attributing exclusive dominance to these strategies within a policy could only come at the risk of a diluted idea of primary health care that is in conflict with the idea of a comprehensive approach as envisioned within the Alma Ata and Astana Declarations of primary health care.

4.2.3 'SANITISED' DISCOURSES ON SOCIAL DETERMINANTS

Yet another way, the discourses on primary health care innovations biased itself to the secondary prevention and curative side of primary health care was through the construction of a social determinants discourse, that was shorn off the 'social' and by extensions the larger politics of social justice and marginalisation in the State.

"Speaking from the perspective of preventive aspects for both communicable diseases or non-communicable diseases, more than the health department, other departments have a bigger role. Specifically, from the aspect of the idea of social determinants, only if we address them, can we prevent diseases. So, the most important areas from this perspective are safe drinking water and proper waste management. When we say waste, it can be solid, liquid or general waste there should be proper management of them. So, if we address both these aspects, we can address more than 90% of communicable diseases" (Directorate of Health service 5)

One of the most repeating themes that emerged from the policy discourse on primary health care was the idea of social determinants and the need to address it. The above narrative talks about the idea of safe drinking water and hygiene as two key themes within its social determinants discourse. It categorically asserts that addressing both these determinants can almost completely prevent communicable diseases. Though at one level it remains a factual statement on health and disease prevention, it also risks

being a reductionist one at that. For, it paints a picture of these aforementioned determinants from a largely neutral perspective without attaching any possible social dimension to it. This is being achieved by equalising the idea of health determinants to that of social determinants of health. By stripping off the 'social' from the social determinants, it remains blind to the likelihood of disparities within the distribution of determinants due to societal attributes. By implication, there is a taken for granted view on the existing patterns of health determinants and the different ways in which they could be differential distributed within communities.

The examination of the Aardram policy too suggests a similar stance on social determinants within its primary health care discourse.

'The social determinants of health (safe drinking water, environment, cleanliness, sanitation etc) being crucial to the health of a community, the FHCs will take a lead role in organising community-led interventions to improving the same' (Aardram Mission)

The above excerpt from the FHC policy equates the idea of health determinants like safe drinking water, environment, cleanliness, sanitation to that of social determinants of health. Here too it excludes any reference to the disparities in the distribution of these health determinants between social groups. The policy reiterates the word social determinants close to 33 times within its 140-page document. Not once does it attempt to delineate between the idea of health determinants and the social determinants. There is also an evident gap in terms of linking how various health determinants with various marginalised social groups. For, the policy refers to the word marginalised or vulnerable only 13 times within its documents. However, nowhere does it succeed in linking the idea of health determinants in the context of the marginalised or vulnerable social groups within the document. By maintaining a reductionist view of social determinants through the lens of health determinants, the policy too fails to recognise the differential capabilities of various social groups including marginalised sections to achieve equal access to these aforementioned determinants.

4.2.4 DISCOURSES ON COMMUNITY PARTICIPATION WITHIN PRIMARY HEALTHCARE INNOVATION

A key analytical framework that was adopted within CDA phase of the research was that of the idea of community as active stakeholders within primary health care approaches, as envisioned through the Declaration of Astana on Primary Health Care. Hence a key construct that was analysed within the CDA of innovation discourse was the way in which communities and their role was placed within the discourses on primary health care innovations.

4.2.4.1 LSGIs as welfare distribution mechanisms and community as recipients

The dominant discourses on primary healthcare innovations and LSGI projects by policy actors was observed to be suggestive of the role of communities in indirect ways too. A dominant discourse that exists in association with innovations at the level of LSGIs in Kerala among senior health and LSGI leadership is the way in which LSGIs were largely conceived as welfare distribution mechanisms.

"So, when we speak about health within a panchayat, we have three sections ayurveda, allopathy, homeo. So, whenever we have any gaps in health, we consult with these three groups and take into consideration their views. So, in order to make sure that they are able to perform at their best, that people within our panchayat are benefitted in terms of medicines, or to improve their basic infrastructure we provide them sufficient funds" (LSGI 3)

This by implication also was translated within innovation discourses too, where they were also perceived by key policy actors as novel ways of distributing welfare schemes by the LSGIs.

"What I feel about innovations is that, it is a mechanism through which grama panchayats can do some good for their local community. Or they are a great mechanism for the LSGIs to do some welfare, like some financial benefits for their people." (Directorate of Health service 1)

The general assumptions on the role of LSGIs and by extension the projects by LSGIs including innovations were largely seen from the perspective provisioning of financial benefits or welfare goods for communities. This is in a way legitimised through the value judgement that innovations are a way to 'do good' or being 'beneficial' to the communities. And by extension doing good is being equalled to the idea of provision of goods or other forms of financial benefits. Similar equalisation of innovation and distribution of free good were also observed within the discourses among LSGI representatives within the study. Where health related projects were largely dominated by provisioning of free medicines and other related activities. Hence, by placing LSGI as welfare distribution mechanisms, the discourse implicitly places communities as mere recipients of projects devised by LSGIs. Such an idea of decentralisation is by implication shorn of its ideals of active community participation and empowerment, which are also one the basic tenet of primary health care approaches too.

4.2.4.2 Equalisation of community's utilisation and implementation support as community partnership

Reading along with the discourse on community as recipients of innovations and programs are also the ways in which ideas of community partnership are recontextualised within the discourses. Though community participation as a formal word was found repeatedly mentioned within innovation discourse, they remained as stripped-down versions of partnership models which ignored the possible role of communities as active stakeholders within conceptualising and planning of local health related projects. The discourses thereby largely tended to equalise the larger aim of active partnership to that of program utilisation and additional manpower for implementing of innovations.

"If we speak about innovations, be it any program or any activity they are only as effective as the level of public participation within them. We already have a really good example for that, pulse polio immunisation program. That is a very good example in this case, it's a common knowledge that Kerala has never had any other program with as much community participation as polio program. Not just within Kerala even

in other states too. So, similarly be it any program we need public participation." (Directorate of Health service 4)

Here, the idea of community participation is being equalled by its recontextualization of participation of community as how they successfully make use of a given program. Such recontextualization is being attempted in the aforementioned narrative through its reference to the Pulse polio immunisation program which in this case is assumed to be as an innovation. The polio program attains the quality of innovation within the above narrative, since it had significant adherence by community which is construed as community participation. The role of communities is therefore being relegated to that of mere beneficiaries of a given program. The narrator as a senior health staff is by implication establishing a value judgement to be used as yardstick for a project to be categorised as an ideal innovation. For any program or activity to be deemed innovative is therefore to make sure that it is being utilised by communities at its maximum.

Similar recontextualization are also evident in terms of viewing community partnership within the limited sphere of communities' role in achieving better implementation of health projects.

"Be it any project, if we have to make it successful community participation is a very big factor. So, within community participation what we mainly need is community involvement, hardcore involvement. However, there will only be very few people who can contribute a hardcore involvement. These will be the ones who can mobilise the rest of the people. Suppose we conceive a new project for delivering insulin pump to around 40 insulin patients. We might have already traced these 40 cases, but the job of bringing these 40 people will be done by a group. This core group of people who achieve this, their willingness is a major factor…so this core group of human resources, they will be the ones who will pull the innovation further" (Directorate of Health service 7)

There are a few major themes that is evident within the above narrative on community participation. The narrator uses multiple words within the context of community

participation that included ‘participation’, ‘involvement’, ‘human resource’ for primary health care innovations. The initial use of the word community participation is being reworded towards the later part as ‘human resources’ by the narrator. Therefore, through the interchanging use of different words to express a single idea, in effect within the above narrative participation is being equalised to that of community as a resource for project implementation.

The example of innovation provided within the narrative is also key in the context of community partnership. For, it was that of free distribution of an insulin pump for diabetic patients. Here the innovation is also by implication a technical activity meant as a welfare for diabetic patients. Hence, by extension the innovation it is purely driven by health experts and the role of community is therefore limited to that of the ‘receiver’ of the ‘innovative product’. However, community participation was portrayed as crucial because, to distribute the ‘innovative product’, there needs to be volunteers drawn from community. Here distribution is an activity merely within the implementation of innovation and the role of community is one of ‘human resource’ to achieve the distribution of the innovation.

4.2.4.3 Relegation of community’s role to a lower hierarchy as primary healthcare innovations are technical and expert driven

As was suggested above, yet another aspect relevant within the examination of community role is the way in which primary healthcare innovations are conceived by healthcare professionals. A key theme in relation to this is the perception of innovations as technically driven activities.

“If it’s a PHC then if the medical officer there is a person with critical thinking, or the health inspector, it need not be the doctor always. If the HI is a person with such a thinking innovation will automatically evolve, that is my view. So, only if there is critical thinking will there be new ideas and activities.” (Medical Officer 3)

The above narrative on innovation unconsciously excludes the roles that other actors could have had within innovations at the panchayat level. The development of innovation within this narrative is almost exclusively pivoted around the creative and

technical expertise of healthcare professionals at the PHC in a panchayat. Such a narrative excludes the roles and responsibilities that could have been played even by LSGI representatives, members from larger community nor the role they could have potentially had within the conceptualisation or development of a healthcare innovation. Such a perspective on innovations by extension perceives community-based stakeholders at a lower hierarchy in terms of expertise and are excluded from within conceptualisation and development phases of innovative healthcare projects.

"For communities, since implementation phase is mostly dealing with technical aspects, their role is beyond that. They are the ones to ensure that the projects are being implemented correctly, within monitoring. So, they have a huge role in monitoring. That is why we say that within all such projects, there should be someone from the community within the monitoring team. This has been in existence since long back, there should be someone from the community in monitoring." (Directorate of Health service 8)

Here too, the dominant view of healthcare innovations as technical activities planned by experts was evident within the narrative. This view of innovations from an exclusively technical stance clearly relegates the role of community towards other 'non-technical' aspects of implementation. The implicit assumption being established here is the duality of 'experts' and 'non-experts', where health professionals are the experts and community as 'non-experts' in developing local healthcare projects. Hence, the role of non-experts is limited to that of a monitoring agent for the financial transparency of projects as well as other aspects within the delivery of innovations. This is also being legitimised in the above narrative through the generalised assumption being made in terms of 'this has been in existence since long'. The implied meaning being, communities have been since the implementation of decentralisation involved mostly within the spheres of monitoring LSGI projects, but not in their development.

4.2.3 DISCOURSES ON MARGINALISED AND VULNERABLE SOCIAL GROUPS AND INCLUSIVITY OF DALITS WITHIN INNOVATIONS

A core theme that was explored through the CDA of innovation discourses was the ways in which they represented ideas of marginalisation and vulnerable social groups in Kerala. This was also specifically examined for the ways in which Dalit communities were included or excluded from the discourses on primary healthcare innovations at the panchayat level.

4.2.3.1 INVISIBILISATION OF DALITS AS A MARGINALISED SOCIAL GROUP

Exclusion of caste as an axis of marginalisation

A common theme within the discourses on marginalised social groups was the ways in which they carefully avoided references to caste as a probable axis of marginalisation in Kerala. Such caste exclusive discourses therefore by extension also ended up as exclusive discourses for Dalits in terms of any priority within primary health care initiatives in the State.

"Definitely, there are sections that are vulnerable and needs to be prioritised. From the perspective of health, we normally consider women within a vulnerable age group who are in their reproductive age groups, children below 5 years. We also talk about old age, though old age is technically above 60 years, now I feel the minimum age could be increased a little more. Then we can consider people with chronic diseases and cannot lead a productive life, people with mental health issues, then people who are our guests which are the migrants and finally tribal population. All these are prioritised by us. That means that all others healthy males and females who are able to work and within the reproductive age group are important to us" (Directorate of Health service 1)

The narrator in this case was listing out the various priority groups and the first category that was listed as a priority section were age related groups. Also, the most dominant theme owing to their frequency of occurrence are categories like age groups, which is also underscored towards the end, by reiterating it again. Yet another key

theme that underlies within this discourse would be the implied ideology of health as a raw material for economic productivity. This is suggested through the use of the words like 'productive life', 'able to work', 'reproductive age group' which also seems to have shaped their ideas on marginalisation. Where people from these specific age groups are largely considered vulnerable and mandates specific priority as they are an important group in ensuring productive communities. However, these groupings were evident with their absence of any concrete social groups that might require priority attention. The only occurrence of social locations as a marginalisation category within the above discourse is the subtle reference to tribal population as well as migrants. However, what is missing from the above narrative is the acknowledgement of the existence of Dalits as a marginalised social group in Kerala.

Subsumption of caste categories under the abstract yet homogenous 'General community'

Dalit exclusion was also evident in terms of their backgrounding within the discourses under abstract categories by the policy actors. One way in which this was attempted within the discourses was by subsuming caste groups within the abstract idea of 'general community' when it comes to marginalisation. Ideas of marginalisation were often found shaped from the point of a tangible and geographically and religiously categorizable social groups.

"Marginalised communities, see actually if we think about Kerala, if you ask about such communities, definitely tribals. In tribal areas they are still remaining as a marginalised section. One of the main reasons for it is our infrastructural changes, one they are living in very remote areas. Then one other reason is that, their traditional culture is very difficult to be changed. So, there are definitely these challenges in tribal areas. Otherwise, I don't think there are any marginalised section within the general community. I haven't seen from my experience, of course other than the tribal areas. One more thing is when it comes to immunisation, of course definitely there are certain religious settlements. In such areas we still have many unimmunised children. In their issue also we haven't been able to make a change. Other than these, we do not have any issues in Kerala" (Directorate of Health service 2)

A key social group that which was repeatedly mentioned within the discourses of marginalisation were tribals. Tribal communities within the above narrative are evidently inferable and tangible as a distinct social group. This is discernible through the use of the words like ‘remote areas’, ‘traditional culture’. However, the reasons for them being marginalised were also attributed on these communities themselves owing to certain traits of theirs’s as felt by the policy actor. These included, their ‘remote’ locations as well as ‘difficult to change’ cultural attributes. Through the overt references of tribals, religious groupings and the establishment of a ‘general community’, the narrative establishes three distinct social groups within discourse related to marginalisation in the State. The two marginalised categories within the narrative are those of tribals with a ‘traditionally difficult to change culture’ and the ‘religious settlements’ as the second group of marginalised. All others are by implication subsumed under the abstract ‘general community’ which also by extension includes various caste groups within contemporary Kerala diaspora. However, by not mentioning caste as a possible axis of marginalisation the discourse invisibilises or background Dalits as a social group under the abstract and homogenous general community. The general community suggested here is a monolithic social group that dismiss all differences that might exist within itself including caste-based distinctions. This is also being reiterated again towards the end of the statement through the categorical assertion being made through the statement ‘other than this we do not have any issue in Kerala’

Caste as a barrier for innovation

Reading along with the homogenisation of community as a singular social structure is the perception of caste as a barrier for primary healthcare innovations. The discourses on marginalisation largely perceived caste as as fractural constructs that can negatively influence implementation of primary health care innovations, and by implication renders consideration of caste within primary health care related innovations as a negative construct.

“Innovations are always new concepts, even if it is an old idea, it will be presented as a fresh concept, that is the key to innovations. So, there are always the barrier of some

sections not accepting it, a barrier to get an approval, because always few will not agree. A second barrier we can consider is that there are some social determinants. Suppose when we are developing an innovative program for health, we can never consider caste or sex, or some section of the population. It is always difficult to consider only a small section of the community. So once we develop and implement an innovation there will always be complaints that some sections did not get representation. So, normally new projects on health shall not be constrained by such barriers" (Directorate of Health service 7)

The narratives related to primary health care innovations also tended to iterate the need to approach community as a homogenous group. However, by maintaining a homogenous approach to community, the discourse largely remained blind to the relevance of social determinants like caste and even sex. On the contrary, these social groupings were in fact even perceived as negative concepts when undertaking innovations for primary healthcare. The idea of primary healthcare as curated for the needs of individuals both as a person as well as to address any marginalisation generated owing to their social location are however lost within such a discourse. Specifically, the idea of primary health care vis a vis its objectives of addressing disparities within social groups remains mute by placing caste as a barrier to innovate.

The narrative also further argues that exclusions for certain social groups as a normalised and taken for granted situation in the context of primary health care innovations anywhere. This is established through the statement that 'it is always difficult to consider only a small section' and 'there are always the barrier of some sections not accepting innovations.' This view by extension is also normalising and legitimising exclusions that continues to exist in the case of various marginalised sections of the community including Dalits in Kerala as a given within local health related projects.

Dismissal of caste as an irrelevant aspect within primary healthcare

Yet another way caste was excluded as an axis of marginalisation, was through the relegation of caste as an irrelevant grouping when it comes to the idea of primary healthcare.

"When we say about focussing on primary healthcare, we do not speak about individuals. When we see a well-off family that does not need any support, even if one person from that family becomes incapacitated that whole family will be affected significantly. So, we need to see things from such a perspective. Rather than seeing the individual we should consider the family as a whole……when it comes to healthcare, as we all know it does not differentiate between caste or creed. Health is a concept that is beyond all this and is purely a matter of biological concern. So, if you ask who does it affect, it is always an individual level vulnerability. Even though I am not a person to speak about the relevance of all this, I can only say that we should move beyond all this and support all" (Directorate of Health service 1)

The above narrative is largely a self-contradicting statement in the context of primary healthcare. It starts off with the accepted idea of primary healthcare as not purely individual centric. However, the narrator's idea of primary healthcare fails to move beyond the narrow view of social group as families. The narrative fails to acknowledge and perceive primary health care from the perspective of larger social groups and differential distribution of social determinants among various social groups. The perception is that primary healthcare shall see family as 'the' group when considering illness of a specific individual within a family. However, such a view evidently turned problematic, upon enquiries of caste as an axis of marginalisation. On questions of caste the narrator goes on to contradict her/his own initial idea of primary healthcare as 'not individual specific.' Here disease is being placed purely as a biological phenomenon affecting individual(s). Hence, consideration of caste is rendered irrelevant from such a perspective on health within the narrative. Here too caste is placed as a negative construct and this is evident from the value judgement being made in terms of 'we shall move beyond all this' differences in matters related to health. The

implicit assumption here is that healthcare provisioning shall not be differentiated based on caste as disease affects all 'irrespective of caste or creed'.

Santised discourses on social determinants sustaining caste blind discourses

Caste as a non-issue and the negative stereotypes on caste within health is also further fanned by aforementioned issue of the narrow views on social determinants within policy discourse on health. A crucial fact in the context of Dalits is their formal, government sanctioned ghettoization in Kerala. Exclusively owing to their caste status Dalits in Kerala have over the years forced to live within government demarcated land areas, often known as colonies. Dalit constitutes around 9.1% of the population of Kerala, out of this 7.9% are still ghettoised within demarcated colonies by the government (Pramod, 2020). The researchers own findings from informal observations to various village panchayats in Kerala and observations of Dalit colonies suggest this pattern. Dalit neighbourhoods in Kerala are often marked by its limited land availability. More than single Dalit households are located within a small area of under 2-3 cents. The Dalit neighbourhoods more often than not also face the issue of limited availability of running water. Owing to these conditions, safe drinking water and waste disposal remain as key areas of concern drawn from their social location of caste in Kerala.

Exclusion of caste from the ideas of social justice by the State

The examination of website of Department of Social Justice too suggests an exclusion of caste from within the ideas of social justice in Kerala. A cursory glance at the Social Justice department website of Government of Kerala reveals such a narrative on marginalisation.

The motto of the department as displayed in the website is; *"Social Justice Department working with the concept of* welfare state *is underpinning socio-economic development plans of* Kerala Government**.** *The department is working hard for the upliftment of marginalised groups and to provide justice to the victimised. The Directorate of Social Justice under the Department is the nodal agency for*

implementing the social welfare schemes of the State Government and various welfare schemes of the Government of India."

Among the list of beneficiaries considered as marginalised by the department are

1. *Senior citizens*
2. *Differently abled*
3. *Social defense*
4. *Transgenders*

The motto of the social justice department suggests that, as a welfare state, Government of Kerala is committed to the welfare of marginalised and victimised groups. The department goes on to list the four key groups that it considers as marginalised and victimised. However, within these four groups, it does not list Dalits as a possible group that could have faced marginalisation over the years.

An examination of the Scheduled Caste development department's website too suggests a certain approach to the issue of Dalits. The key headings that existed within the home page of the website. The most revealing among them were, 'forms', 'FAQs', 'seniority list', 'schemes', 'eligibility'.

Figure 4. 1 Screengrab of the website of SC development department, Government of Kerala

These words by definition tend to suggest that these were links to receive various benefit schemes that are currently made available through the department. By

extension, the basic theme that was dominant here was one of provision of schemes specific to Dalits in the State. However, nowhere in the website does it contain any reference to the social issues Dalits may face, nor any reference to the themes of social justice within the website. The department clearly concern itself with provisioning of welfare for Dalits.

A similar picture was also evident in the analysis of the State Government's Aardram Policy document. The policy document on Aardram and Family health centre was strangely peculiar owing to the complete absence of any reference to Dalit communities. Though the policy suggests to marginalised communities and specific care for them, it does not speak explicitly about existing social groups based on caste as an axis of marginalisation. Though the document also speaks about social determinants as a major area of impetus, here too caste has been unacknowledged as a possible determinant. By not mentioning caste as a possible determinant of health in Kerala, it largely invisibilises the issue of Dalits and facilitates the perpetration of the historical marginalisation faced by Dalits in the State.

4.3 CASE STUDY FINDINGS FROM THE PANCHAYATS WITH SOCIAL INNOVATIONS

This section discusses the findings that emerged from the case studies of the two village panchayats, that demonstrated examples of social innovation for primary health care. A major objective of the phase II case studies was to explore; why certain village panchayats demonstrate the ability to initiate innovations for health that have communities as a major stakeholder. Specifically, social innovations that could influence and impact primary healthcare of its communities. This is attempted within the current research through the examination of selected social innovations. By shedding light on the factors that led to their emergence through the exploration of the dynamics of decision making within the LSGI. The idea of LSGI here broadly incorporates the various units within a panchayat that includes community representatives, LSGI staff, transferred institutions like health, ICDS as well as other relevant departments, cross sections of the community like kudumbasree and community members themselves. This is conceived such, since the projects initiated

in any LSGI is often the product of the interactions and working together of all these various units. Hence the explanation of any single innovation cannot be done solely through the examination of the innovation in its individuality. Rather the study assumes that it is only possible by understanding how they might have emerged through the dynamics between various actors involved at the level of LSGI.

4.3.1 CASE STUDY OF VILLAGE A

4.3.1.1 Background details

Village A is a village/grama panchayat located in the Southern Kerala. The panchayat has a geographical area of 25 sq. km and is located next to an urban corporation area and has a total of 23 wards. Though the 2011 census suggests a total population of 52417 in Village A, the records available from the health facility suggest the current total population as 68408 out of which close to 51% are women. The panchayat also has a relatively higher proportion of scheduled caste population in the region, which according to the 2011 census is around 10%. The total population according to health data seems higher than the census number, given the 10-year time period between the 2011 census and now. However, similar follow up seems to be missing from the scheduled caste enumeration by the health institution. This could have resulted in an under-reporting in the proportion of scheduled caste communities within the health data. There are also a few scheduled tribe communities in the panchayat which has around 200 members. Owing to its proximity to an urban area, the region also has a high presence of migrant population too.

The following sections will try and present the various aspects of the case study facilitated by the various themes under the politicised IAD as felt relevant to the study. This will therefore include discussions on the various key contextual factors that includes, political, demographical, geographical aspects. Following this the study will discuss the findings related to various actors and the nature of their interactions governed by gender and caste and finally discuss the social innovations as a product of these aforementioned factors.

4.3.1.2 key contextual factors of village A

4.3.1.2a Political context of Village A LSGI

The 2015-20 LSGI term in Village A was led by the Left Democratic Front (LDF), with a majority of 15 members out of the 23 wards in the village panchayat. Out of the remaining 8 members 5 were from United Democratic Front (UDF) and 3 from National Democratic Alliance (NDA). A key theme to be noted with respect to the political landscape of Village A LSGI is its strong left-leaning history. Over the course of 25 years right from the inception of political decentralisation in Kerala, Village A panchayat have had a left alliance at its helm. Over the years the panchayat has witnessed a sense of political stability which is also reflected in the neighbouring grama panchayats as well as at the higher tiers of LSGI, where its block LSGI too have had a stable left government in place.

"Right from the formation of Village A panchayat in 1953 LDF was in leadership and that hasn't changed yet. And, it continues to this date, and that has enabled us to implement good projects very easily and we also have great support from our party too. In the activities of our LSGI too all are in complete support, be it BJP or congress and even if one or two disagrees rest all are in full support. It could have been a trouble in implementing new projects if that was not the case" (CS1 LSGI president)

Political stability in the region has had a positive impact in terms of how projects were also implemented in the region. Leaders at the LSGI too felt that the continuity in the leadership has provided them confidence in terms of implementing new projects. Similar narratives were also echoed by other key actors in the panchayat. It was felt that since Village A and its block LSGI too has always had a left leadership for the last 25 years. The only rare change was at the level of District LSGI. Since the village and Block level LSGI have had a stable and continuous left leadership, it has brought about a continuity in various projects and activities in the panchayat.

Setting up of an organisation called Grameena Padana Kendram in Village A

Owing to the very long history of left politics in power in the panchayat and proximity to the State capital, Village A have also witnessed a unique political trajectory. Village

A was the first village panchayat in Kerala to have conducted ‘vikasana Seminar’ or development seminar when the decentralisation and ‘People’s Plan Campaign’ was launched in Kerala during 1996. Since, Village A was a village panchayat within Thiruvananthapuram District, the ‘vikasana seminar’ was attended by the then Chief Minister of Kerala, Comrade E.M.Sankaran Namboothiripadu and he proposed the idea of forming a resource group for decentralised governments. Under his advice a group of young intellects with strong left leanings and members of Kerala Sastra Sahitya Parishad, (Kerala Science Movement) formed a support structure to aid the functioning of LSGI under the name of Grameena Padana Kendram (GPK). GPK currently is a registered society with its main office located within Village A. Initially it was constituted by around 20 people who were from a cross-section of the society including academics, intellectuals and voluntary social activists.

“Right from the initial phases of the People's Planning Campaign, Padana kendram has been playing a leadership role in helping Village A panchayat to improve in all aspects. They have played a significant role in making decentralisation more accessible to the population and making it a big success” (CS1 LSGI1)

Today, GPK is a key stakeholder in the day-to-day decision-making activities of Village A LSGI with members from GPK a constant presence in project level decisions in Village A. Besides, the staff and voluntary members of GPK too are either from a left political background or by members with strong leftist ideology. The current secretary of GPK was also recently elected as a member of Nedumangad Block LSGI under CPI(M), which suggests this feature of leadership in GPK.

4.3.1.2b Bio-physical contexts

Waste dumping as a challenge owing to geographical and economic factors

A key issue that was repeatedly raised across interviews was one of waste and related issues in the panchayat. The narratives of most LSGI actors cited waste management as a major challenge they faced during their tenure, specifically the issue of waste dumping along the major roads that connected the panchayat with the city region.

"We all know that waste dumping is often a cause of health issues. The most common issue that we face today in Village A is waste dumping. The floating population that emerges due to urbanisation of Trivandrum city and the waste generated by them are often dumped here. For instance, Killiyar river is flowing very close to us, also the major roads that connect Nedumangad or the road to Chengotta. So, dumping of waste into Killiyar river or along these roads is a regular site here. Similarly, towards the other side of the panchayat we have the MC road and the same issue can also be seen there. So, the waste dumped by people who come and go to Trivandrum is a major issue for us" (CS1 GPK1)

The specific geographic location of Village A being close to Thiruvananthapuram city area and the rapid urbanisation of the city and associated floating population were attributed as the major source of waste in Village A. It was perceived that since many people come and go to Thiruvananthapuram city along the highway that passes through Village A has resulted in people dumping waste alongside these major roads as well as into the river which too runs through Village A.

Perspectives on health issues in village a

A natural corollary of the longstanding issue of waste and related challenges in the panchayat was its impact on the health in the community. Interviews with staff at the department of health including doctors at the PHC, health inspector as well as most other field-level health staff revealed that communicable diseases remain a major issue in the panchayat since many years. The panchayat has been flagged by the Department of Health as a hotspot for communicable diseases over the years, given the high rates of dengue, chikungunya, leptospirosis, and scrub typhus incidences over the years.

"Ours is a very big panchayat extending over 25 sq.kms. It is a village and a rural area located between a municipality and a corporation. So, as a result of this there are issues related to it, like wastes being dumped from both these urban areas. People working in both these areas usually live or come and go through Village A. Besides that, since ours is an area that mostly has a rural nature, there are large plantation areas in the panchayat, vast swathes of such areas and a lot of unknown people too,

or people whom we don't know directly. They have just bought large pieces of land that are left unattended. So, there are instances of people dumping waste in these unattended areas. So, there are many such issues here and as a result we have lot of public health issues too" (CS1 PHC2)

The major reasons for the historically high incidence of vector-borne diseases in the region were attributed to three major reasons 1) the large geographical size of the region with large unattended properties and dumping of wastes within them that provides a conducive environment for vector growth 2) The high population density in the region making it difficult to effectively control outbreak like situations 3) unscientific disposal of waste throughout the panchayat, both from commercial establishments as well as household waste. The significantly high rates of CDs have also resulted in the panchayat attaining a sense of notoriety among health staff in the State.

"When I knew that my new posting was in Village A and when I called up my friends to talk about it, the image I got was bad. They said that 'oh no, it's going to be a tough job, it looks like a punishment posting. It is an area notorious for communicable diseases and no one in the department would want to take charge in Village A. You will only have time to stand up during DMO conferences' (smiles)" (CS1 PHC1)

The image that the Village A panchayat had among health staff was that of a tough place to handle. Most of the doctors in the department felt that Village A was a difficult place to work as a health staff owing to the uncontrolled rates of CDs and the constant reprimands that they might receive from higher levels of the department.

Large geography of village a panchayat

A major challenge that was evident from the narratives of most LSGI as well as other health functionaries was also the issue of the large geographical area of the panchayat. This has led to multiple issues including geographical barriers in equally accessing the FHC by people in all areas of the panchayat.

"Our PHC is situated in a corner of the panchayat and this is a big panchayat. When we say it is spread across 25 sq.km, it also has a big population, around 62000. This is a panchayat that can be divided into two different panchayats, and this PHC is towards a corner location. Due to this unique location, not all people who are entitled to access our services are receiving it currently" (CS1 PHC2)

The large area of the panchayat and the location of the FHC towards a corner area of the panchayat were felt as an access barrier for many sections of people in Village A. This has been forcing in other parts of the panchayat to access hospital facilities nearer to them but outside the limits of Village A Panchayat, including secondary care facilities. Yet another feature was how the Village A FHC owing to its unique location is also being used by people from nearby panchayats. These geographical barriers were felt to be barriers in provision of FHC services and medical care to the people of Village A by many interviewees.

4.3.1.2c Demographic and economic contexts in Village A

Elderly demographic in village A

Yet another key demographic section in Village A was elderly communities. Based on the data collected from the health staff, Village A had a population of 8963 (14.6%) individuals above the age of 65 out of a total population of 61326. Since this was the data of individuals who were above 65, the total proportion of elderly in Village A could very well be on par with the state average of 16.5%. The interviews with LSGI leadership too tend to acknowledge elderly as a section that needed priority attention in Village A.

"Yes, there are sections that need prioritised attention in Village A. During times of corona, we have been giving them meals thrice daily. In my ward we are giving free meals for 11 people through the 'padheyam' project. They are from all sections, they will be from scheduled caste, general section and we cannot say they are from any particular group. They will be either abandoned by their children, people who only have social welfare pensions as their only income. We are giving food for such people" (CS1 LSGI2)

The significant proportion of elderly individuals in Village A was also reflected within the opinions of LSGI leadership in their narratives on marginalised groups in Village A. They were considered as a priority group who needed special attention through LSGI activities.

Economically weaker sections as vulnerable/marginalised

Yet another section within the Village A demography that constantly got referred to within the discourse of LSGI and health actors were economically weaker sections.

"Yes, there will be sections that need priority here, and that will be from different sections and I don't want to call them 'forward' or 'backward' in any sense. Because there will be people who have been farmers and have been suffering losses in that sector. There will be people who are manual labourers and daily wage labourers. And there will be some who are self-employed workers. So, there are many who are facing vulnerability here" (CS1 GPK2)

"Yes, there is, if you say about marginalised groups, they will be people in certain areas with some sort of economic backwardness. So, they will be having issues with basic infrastructure and there are many people like that" (CS1 PHC2)

It was felt that the Village A panchayat has sections within their population who are economically weak and those who deserved prioritised attention by the LSGI. These included people who are engaged in low-income labour including manual and coolie jobs in Village A. The narratives on elderly as a vulnerable section too approached them from an economic perspective, where it was felt that there is a big section among elderly who are economically poor in Village A.

4.3.1.3 LSGI ACTORS AND THEIR POWER DYNAMICS

4.3.1.3a STRONG LEFT LEADERSHIP WITHIN THE LSGI AND OTHER RELATED INSTITUTIONS

As has been described above as part of the political context of Village A, right from the inception of political decentralisation in Kerala, Village A has remained a bastion of left political parties. This was also the trend in Village A even before political

decentralisation was initiated where panchayat leadership was always represented by left political parties.

Strong presence of political left in institutions like Kudumbasree

The dominance of left in the LSGI leadership has also made a significant impact in the political milieu of related institutions in the panchayat like Kudumbasree. A key pattern that could be noted within Village A kudumbasree was the dominant presence of the left within its leadership structure.

"I have been a part worker for the last 25 years and I have been part of Kudumbasree for 22 years now. I have been well received by all sections including community, kudumbasree, party and the panchayat. The Panchayat committee has always supported and respected us. They have provided us with all the financial support and we are always a partner in the development activities of our panchayat" (CS1 Kudumbasree1)

The kudumbasree leadership in Village A have historically overlapped with communist party leadership in Village A. This has evidently resulted in Kudumbasree as a major supporting partner in all the activities of Village A panchayat as well as benefiting Kudumbasree activities in the region. Most of the members were either members of Communist Party of India (Marxist) or All India Democratic Women's Association (AIDWA) or Balasangam (Children's unit of CPI(M)).

Though Kudumbasree does not openly endorse any kind of politics and can have members from different politics, the organisation as a whole is informally driven by left politics in Village A. Hence, the selection of Kudumbasree leadership is often decided or influenced by CPI(M) leadership. Based on the information available from the interviews, no kudumbasree member without CPI(M) membership have occupied CDS chairperson positions in Village A yet. Besides, Kudumbasree has been a constant presence in positions of power in the LSGI, including the current LSGI president who was both a Kudumbasree member as well as an ASHA volunteer from the panchayat.

Influence of political left within anganwadi workers and ASHAs in Village A

A similar overlap of left and anganwadi actors was also evident from the field research. This could also be attributed to the overlap between Kudumbasree members and their roles as anganwadi workers. Since, most of the anganwadi workers in Village A either had or currently are kudumbasree members too in the panchayat. This has resulted in a strong presence of left politics within anganwadi workers too.

"I have been an anganwadi worker for 21 years. I was initially part of Kudumbasree, it was called 'ayalkoottam' in its initial days and it was later reconstituted as Kudumbasree. I was initially a member in kudumbasree and it was during the last governing body that I was selected as CDS vice-chairperson." (CS1 ICDS2)

The current kudumbasree CDS vice-chairperson was also an anganwadi worker in Village A. She has been a kudumbasree member long before she started her career as an anganwadi worker. This continuity of left and kudumbasree was also reflected among ASHAs in Village A. It was observed that almost all ASHA volunteers in the panchayat were also kudumbasree members, 44 out of the total 46 ASHAs in the panchayat. The result is a common political ideology guiding these various structures in the panchayat and better coordination and implementation of activities with mutual support.

4.3.1.3b GENDER DYNAMICS AND POWER RELATIONS IN VILLAGE A

Along with the power of LSGI drawn from their political leanings, yet another axis that was evident as a key source of power among LSGI actors was gender in Village A LSGI.

Hierarchy between male and female LSGI representatives

The case study interviews with multiple LSGI actors from Village A did reveal the existence of a power disparity between male and female LSGI representatives within decision-making spaces. The narratives of women LSGI representatives did suggest to the existence of such a pattern within Village A

"As a woman, I have always felt that when we say something it is less accepted and I have said it many times too at my home, it happens because I am a woman. I am saying this as a general fact, when a male says the same thing, it always has a better effect. This happens even when we are talking to women" (CS1 LSGI4)

Anecdotes of female representatives often alluded to the acceptance males often received in various LSGI spaces. It was felt that as a woman they had a tough time convincing others which they felt males could easily achieve in Village A.

"There is always a general view here you know, when a woman represents a ward and when she grows as a leader there is always this feeling that 'oh how can a woman achieve these things.' This was a common feeling I could get from here. They are thinking that 'if a woman who was a nobody can become a member and can do all these things, we men can do better'. Such a talk was heard from many corners, I heard these comments personally. Then I thought, let it be, this was a ward which was represented by two men before me (sarcastically). It is from such a male-controlled space a woman like me came forward and did so many things" (CS1 LSGI6)

Female representatives did feel that Village A LSGI has always been a male dominated space and achievements of women members are always seen as lesser. That males can do way better than what a woman can achieve.

Reservation as the only enabler of women representation

A key pattern that was evident was the role of reservation in achieving gender justice within LSGI leadership in Village A. Specifically in the case of left political parties in Village A reservation often played a major and explicit role in achieving equal representation for women. The narratives of certain female representatives too suggested that this has been the conventional system in Village A since many years

"Without women reservation, there will never be these many women members in Village A. How will that happen? For instance, this ward, this was a general ward and the three candidates who contested here were males. Did any party field a female candidate? So how can that happen without reservation? Without reservation for

women, never will a woman get a space here and there is no doubt in that matter (smiles sarcastically).” (CS1 LSGI6)

It was felt beyond doubt that women reservation was the only mechanism that had enabled Village A to have the number of female representatives that it currently has.

An examination of the numbers of women representation in Village A over the last decade too suggests this trend in Village A.

Table 4. 1 Details of women representation over the last decade in Village A

Party	Number of members	Number of women representatives	Number of women in unreserved wards
2010-15			
LDF	14	8	0
UDF	5	5	2
NDA	3	1	0
2015-20			
LDF	16	6	0
UDF	6	5	0
NDA	1	1	0

During the last two terms of Village A LSGI, the status of women representatives suggests the role of reservation in women representation. Specifically in the case of

left parties, never have during the last decade a female candidate who was in the LSGI elected from a general seat or unreserved seat. These numbers do suggest the fact that reservation was almost exclusively the only enabler for women in being part of LSGI politics in Village A.

As per the constitutional norms, it is mandatory that every LSGI reserve a minimum of 50% wards for women candidates. Going by this logic, Village A LSGI had more than the minimum 50% representation by women in its LSGI. Though at the outset this appears to be a welcome change, further exploration suggests otherwise. These include instances like last minute changes in fielding candidates due to changes in reservation policies. The current LSGI president in Village A, a female member, was elected from a general seat. Further exploration into this pointed out that it was due to a last-minute change taken by the CPI(M) leadership in Village A as LSGI president position was reserved for a woman. This announcement of reservation of the president's post for a woman candidate was announced rather late into the election phase. CPI(M) leadership in Village A had in fact fielded a male candidate as the presidential nominee prior to the election in a ward with a good prognosis of electoral victory. However, the decision to reserve the position of president forced CPI(M) to field a woman candidate in the general ward that was fixed for a male candidate. Leaders from CPI(M) in Village A had in fact filed a suit in Kerala High court questioning the last-minute decision of the state Election Commission to reserve the post of president for women. It was argued that the panchayat had already a female president for a term and it was felt as an injustice to have woman reservation for a successive term.

However, in defence to the argument of male centric politics of CPI(M), leaders tended to cite the example of a specific ward in Village A which had women in general seats over the last two terms by male actors.

"We have historically had good women representation in Village A. An example for that will be one of our wards where we had a woman candidate this year who has been a member for 10 years. But she contested in a general seat this time and it was not a reserved ward. So, she is willing to contest so there has been a big change that way.

Though she lost, she overcame the limitation women had in contesting only in reserved seats" (CS1 GPK1)

However, such exceptions in fact further point to the fact that such cases are indeed uncommon in Village A. The repetitive trend of having no women in unreserved seats also suggests the strategy adopted by political parties in fielding female candidates in general seats with low prognosis of electoral victory. In the case of the woman member suggested in the above example, it was observed that she was fielded in a general ward that had a history of electing only congress candidates. The candidate from congress has been representing the ward for a decade and clearly the prognosis of an electoral victory was poor for the woman CPI(M) candidate. Besides, a major implicit assumption within the aforementioned narrative was the projection of an image that females are only capable of winning if they are reserved wards. It is seen here as a limitation woman have as compared to their male counterparts.

Justification of disparities in male-female representation as party decision by female members

The preferential representation of male over females and this disparity in male-female representation was repeatedly justified as party decisions by female CPI(M) members in Village A

"I have never desired for any position (smiles), because I have never dreamt of being a member ever. So, I was asked to be a member by my party, and I personally never wanted to be a candidate. Now, I have been a member for 5 years and if the party asks me, I will contest again. But I will never contest on my own." (CS1 LSGI4)

When asked about the lack of women in general seats in Village A, female left candidates seemed to justify them using the authority of the party. There was a dominant sense of benevolence that was attributed to the party for 'gifting' them a seat in the election and the 'chance given' to represent their wards. These narratives were expressed by female members who have been party workers for many decades and yet they chose to accept what party leadership decides 'for' them.

General seats as 'male reservation' wards

A dominant convention that was evident within Village A was the way in which general seats were perceived exclusively as male seats, or to be more accurate 'male reserved' wards. The existence of a formal and constitutional women reservation in LSGI election has in fact resulted in an informal and unconstitutional 'male reservation' system in Village A. These were also evident from the narratives of female members of left parties.

"In my personal opinion, men can only contest when it is a general seat. Because when it is reserved for women, they obviously cannot contest from that seat. So, naturally when the ward is general it will be allotted to men mostly, because they will get that chance only when it is a general seat. So, usually women will move aside for men in such cases. There are also cases, where there will be women who will be attracted to power and positions who will be reluctant to give away" (CS1 LSGI3)

Though most of the female representatives from left parties felt that their representation within LSGI was through reservation, it was felt that it is only desirable to give general seats to men. This was justified from a perspective that it is the only chance available for male candidates to contest in elections. Such narratives on giving away general seats to men were perceived from an angle of being the 'morally right thing' to do for a female party member. Because it was felt that, only those women who are addicted to power and positions will decide not to give away their candidature in case of general seats.

Stereotyping of women leaders

The general view among males on female representation was perceived as a positive change. However, these narratives tended to perceive women leaders from a conventional 'feminine' angle.

"I feel having women representatives is a very good thing. When women come, there will be less corruption, when there is a new project women cannot ask for their cut and it is good. Also, they have a quality of showing love, compassion, so when someone

comes and asks for help, they will try and help better. These qualities will help us in having more attachment with the community." (CS1 LSGI2)

Women leaders were attributed with the conventional stereotypes of being compassionate, lovable and incapable of being corrupt compared to their male counterparts. Similar narratives were also expressed by female members, and it was felt that having a woman LSGI president is good for the community, since she will be more approachable and compassionate to the issues of community. Clearly these suggest the dichotomy in the conventional roles attributed to men and women as leaders within the gender discourses in Village A. They in fact tend to magnify the power hierarchies between male and female LSGI representatives, where men are seen as more powerful, capable leaders and women as compassionate, approachable and lovable.

4.3.1.3c CASTE DYNAMICS WITHIN VILLAGE A LSGI

Limiting Dalit representatives to Dalit reserved wards

Yet another axis of power in Village A was the social location of caste among the LSGI members in Village A. Similar to what was observed in the case of women reservation, Dalit members of the party were seldom provided with the opportunity they deserve to be part of LSGI leaders in Village A. There was a sense of frustration that was evident in the narratives of SC leaders in Village A

"I can say one thing, what gives me the most happiness is the introduction of reservation, SC reservation. Because had there been no reservation for SC, we could never come up. It is for sure, no doubt. Last time we had an SC as president, but will that happen this time? No, they will not. Because near my ward there was a party worker who had given his everything for the party, he was a CPI(M) member, but even this time they have not given him a seat. They had asked him last time to wait, do you know why? They were waiting for that ward to be an SC reserved seat, but that did not happen this time." (CS1 LSGI6)

A key theme that emerged from the interviews with Dalit leaders as well as Dalit community members was the exclusion they have been facing when it comes to positions of power. They feel that they are almost always side-lined within their political organisations as well as in LSGI representation by all political organisations. It was felt that left parties never gave Dalit party workers their fair chance in LSGI representation. Such discriminatory politics based on caste has in fact resulted in certain local leaders of CPI(M) rebelling against the party and joining other political organisations.

Condescension towards Dalit ward members

Narratives of Dalit representatives also suggested to the condescending and insulting attitude often faced by Dalit representatives in Village A

"My biggest sorrow is that, and I know he would have seen me from a perspective that I belong to an SC community. So, there is a feeling that he can insult me in whatever way he pleases. Don't you think he did that since he had the courage that there will not be any consequences? I am sure these are instances when we should retort and I would have done that too. But people who came with me said not to, and they said to forgive it for their sake and not to say anything" (CS1 LSGI6)

Instances of condescension and insult were felt by Dalit representatives, during instances when they approached senior State level leaders of communist party for discussing issues in their ward. Often, during such instances they are asked to hold themselves and not to defend themselves. In a way there is a general acceptance of the idea to silently accept such insults as a Dalit leader to survive. These instances suggest to the perception of left party leaders that Dalit leaders as lower by their non-Dalit party peers.

Rhetoric narratives on Dalit reservation

There was a sense of blindness to the issue of hierarchy and power drawn out of social locations of caste among non-Dalit leaders. Often their narratives on reservations for

Dalits in LSGI sounded as rhetoric that failed to acknowledge the issues that were felt by their Dalit peers.

"A team of SC members from Gujarat came here to visit Village A. When they came to visit our SC president they asked if they could sit in her chair, because in their place they sit in the ground, I have seen it. So, Kerala is such a place and SC reservation is good, only then will there be equality among people" (CS1 LSGI2)

The LSGI vice-president was a very senior member of CPI(M) politics in Village A. He felt that Kerala was a progressive state which provided Dalits an equal space among all others. He felt that reservation for Dalits was important since it is a mechanism to achieve equality among all sections of people. However, as a senior leader of his political party, he never acknowledged the significant lack of space for Dalit leaders within the party nor in their reduced share in LSGI representation in Village A. Similar narratives were also observed by key other stakeholders in Village A LSGI, when asked if Dalits will be excluded in case there was no reservation policies

"Here in Village A as I suggested very early itself, we have been a panchayat that has demonstrated a progressive thought and nature. So, even if there is no such law or no system of quota for them, scheduled castes do not have any barriers to come forward in Village A. If you ask me, will they come? I can't answer that, but I am sure there are no barriers for them." (CS1 GPK1)

The Dalit question and exploration into the aspects of space for Dalit political leaders, were met with a sense of dismissal. There was a conspicuous attempt to project Village A as a progressive panchayat that never side-lined Dalit leaders in any way. It was felt that even if there was no policy on reservation, Dalits will get a fair share of representation in the LSGI. In a way the onus of being a leader was placed exactly on the capability of the individual to rise up as a leader. These narratives in a way alludes to the extension of the often repeated 'merit' narrative as the only factor that dictates the quality and progress of an individual. Again, these narratives turn a blind eye to the existing realities of Dalit exclusion within the political milieu of Village A and in fact contributes further to their challenges. Both these narratives of non-Dalit

representatives on the Dalit question tended to dismiss and try and project a progressive picture 'upheld' by CPI(M) in Village A.

Table 4. 2 Dalit representation in Village A LSGI

Total number of LSGI members	**Total number of Dalits in the LSGI**	**Number of Dalits from unreserved seats**
27	4	1

Intersection of caste and gender

The LSGI president position in Village A during the 2015-20 term was reserved for a woman Dalit representative and was occupied by a CPI(M) member. However, this intersection of being a woman and also a Dalit had in fact put her at a vulnerable spot in the LSGI. Though this was not directly mentioned by the female president herself, narratives from her female peers in the LSGI did suggest such a position she had in Village A.

"Definitely people found it difficult to identify a Dalit woman as the LSGI president, many times. At some point there were talks about moving her from the president post since she was made since it was reserved. Then we had told her that, no matter what party we are in, if they want to change the president we shall see. It was legally both woman and SC reserved and that's how she has become the president, so shouldn't we stand with her? Party is not the issue there and we said that if that was going to be the case, we all would stand with the president. The efforts to change her was made by her own party members. It was both LSGI members as well as CPI(M) party leaders and in fact they have gone to the extent of emotionally hurting her in the panchayat. Because, when a woman is sitting as a president or as a member there will be people behind them pulling the strings. In such a situation we will not be able to do things independently, can we?" (CS1 LSGI6)

It was felt that there were attempts from CPI(M)'s own party members to change the president who was from a Dalit background and was a woman. They felt that she did not deserve to be there in such a position since she came through reservation. As per the opinions of her peers her own party members have at multiple occasions tried to undermine her. Being a woman was always found to be limiting within LSGI spaces, as they are always under the control of male leaders which makes it impossible to act autonomously. Anecdotes of female members also allude to the control on their autonomy as a politician were also from among their family members. Female members were often accompanied by a male family member, either by spouses, fathers, male siblings or even by their sons.

4.3.1.4 Manifestation of the gender, caste and political hierarchies within decision-making and interactions between actors

The differential power relations drawn out of gender and caste in Village A was also evident in the way project related decisions evolved in Village A LSGI.

4.3.1.4a *Political domination of left in Village A decisions*

The historical power wielded by left politics in Village A in terms of key decisions. Often, LSGI representatives who were from opposition political parties had limited room within the decision-making spaces in Village A.

"Fund availability is a major issue for us, but it is not due to lack of funds at the LSGI. As I have been saying, the major issue here is seeing everything from the perspective of the left parties, everything is politicised. Though we talk about decentralisation, I feel people are watching all this, but these left parties will only see their politics" (CS1 LSGI7)

A major issue felt by members of other political parties in Village A was the dominance of the left in LSGI related decision-making. It was felt that everything is decided based on party lines and has been affecting the overall development of the panchayat. Often in wards that are not represented by a left party member decisions are made by bypassing the authority of the non-left ward representative. These included decisions related to legalisation of commercial establishments or similar

decisions within a ward that is not controlled by representatives from left parties. During such cases, the left LSGI leadership often sanctions these activities by getting approval from the LSGI secretary often without the knowledge of the non-left ward member.

Resistance faced by non-left party members in implementing activities

Yet another way in which the left exerted its dominance in the panchayat was by resisting projects and activities by non-left ward members in the panchayat. The narratives of a BJP ward member who was previously a CPI(M) party worker alludes to such conflicts she had to face in achieving various activities in her ward.

"I had to face severe conflicts from people backed by CPI(M) when I tried to install a mini MCF in my ward. I went there personally and tried to explain them multiple times and yet they were not ready. I then called the party member who was leading the protest to explain the use of MCF in that area, he was also a previous ward member there. He then said to me that I should back off since people are resisting. Imagine how much understanding that man had if he said that to me. I was really angry at that point. I then said that, I know they are protesting since I am a BJP member and even if they try to explain to the people that I am installing that MCF to harm the people, it is not true. So, I was adamant and I said I will not change its location" (CS1 LSGI6)

Conflicts were observed when non-left party ward members attempted to implement any sort of developmental activities in their area. Non-left ward members felt that these conflicts were placed as people's protest but led largely by left party workers. Such instances were also observed when non-left representatives were trying to implement activities that were initiated by the left LSGI leadership in the first place. Similar instances of building politically motivated challenges to opposition members were also observed including through spaces like gramasabhas. Non-left ward members felt that left politicians often used gramasabhas to generate discourses against opposition ward members by bringing in party workers as attendees.

Disparities in fund allocation based on politics

A specific pattern within decision making in Village A panchayat was the power wielded by the left party, specifically CPI(M). The dominance that left parties had in Village A was reflected in the way decisions related fund allocation was made in Village A.

"This place here is a colony area and we have more than 300 households within this area. But it is very difficult to bring funds for developing such a big area. Our panchayat has 23 wards and when we divide the funds across these 23 wards, the money available will be very less. Also, there is party influence too in distribution of funds, so what we ultimately get will be a meagre amount. We are rightfully entitled to a division of the LSGI funds, but we never get that amount completely, because whoever is ruling, funds will be distributed based on that" (CS1 LSGI6)

Since Village A has been historically a left ruled region, there was significant influence of their politics in the majority of the decisions. Members from non-ruling political parties felt that distribution of funds were often political and they often received a lesser share of LSGIs Own-funds for their wards.

4.3.1.4*b* *Male dominated decision-making dynamics*

The dominance of left political parties was also in a way structured along gender lines, where 'dominant left' was equal to 'dominant male' left in Village A. Often women leaders within left political space felt subdued and forced to toe the party line when it came to decision-making in Village A LSGI. Instances of males undermining the authority of female leaders were replete in the interviews.

"When we talk about the health and education standing committee, it is responsible for recruiting lots of staff like for schools and since we have the primary health centre. So, there will be many new appointments of staff. During such procedures, I have come across multiple instances which I could not agree to. But even though I disagreed and since the party also has an influence I am forced to submit. When there is a new job opening, the party will nominate a person, and though it is a party nominee it is not necessary that they would be an agreeable candidate. So, as a chairperson I had

disagreed and that have created issues for me and party always had its way" (CS1 LSGI4)

Despite their position as leaders of panchayat standing committees the decisions of female LSGI representatives in Village A were often overridden by party decisions. The power male representatives had over their women counterparts were often drawn from their position within party leadership and are hence justified as party decisions.

Grameena Padana Kendram (GPK) as a powerful stakeholder in Village A LSGI

A key actor in LSGI decision-making in Village A that was evident through the case study observations as well as interviews was 'Grameena Padana Kendram'. As mentioned before GPK was initially conceived as a voluntary agency to provide intellectual support to the LSGI planning and project development. However, today GPK is a regular presence in most of the key decision-making in Village A although in an informal nature.

"Members of GPK are always part of our activities like decisions on project development including working groups, planning committee and also in spaces like project development gramasabhas. They will be present in almost all working groups. They will not come for all gramasabhas, but during the main committees and development seminars" (CS1 LSGI1)

GPK in Village A has remained an inevitable partner in all major project related decisions in Village A. According to the narratives of LSGI leadership, they have been a vital partner in helping Village A in achieving good developmental projects through their creative involvement. It was felt that the members of GPK were experts in decentralisation due to their close association with Kerala Institute of Legal Administration (KILA) as faculties.

However, GPK was also a key partner owing to the nature of its political constitution too. Almost all the members of GPK also belonged to the political left or had strong allegiance with CPI(M) owing to the unique historical trajectory of its evolution in

Village A. Due to these specific patterns within GPK membership it was also found to be an assertive partner in Village A LSGI by certain representatives.

"The members of 'Padana Kendram' are all very strong members of CPI(M), so they are the key decision-makers here. Not in the case of funds, but things related to various projects. President does not have the space to voice any conflicts with them, she is bound to agree to them or she will be without job sitting at home (smiles sarcastically)" (CS1 LSGI6)

"He has great ideas, it is because he is a professor at law college and he also has a doctorate. Specifically in the case of projects he is a king. He is an expert and can develop projects in a very good way as well as convince the ideas." (CS1 LSGI1)

The role of GPK was more in line with a dominant partner owing to the strong political roots of its members within the senior leadership of CPI(M). Besides, the membership of GPK was unique as it had members who were academically and professionally elite, including professors of law as well as medical professionals who were also mostly male. Such a constitution of GPK that had members drawn from elite political and academic backgrounds and its gender context place it at a privileged position when it comes to its interaction with Village A LSGI. They had a powerful role in decision-making in Village A LSGI, which often overruled the authority of the female president in Village A.

4.3.1.4*c: Intersections of gender and caste axes as a weaker position within decision-making*

The social locations of being a woman and also one with a Dalit identity placed the female LSGI president in Village A at a far lower hierarchy among her other peers from within CPI(M). Though she has been a member of CPI(M), her status as a junior party member compared to other CPI(M) LSGI representatives too limited her power as a president. Though personally she felt that she was accepted by all other LSGI members, her narratives alluded to the position as lower to certain other party members within Village A panchayat.

"Many people have asked me this question, because it was a woman president, so how was the vice-president's role? Vice-president often says to me, you just do it on your own. He was a very senior party leader and even visibly also he was tall with a big stature, haven't you seen him yet? But he involved very little and had the attitude that let the president handle it. That was a great relief to me and it is because of that I feel I am informed of everything here. Legally president should know everything, but the way he did things was, he just allowed me to do things" (CS1 LSGI1)

When asked about her experience as a woman leader, the first reference she made was about the male vice-president. The way she explained the seniority of the male vice-president in the party and the use of words like, 'he allowed', 'big' alluded to her lower status in the decision-making hierarchy. Though she felt that she was allowed to be free in making decisions, her role as a female president was in her own words felt to be within the control of other senior party leaders in the LSGI. Similar reflections were also made by her peers in the LSGI from other political parties.

"Sometimes I feel so angry at the way they decide things. During discussion meetings at GPK we sometimes storm out of it, and that has happened even among LDF members too. President will later ask us why we did so and we used to say 'what are we supposed to do when we want to disagree with what they say'. President would then say that 'we can only do what they say'. If we have to survive, we also have to compromise many things" (CS1 LSGI 6)

It was felt that there was little room for the female LSGI president to be in conflict with the decisions made by GPK leadership. Instances of conflicts from members from opposition parties and even left representatives were often negotiated by the female president. The role of the Dalit woman member as a president was evidently limited in terms of her autonomy as a decision-maker in Village A. Dalit women leaders felt that, they are expected to compromise to survive as LSGI representatives and to achieve things that they feel are meaningful for their electorate.

The powerlessness and fragility of Dalit women leaders within Village A LSGI was also reflected in the way the Dalit woman president saw Dalit issues and required

strategies. When asked about the reasons for lack of sufficient projects in place to address the Dalit question, the president felt that;

"Honestly there is a need for many Dalit projects here. But somehow there haven't been much efforts in that direction in Village A. The fact is that such activities have never gone far ahead. We only have limited funds, and there is only a specific percentage of funds allocated for SC. So, to uplift them as we hope will require more funds. We do things based on what is currently available. What we can do is to raise their issues to the SC/ST development corporation, similarly ministers in the State. Only then can we have good projects for them, but panchayat alone cannot do much" (CS1 LSGI1)

It was felt that the panchayat is unable to take up good projects for Dalits as the funds are always limited. The narrative also alludes to the perception that only funds earmarked for Dalits can be utilised for Dalits in the panchayat. This meant that general funds or LSGI's own funds are almost never utilised for any Dalit specific projects. Besides, there was a sense of helplessness within her narratives, that only departments and Ministers higher up in the State government could intervene into the issues of Dalits in Village A. This came from a member of CPI(M) party in Village A which has been enjoying political dominance in all the village panchayats under Nedumangad Block LSGI which too has a CPI(M) leadership along with State government. Despite all this she felt that it was difficult for Village A LSGI to initiate projects that can uplift Dalits. This alludes to the weakness in terms of power and control a Dalit women leader could have within Village A LSGI in terms of its decision-making.

4.3.1.5: Project outcomes in village a & the emergence of 'I care we care'

Most of the projects examined and was directly or indirectly related to primary health care in Village A was reflective of the unique political, economic, bio-physical contexts in the panchayat. However, the current section aims to discuss more about the social innovation in question, 'I care we care' and the factors associated with it. A key relevant aspect that emerged in relation to the 'I care we care' project in Village A was

the priority attributed to the issue of CDs and the historical pattern related to CDs within the panchayat.

4.3.1.5a*: Special projects for control of CDs in the panchayat*

Given the longstanding trends of higher rate of CDs in the panchayat, Village A LSGI has prioritised health projects for the same. Village A has had a special project called 'Mukthi' for many years that is aimed at improving the public health activities for CD control in the panchayat. Since Village A is a large geography with a relatively larger population of around 70,000 the funds available from the department of health are often insufficient for the health activities in the panchayat. Hence, to support the public health staff at Village A FHC, LSGI has been allocating additional funds for control of NCD. Through these additional funds field health staff are able to perform comprehensive disease control measures including extensive fever surveys during instances of fever reporting supported by the health promotion team. The health promotion team accompanies the field health staff in source reduction activities and other related responsibilities. Using the additional funds, extra honorarium is paid to ASHAs too to support the public health staff to undertake source reduction activities.

4.3.1.5c: Quicker disease control response owing to the history of CD outbreaks

Yet another pattern that was observed during the narratives on the issue of CD outbreaks was the way in which Village A responded to instances of CD in even nearby areas.

"Once there was a case of cholera being reported in Thiruvananthapuram. Somewhere near Valiyathura or nearby place during 2005 or 2006, I guess. That was a coastal area and ours is somewhat towards the central part of the district. Despite this the moment we came to know about such an outbreak we initiated chlorination of all freshwater bodies in our panchayat within 2 days. It was a very quick response from our side." (CS1 PHC2)

The tendency of disease outbreaks as a historical pattern have also had impacts on how the health staff and LSGI responded to instances of CD outbreaks in nearby areas. The

perspectives of the health staff alluded to the quick response strategies often adopted by the health and LSGI in avoiding newer outbreaks in case of CD outbreaks in other areas of the district.

4.3.1.5d: History of community collaborated projects and activities

History of community collaborated activities to control communicable diseases

A Key background that needs mentioning in the context of project outcomes in Village A is the unique history of community collaboration in various projects and activities. Two main factors are of key relevance in having such a trajectory unique to Village A. One, the specific political context of Village A with the history of the left in Village A and surrounding panchayats. Second, the semi-urban geography of Village A and its vast area has contributed to a longstanding history of communicable disease related events in the Panchayat. The combination of these two overlapping contextual factors has resulted in Village A witnessing multiple projects that have community as a major collaborator. Given the left underpinning of Kudumbasree, anganwadi workers as well as in other sectors including NREG members enabled the LSGI to easily achieve active participation of community level volunteers in various projects.

"There was a time when the preventive activities that we do here could not be sustained if we did not have the support of the community. We often did not get results when we attempted to control them on our own. Most often they will end up as some campaigns, we will do something and there will be limited outputs from them. Due to such a history, from very early on the LSGIs here have focussed on such activities and they are not recent also. Such community planned activities have been planned here by the LSGIs even 15 years back. Very effective activities like 'Health promotion' team have been constituted here like 20 years back and their activities have been done here" (CS1 PHC2)

It was felt that the prevention of CDs was not possible just through the single-handed efforts of health staff in the panchayat. Hence, the process of controlling the persisting issue of CDs in Village A has forced the LSGIs to think of activities that were more democratic and community collaboration. Such attempts have in fact resulted in unique

projects that had community volunteers as a major stakeholder like the formation of 'Health Promotion' team in Village A.

Formation of a Voluntary health workers team/Health Promotion Team during 2002-03 period and the role of GPK

As part of the community partnered drive to improve environmental hygiene and source reduction activities, Village A LSGI had formed a grassroot level team called voluntary health workers. They are also now called the Health Promotion Team and it was formed at the level of wards. Every ward had a team of 15-20 teams of health volunteers selected from kudumbasree as well as other male individuals who were interested in voluntary activism. These teams were also given training on various activities at different periods by the LSGI in collaboration with the health staff in the panchayat. The narratives of senior party leaders and members of GPK alluded to the unique history of Village A and its activities to control CDs.

"A great example of this history would be the one connected to the much talked about fever related outbreak across Kerala during 2003-04 period. During the debates in the legislative assembly at that time, the then opposition leader of the State raised the news feature about a Village A LSGI project. It was titled 'panikkunna keralathinu karakulathinte mathruka' (A Village A model for the feverish state). I am not saying it was a perfect project, but it was an attempt by collaborating with community members. Making them prepared for action through training for disease prevention and activities like house-to-house awareness activities and cleaning drives. We developed education and awareness materials for the activity and the volunteers were trained on them. These volunteers went to all households, commercial establishments as well as educational institutions as part of that drive." (CS1 GPK1)

During 2002-03, when there was an incidence of dengue and chikungunya in Village A as well as in other areas of the State, Village A had initiated a unique project to tackle the challenge. As part of this activity, the LSGI had trained community level volunteers for house-to-house cleaning drives as well as to build awareness about source reduction activities among the community. As part of the disease control measures, LSGI had also trained student volunteers from two government high schools

in the panchayat. Students from 8th-10th grade were trained for house surveillance as well as in other areas of the panchayat. The project was planned by Village A LSGI in partnership with GPK at the time. This project had achieved State wide acclaim as it was featured in major newspapers as a unique model to tackle the issue of communicable disease outbreaks in the State.

4.3.1.6: Social Innovation- "I care we care" project, 2020

One of the latest activities that could be seen as a continuation of the historical pattern of community collaboration movements in Village A is a project called 'I Care We Care'. This was an activity that was initiated and implemented in May, 2020 by Village A LSGI to prevent the occurrence of CD outbreaks in the context of Covid lockdown implemented across the State. The current study tries to explore the 'I care we care' project in specific given its fit with the concept of social innovation adopted within the study. The details of the project are attached under Annexure B as appendix AXVIII

4.3.1.6a: Why "I care we care" is a social innovation in health?

Why *'I care we care'* is an innovation

'I care we care' as an LSGI project could be considered innovation as the activity was unique to the panchayat to specifically tackle the issue of CD events. The discussions on the possible strategies to prevent occurrence of CDs during the Covid lockdown period by LSGI actors, GPK and health staff resulted in the 'I care we care' project. However, the way in which community volunteers were recruited on an emergency basis to undertake house to house surveillance and provision of training sessions through online media were unique to the panchayat. The key actors involved in the project too felt this as an innovative strategy for CD control.

"No, we did not have any other reference activities when we planned it and we have not heard about any other similar projects elsewhere. This idea came to us at that point. When GPK suggested such an idea we had a second MO here, he provided some good contributions in terms of ideas. That we can have such and such activities too, such valuable contributions were made by him and ultimately we had such a project here" (CS1 PHC2)

These narratives allude to the way discussions on ‘I care we care’ occurred between GPK actors as well as from the part of health staff. The initial idea was suggested by GPK and it was further customised and improved through the ideas provided by key health staff in Village A. The project was also acknowledged by the department of health as an innovative strategy to control the occurrence of communicable diseases.

“During lockdown when the health department has been enquiring about any innovative or model activities. That is when someone informed them about our ‘I care we care’ program. So, to support us in our activities Mass Media Officer had come from the District Medical Office and inaugurated the program. We had invited the DMO, but due to some commitments the DMO could not come, so the Mass Media Officer has come on his behalf for inauguration.” (CS1 PHC2)

District Medical Officer (DMO) had been a supportive partner from the start of the program considering its innovative nature. The district health leadership had provided their complete support to undertake such an innovative activity including financial support in case it was needed.

As an innovation to address the social issue of high rates of communicable diseases

As has been discussed before, Village A is an area that has been historically prone to outbreaks of CDs over the years. Mostly diseases including dengue, chikungunya, leptospirosis as well as scrub typhus. However, the 2020 Covid lockdown in the State had in fact affected the regular public health activities including pre-monsoon cleaning drives as well as source reduction activities in the panchayat.

“During the corona pandemic we had gone into a lockdown and we were in the first stage of lockdown. During then none of us were able to get out and as a result our health system was totally stuck. When that happened, we had then initiated ward level committees. That was also the start of monsoon season and every year we used to conduct pre-monsoon cleaning. This time too if we do not conduct these activities, our history is different, Village A can witness outbreaks very easily and more cases will be reported. So, when we were forced to do the routine cleaning drives, we thought of innovative ways like involving people for achieving our objectives” (CS1 PHC2)

The situation of covid lockdown in the State had in fact acted as a trigger for the 'I care we care' project in 2020. Given the history of communicable disease outbreaks and the additional burden of covid control measures and statewide lockdown made it impossible for effective public health activities by the health staff.

Why it is a social innovation? the role of community volunteers within the innovation

A major feature that sets apart any social innovation is the role and participation of community members in addressing a common social issue. 'I care we care' was unique in terms of the role of the community within the whole activity to undertake activities like; pre-monsoon cleaning, source reduction and ensuring environment hygiene. Given the additional burden of covid control activities on health staff, volunteers recruited from the general community played a major role in supporting health staff in the project.

"In the context of covid the health staff are burdened with their pandemic related responsibilities. In such a situation invariably activities like pre-monsoon cleaning and others it was important to find a democratic alternative. Only if there is a community level or social support system to aid the official health system is present can we undertake such a responsibility. Since the health staff are already handling covid related activities, if we make them do such additional activities, there is also an issue of how effectively they can undertake it. That is the reason why we went for a social or democratic strategy." (CS1 GPK1)

It was felt that the additional burden of covid control measures being undertaken by the health staff made it impossible for them to also perform routine public health activities to control CD in the panchayat. Besides, the perception that such additional responsibilities might affect the quality of pre-monsoon cleaning activities and further increase in CD numbers made the LSGI leadership to think about alternatives. This prompted the LSGI to think of community level alternatives to perform the activities to undertake source reduction and other activities within the panchayat boundaries. As part of the campaign at least 2 volunteers were recruited for every 50 households in the panchayat and at least 50 members were recruited from all 23 wards in the

panchayat. In total the whole campaign had the support of around 1000-1500 volunteers including community members, Kudumbasree members, Health promotion team, ASHA, Health staff, ward members as well as staff from LSGI.

Project details are given as annexures

4.3.1.6b Key actors involved in 'I care we care' campaign

The explorations of the 'I care we care' campaign in the panchayat did reveal a set of actors who dominated within its conception and implementation.

Actors involved in the initial planning phase of 'I care we care'

Grameena Padana Kendram

The most dominant stakeholder in the inception as well as the way it has been conceptualised and implemented in Village A has been the leadership of Grameena Padana kendram. This was evident from the narratives of other actors at LSGI as well as health.

"When we had all this covid related issues in the panchayat environment hygiene was inevitable for us. This was the idea of Padana kendram and the executive director of Padana kendram was the key person who was behind this idea. It was him and also the coordinator of Padana kendram who helped us the most" (CS1 LSGI1)

The enquiry about the 'I care we care' project among the various stakeholders almost invariably referred to the role of GPK in conceptualising the idea for the campaign in Village A. The leadership at GPK were attributed for the initial idea as well as in providing all the key support in terms of implementing the campaign. These included using the expertise available at GPK like the development of a mobile based ODK application for collection of household level hygiene data. The training for the community volunteers in conducting the household survey was also achieved using the support of GPK including the use of GPK Facebook page for live training purposes. The pre-recorded video of health experts was also recorded and used for training through GPK. Once the household survey was completed, compilation of the data collected by the community volunteers was also done with the help of manpower at

GPK, which were then shared with health staff for implementing phase 2 and phase 3 household survey.

Technical expertise of GPK as a trigger and support for the campaign

Yet another advantage Village A panchayat had possessed in terms of implementing the 'I care we care' campaign was the technical expertise of GPK. As part of the GPK structure, they have a specific wing called 'Integrated Information and Technology Centre' (IITC) which has IT level experts working as part of GPK. As a result, even before the occurrence of Covid and related issues, GPK had championed a GIS mapping of Village A and four neighbouring panchayats under Nedumangad Block. These included mapping of all the houses in the panchayat, as well as other key institutions, commercial establishments. As part of this process GPK had also mapped key water bodies, road connectivity and other agricultural areas in the panchayat. Availability of such an information about panchayat and its resources and demography had in fact better facilitated the smoother implementation of house-to-house survey using mobile application for the 'I care we care' campaign.

LSGI actors

Besides GPK, major actors that were involved in the initial planning as well as implementation was also the leadership of the LSGI in Village A.

"All these activities that we conducted have been done through a coordinated effort. I remember the FHC doctor, also the NHM doctor at the FHC, then the HI from the centre they all came from their side. From the LSGI we had president, health standing committee chairperson and then from our side me, coordinator of GPK. So, in a platform with all of us we had evolved the ideas" (CS1 GPK1)

As per the narrative of GPK, the key LSGI actors who were involved in the initial discussions of 'I care we care' were LSGI president as well as health standing committee chairperson in addition to the medical team. It was felt by GPK that the idea was planned initially through a mutual discussion involving all these above said actors.

Health actors

Staff from Village A FHC too were a major stakeholder in the initial discussions and planning of the 'I care we care' campaign. These included doctors, including the FHC medical officer and a second doctor from the FHC. The HI too was a key actor during this phase.

"All our initial meetings and discussions were held at the FHC, in spite of the panchayat office the central point for 'I care we care' discussions were based at the FHC. For them it was convenient as they could easily be part of the planning and putting forward their suggestions, along with their routine healthcare responsibilities during Covid. So, the way we adopted was, go to them rather than asking them to come to us. Because as far as they are concerned, they were at that point handling a major healthcare responsibility for us, so we went to them." (CS1 GPK1)

A key aspect was the way the meeting venue was decided for the initial discussion for the campaign. GPK and LSGI leadership felt that it was prudent to convene the meetings for 'I care we care' planning at the FHC as it would be easier for the health staff. Since covid related responsibilities was also part of the health staff activities, to achieve their participation in the planning of campaign without compromising other responsibilities FHC was the key venue for meetings.

The health staff was also responsible in planning some key activities including the application of online mediums for training of the volunteers as well as use of online methods for data collection.

"One of the doctors from the FHC was technically very efficient. A key area that was crucial for this campaign was its technical aspects. So, the second doctor at the FHC had good knowledge about such aspects and he supported us in devising online activities of the campaign" (CS1 LSGI1)

As per the narratives of LSGI leadership, the health staff, specifically doctors from the FHC had a key role in the idea of applying social media as a training method for the project. They were also key in final verification of the collected data as well as

selection of households based on the scores they received. The role of health actors was also evident in terms of how various components of the campaign were also devised. These included the addition of elements like the 'Aardra bhavanam' survey that was planned as phase II and phase III survey on top of the initial survey of households by community volunteers.

Actors involved in the implementation phase

Following the conceptualisation and planning of the various components of the 'I care we care' campaign, the implementation of the campaign saw involvement of a wider set of actors. These included;

Elected representatives

The implementation of the 'I care we care' campaign saw an active involvement of almost all ward representatives from the LSGI in Village A. These ward members played a key role in terms of identifying the volunteers from their ward for community survey as well as providing the needed leadership in its implementation in their respective ward areas.

"We already have a system that is very community oriented like ward level members or representatives. We identified ward members as the core individuals for the campaign. Around them we planned the whole implementation structure of the campaign. It was them who identified the volunteers and brought them onboard. So, obviously the ward level activities were led by the elected representatives of that ward. Rest all were structured like an army around the ward member for this campaign" (CS1 GPK1)

As per the narratives of GPK leadership, the whole aspect of implementing the project was structured around the leadership of ward level LSGI members. They were delegated with the responsibility of overseeing the entire campaign related activities in their wards.

LSGI administrative staff

A second major group from within LSGI was the role of LSGI administrative staff. These included LSGI secretary, assistant secretary, section clerks, technical assistants amongst others who worked at the panchayat office.

"Even if ward members do not come forward, we have given charge to LSGI staff in the campaign, one person from the panchayat. Because we felt that if the entire campaign was entrusted to the members, it might not succeed. So, we assigned a staff too in all wards, suppose even if it's my own ward there is a clear staff pattern for the campaign. So, even if the activity is being led by the ward member, all the records and their collection were handled by an LSGI staff." (CS1 LSGI1)

Administrative staff from LSGI office were also included as key actors in all 23 wards of Village A as part of the campaign. These staff were in charge of ensuring the timely conduct of campaign related activities as well as the key contact for volunteers during the survey and cleaning activities. LSGI staff were also responsible for collection and documentation of the campaign related activities.

Public health staff

In addition to LSGI staff and ward members, health staff too played a major role in the implementation of the campaign. Specifically, ASHAs were a key presence in coordinating the activities of community volunteers as well as supporting the survey activities.

"All the activities were to be supervised by ASHAs, they had to ensure that the volunteers were going to all households, report us their activities, all these were their responsibility." (CS1 PHC2)

ASHAs were given the charge of supervising the field level activities of volunteers including survey and cleaning activities. ASHAs were also in charge of the phase II survey of the households, where they administered the 'Aardra bhavanam' questionnaire to score the households with 5 stars as part of the phase I survey.

In addition to ASHAs other field health staff including JPHNs and JHIs were also part of the activities in their role as supervisors as well as support staff. They were also key in conducting the phase III survey of households to select the model household according to the concept of 'Aardra bhavanam'.

Kudumbasree

A major actor in the implementation of 'I care we care' campaign was the role played by kudumbasree in Village A.

"In each ward we had 'I care we care' committees. In that there were members of residence association, NREG mate, ASHA workers and kudumbasree executives were there." (CS1 LSGI1)

The executive leadership of Kudumbasree in each ward was a major partner in ward level committees for the campaign.

"In every ward we already had health volunteers called HPT from very early on and in all 23 wards we had 5 HPT volunteers. They are mostly females as males are rarely available for such activities. In emergency situations they themselves will also help us get more volunteers in case we need more people at ward level. But when we start talking about it, they are all a single person which is kudumbasree (smiles). Most of the ASHAs are kudumbasree, the HPT people are in kudumbasree and there are also people from outside kudumbasree too." (CS1 PHC2)

In addition to being part of the ward level leadership for the campaign they were also a major presence in the campaign activities too. Kudumbasree members were a dominant cross-section of the community volunteers in terms of their roles as members of Health Promotion Team, ASHAs as well as NREG workers. Hence a major proportion of the women field level community volunteers were drawn from the pool of kudumbasree in Village A and were a backbone for the successful implementation of the campaign.

The political orientation of Kudumbasree in terms of its strong left allegiance has also enabled the LSGI and health staff to overcome the challenges within the implementation of the campaign.

"There have been instances where ward members remained inactive in some wards. For some members it was due to their strong political differences, some were incapable and some were reluctant to put in an effort. So, there were such issues in some of the wards. In such areas we sought the help of parallel institutions like Kudumbasree and depended on their support in coordinating activities" (CS1 PHC2)

In wards which had limited support from elected representatives, the health staff and LSGI had sought the support of Kudumbasree leadership in the smooth functioning of the activities.

Community members

In addition to kudumbasree a major cross section of the volunteers for the campaign were individuals from the community.

"Since it was the lockdown period and most of them were idle at home, so as part of the covid response we had constituted ward level groups then. It was called Rapid Response Team or RRT for covid related activities. So, for that activity we had some young people from ward level as volunteers to visit households. As part of it there were also people from residence associations. So, it's these people who formed a core of the 'I care we care' campaign and actively involved in the activities. Normally it would have been difficult to get enough people for such activities, but since this was the situation, we could easily achieve it. There were also members from local political parties and without political parties we cannot achieve such activities anywhere. The nature of the party will depend on the ward member in that area." (CS1 PHC2)

Since, as part of covid response village panchayats were asked to constitute Rapid response teams at ward level as per government guidelines. This enabled Village A LSGI to easily recruit community level volunteers for the campaign. These volunteers

were drawn from local political groups, NREG workers, residence association, previous membership as HPT volunteers in their wards.

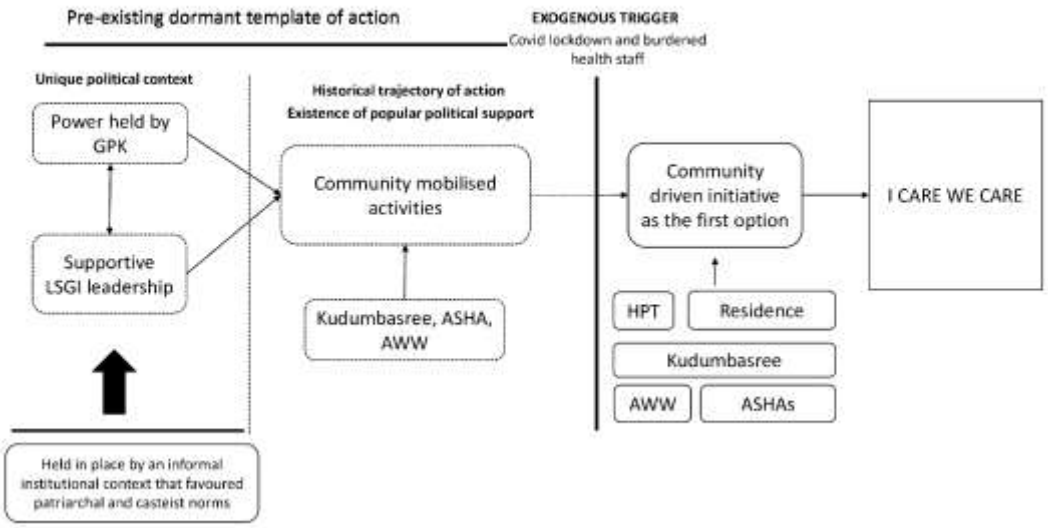
4.3.1.6c Summary of the key factors and pathways that influenced the emergence of 'I care we care' campaign in Village A

The emergence of 'I care we care' in Village A could therefore be summarised and perceived from three key themes

1. **A pre-existing template of action in cases of emergency:** One that favours community collaborated actions facilitated by the long history of left politics and the affiliation of various LSGI related structures including Kudumbasree, ASHAs, AWWs amongst others. This was also further reinforced over the years given the history of communicable disease outbreaks in the region and the ability of the panchayat to overcome them through community partnered solutions including HPT.
2. **A unique political context:** Specifically, a left oriented political leadership in the panchayat, that exclusively favours a strictly patriarchal and casteist leadership structure. This also meant that structures like GPK that is closely associated with CPI(M) leadership had an unfettered access to power and significant role in LSGI related decision-making. This structure also ensures that non-Dalit and non-male actors within the system rarely challenged the leadership structure nor problematise it. The result is also the ability of this leadership structure to convert their ideas as real-life projects without much conflict
3. **A sudden external trigger in terms of covid lockdown:** The onset of covid pandemic and consequent control strategies like lockdown in this case acted as a trigger to the system. The rising covid cases and burdened health staff meant that, the usual pre-monsoon health activities that aimed at preventing CD outbreaks was challenged. This triggered the system to urgently take up an

initiative that prevented the occurrence of CDs and the default pathway was to undertake community partnered initiatives under the leadership of GPK and LSGI.

Figure 4. 2 Representation of the factors and pathways that led to the emergence of 'I care we care' in Village A



4.3.2 CASE STUDY FINDINGS FROM VILLAGE B

4.3.2.1 Background information on Village B

Village B is a grama panchayat located in Pathanamthitta District in Kerala. It has a population of 25172 as per 2011 census out of which close to 53.5% are women and has 17 wards. It also has a relatively higher proportion of Dalits at around 15.36% (2011 census) in the State.

Village B is also unique given its popular status as a model LSGI for others across the State. The panchayat through its innovative projects achieved the feet of being the first in the country to win a national Public Administration award in 2015 from the Prime Minister. The award was based on a selection of innovative initiatives by the LSGI in various sectors including digitalisation of LSGI services as well as other citizen friendly services.

4.3.2.2 Key contextual factors of Village B

A crucial theme suggested in the analysis of institutions are how various contextual dynamics of a specific geographic location have a role in influencing and shaping its decision-making and thereby affects the outcomes or innovations in the case of the current study. The following sections tries to explore how various political, bio-physical, demographic and economic contexts of a village plays a role in project related decision-making within the LSGI as well as shape their projects.

4.3.2.2a Political context of the LSGI over the years

Over the years, decentralisation and people's planning at Village B has witnessed multiple shifts in the political leadership at its helm. During the initial years of decentralisation between 2000-2005 the LSGI was governed by United Democratic Front (UDF). However, later in 2005-10 period there was a period of political instability as no alliances had a clear majority to govern on its own. The initial two years had a UDF led leadership which lost its majority midway due to certain LSGI members withdrawing their support to the UDF alliance. Lack of a clear majority led to a new leadership from 2008-10 the panchayat that was governed jointly by Left Democratic Front (LDF) and National Democratic Alliance (NDA). This specific

alliance shared the leadership of the LSGI with the president from LDF and vice-president from NDA.

"There were very limited developmental activities when there was no clear majority. Not just that there were no good projects, even allocation of funds too was political. Scheduled caste funds were distributed to wards where there were no scheduled caste members. Once that is done, then they will reach on an agreement among each other personally. Once a ward member without SC population receives SC funds they will discuss with their other members and exchange their SC funds for other funds" (CS2 LSGI2)

"In the case of panchayat governance, if we want to oppose everything could be opposed. For instance, the current panchayat committee has 9 members from CPI(M), 8 from opposition including congress and BJP, so there is only a majority of just 1 member. So, if we start looking everything from a political vantage point there will only be conflicts, to write disagreement notes" (CS2 LSGI8)

However, as perceived by the LSGI representatives, lack of a clear majority by any political factions also led to limited developmental activities by the LSGI during the term. It was felt that the LSGI leadership was forced to favour all alliance members to sustain their position leading to mindless utilisation of funds that benefited no one.

"This term we only have nine members and we have the support of an independent candidate too. But last time was different, last time CPI(M) alone came to a status of having an absolute majority. The term before that (2010-15) LDF alliance had a majority, and last time out of the 17 wards LDF won 13 wards and out of that CPI(M) alone had a majority. (CS2 LSGI2)

However, since 2010 LSGI elections Village B have been governed by Left Democratic Front (LDF). The 2010-15 term the LSGI was governed by LDF with a majority of 11 wards out of the total 17. The 2015-20 term too, saw LDF in leadership again with a majority of 13 seats in the council with an absolute majority for Communist Party of India (Marxist) (CPIM) a major party within the LDF alliance. However, the recent LSGI elections however witnessed a close fight between the various political fronts with LDF gaining only 7 seats and with support from 2

independent candidates is presently the ruling party in the region with only a marginal majority.

"I brought a system where the members who decides to take plan fund will only get that, those who take maintenance grant can only have that and similarly for SC funds" (CS2 LSGI2)

"In truth it could be told that I followed an authoritative leadership style" (CS2 LSGI2)

Based on these narratives a clear majority for LDF and CPI(M) allowed the LSGI leadership the space to have an authoritative leadership style. The ruling alliance could in fact start taking crucial decisions that were not really possible without a proper majority within the LSGI committee. These included decisions related to how the funds shall be managed that the leadership thought was much more beneficial for long term development of the region. The term of LSGI between 2010 till 2020 was also marked with several new projects including in health sector as well as in other sectors. This was the term when the LSGI initiated major renovation of the PHC in the village as well as achieved ISO and NQAS accreditation for the PHC. During this period the LSGI was also renovated and ISO accredited and had also initiated several innovative projects in the region. The 2010-15 terms also saw Village B receiving national acclaim through Prime Minister's Public Administration award owing to the various new projects initiated by the LSGI.

Village B is one among the 5 village LSGIs under the Block LSGI. Though Village B have had a stable left leadership since the last 11 years, the Block LSGI leadership have been under the leadership of UDF alliance since the last three LSGI elections. However, the district LSGI in 2010-15 was led by LDF, and from 2015-20 was under a UDF leadership.

"It's all political and they all look for their own. When we start introducing such activities it would have been a great help if they provide us a financial support, so that we can improve what we have been doing. But what do they think? These people are becoming popular with the activities they have been doing, and even if we give them

funds it will only be added to their name and will never benefit the block LSGI." (CS2 LSGI2)

The presence of different political leadership at village and block panchayat levels was felt to be a hindrance by the vice-president. He felt that specifically if a village panchayat is perceived as a successful model, political leadership at higher levels becomes reluctant to share funds in fear of lack of electoral gains. This often resulted in limited sharing of funds which created bottlenecks for better implementation of projects at the village panchayat level.

4.3.2.2b Bio-physical contexts

Bio-physical contexts in the current study are the locally specific attributes in relation to the geographical, demographical and biological characteristics of the panchayat. Some of the key aspects related to these aforementioned bio-physical attributes that emerged from the interviews with LSGI, health and community level interviews specific to Village B were;

Issue of water scarcity

A major theme that emerged from the perspectives of various actors was the issue of water scarcity faced by the panchayat since many years.

"A major thing in our ward is that it is geographically a rocky terrain and even deep down the earth its mostly rocky. And due to this reason drinking water scarcity is a major issue in our area. We started two small drinking water projects in this ward, one from a panchayat well and a second one newly dug for the project. We inserted ring five feet down, but the availability of water is still low" (CS2 LSGI8)

Many felt that during summer season, the region faces shortage of water in many of its areas, specifically higher regions within the panchayat. Besides many wards in the panchayat had a rocky terrain making availability of ground water a challenge in such areas. Owing to the limited availability of ground water in most of the areas within the panchayat which resulted in severe crisis of drinking water during dry seasons. Many areas in the panchayat are being supplied with water in tankers during summer season

including the ward where the FHC is situated. Though the FHC has a well and an overhead tank, during summer season without additional water supply even regular functioning of the FHC could be interrupted. Few felt that after the floods in 2018, which struck many areas of the panchayat severely, the water table has reduced further which has worsened the situation.

Challenges in waste management in the panchayat

Along with the challenge of water scarcity, yet another theme raised by many actors were issues related to waste management. Many felt that panchayat has to have better facilities and infrastructure to process waste originating from within the panchayat specifically organic waste and their disposal

"Waste management, that is a major issue in this panchayat. It would be really great if there are some projects for it. Mainly management of plastic waste and its recycling is a major challenge. In town like areas, there is an issue of clogging of channels due to waste dumbing, which can lead to breeding of mosquitoes." (CS2 PHC3)

Dumbing of waste along the roads and the issue of plastic waste and its recycling was an issue that was perceived as a challenge by most of the interviewees. This has been an issue since many years within the panchayat as observed from the narratives of the many LSGI actors.

4.3.2.2c Discourses on health issues in the panchayat

NCD as the main health issue

"*It is mostly issues related to lifestyle diseases here and we have been conducting activities to control them…and approximately 30% of the population has these issues"* (CS2 PHC3)

"What we prefer more is, we have more lifestyle related issues like pressure, sugar and hence need treatment for these issues. Such diseases among poor people are difficult because they will have difficulty in getting them treated outside the panchayat or to know more about them" (CS2 LSGI1)

A key theme with respect to the major health issues within the panchayat was that of high prevalence of non-communicable diseases as felt by the health and LSGI functionaries. It was felt that a big proportion of the community had some sort of NCD related issues including diabetes mellitus or hypertension. LSGI representatives too echoed a similar narrative and felt that high rates of NCD are an economic burden on sections of poor people since they are detected often very late. Cancer too was found to be an issue by a few LSGI representatives which they thought had to be addressed through better awareness.

"*If we talk about innovative projects, we have a project for people above 60 years since they are in a way an excluded group in the panchayat. So, for them we have a project called 'Sayamprabha' with clubs for elderly people and conducted health check-ups and other activities for them"* (CS2 PHC3)

The high prevalence of NCDs often overlapped with that of the issue of elderly as there was a recurrence of NCD issue among elderly as a common theme within the narratives on NCD by health actors. Most of the health staff alluded to the ''Sayamprabha'' project that was specifically developed for preventive care for the elderly people through routine monitoring of their health status as well as through nutritional support.

4.3.2.2d Demographic & Economic context

Within the bio-physical attributes, one of the key aspects of interest were to explore the demographic attributes and issues within the panchayat and how they are prioritised by the LSGI for developing projects. One of the key issues that emerged from the case study exploration was the issue of relatively higher proportion of elderly and their health care as a challenge to the panchayat. This also alludes to the economical dimensions of the region, given the link it has with people migrating out of the panchayat for livelihood reasons, leaving a big majority of the elderly without support from their immediate family member.

Elderly communities within the demography

The interviews with key LSGI actors suggested how Village B had a relatively higher proportion of elderly individuals within their demography. The discourse on various key sections of the population to be prioritised often included elderly members.

"Obviously every community will have marginalised sections. Like all other societies there are such sections in our panchayat too. Homeless people, people who are living alone, elderly people with no children to take care of etc." (CS2 LSGI2)

When asked about the various activities that the health centre has been doing to improve the health of the community, health functionaries often alluded to the care and services being provided to the elderly sections.

"At our centre we have been organising geriatric clinic. We have been doing it to detect if they have any health issues. They have been coming here, they come to our clinic. They tell us their stories and all, they are old and are living alone so they will always have something to share with us. Also, at anganwadis we have been taking classes and its usually elderly people who attends such classes." (CS2 PHC4)

"What I felt was that there are many elderly people in our panchayat, so I feel what we need more is a pakal veedu (day home) for them. I have been having this wish from the time I came into this position in my mind. I have also raised this issue here, a facility like pakal veedu will allow the elderly individuals to come and relax during day time which I feel is something everyone would want." (CS2 Kudumbasree1)

According to the perspectives of Kudumbasree Community Development Society (CDS) chairperson, infrastructural provision for the elderly was a key issue that needs to be improved within the panchayat. These repeating narratives on elderly people and their issues among various LSGI actor's points to a tangible issue of higher proportion of elderly people in the panchayat and the need to address their issues.

4.3.2.3 LSGI actors and their power dynamics

This section deals with the nature of power dynamics that existed within the panchayat decision-making spaces. Specifically, around the axis of gender and cast and to

examine how they influence the interaction of actors and the nature of decision-making.

4.3.2.3a: Gender and caste-based locations of power

A key theme that emerged through the interviews with various actors at Village B LSGI was the significance of how gender and caste intersected to create hierarchical power positions in the panchayat. Both gender and caste as separate entities and often together played a major role in deciding the way in which how various individuals could or could not influence the decisions by the LSGI.

Perception of female representatives as less capable than male counterparts

A dominant theme that emerged within the narratives of LSGI actors was the gendered views on politics and political actors. Women politicians were often perceived as less capable or ineffective by male members. More often than not women were side lined within decision-making spaces at the panchayat. The discourse on women and their role within decision-making almost often alluded to a male centric narrative that existed in the panchayat.

"I think where the failure in women reservation is that, it is only fruitful when women who have experience as social activists. However, political parties often field candidates who they think will have better odds of winning in election. They are not bothered about the fact that whether they have any connections with the society or an experience as a Kudumbasree worker. Only those candidates who have experience and skills can shine, but they also don't show any interest in learning" (CS2 LSGI7)

The narratives on women representatives and women as representatives by their male counterparts often saw it as a failed experiment. The performance and the works of female representatives were always under the scanner and their failures were stereotyped as failure of women as representatives. The failure of women representatives was attributed to their lack of commitment to learn new things as well as due to their lack of experience as a social activist.

"If I say personally, the panchayat president (woman president) was my friend's wife. She was also neighbour to the brother of my brother-in-law. So, I had a very good rapport with her. I often go to her office and advise her how to do things, things not to do and how she should do thorough research before doing things. Also, I advise her about the key issues that may come up during gramasabhas, things related to project development and project implementation. I have said to her multiple times that panchayat president should come after learning all these stuffs and should not say something without studying about them" (CS2 LSGI5)

This above quote was narrated by a male ward member who like the woman president was elected for the first time to the LSGI as a representative. However, he felt that he had the knowledge and power to advise her female counterpart on how to act and make decisions related to LSGI as a president. This implies to his perspective on women as poor decision-makers who unlike him are ill-equipped to make key decisions related to LSGI projects.

"Women members who have come through reservation are mostly interested in an opportunity to be a member rather than the idea that they have come through reservation, so what is the reservation for? It is to make sure that women issues are addressed. Haven't I told you about my experience with Jagratha committees. A woman president who has come through women reservation is not interested to sit in Jagratha committee. Meanwhile if there are some inauguration functions, she will go for that. So, why do we have such committees? This is a space for redressal of issues affecting women and children, and shouldn't that be her priority, especially for a woman president. But unfortunately, she is more interested in public attention and photo opportunities and that's where our visions are different" (CS2 LSGI2)

The narratives of the vice-president too portrayed women representatives in a poor light. He feels that most of the women ward members are interested in being in positions of power rather than a responsibility to their community. According to him the idea of women representation is to bring forward women members who will then solve the issues of women in their society. Such an understanding of representation alludes to the idea that women representatives are bound to work for women unlike

their male counterparts who are responsible for the whole community. These ideas of delegation of responsibilities for women are seemingly drawn from a position of power as males who feels they have a better understanding of how women shall behave in decision-making spaces.

Patriarchal leadership structure within CPI(M)

The discourse that males as more capable and efficient than females was also reflected within the left party leadership in Village B panchayat. The patterns within how women candidates were chosen by the party also reflected how party saw female representation within positions of power

"I was not a party member before, but my husband's family was very active in CPI(M). So, when my ward was reserved for a woman candidate I was asked to stand in the election" (CS2 LSGI1)

This lack of commitment towards women representation was evident in the way how party chose their female candidates during elections. In wards that were reserved for women candidates, party often ended up choosing spouses of male party workers as a last resort. Casual conversations with other members also alluded to, party accepting money from female candidates who wanted a chance at contesting elections under the banner of party.

"Party mainly thinks about the odds of electoral victory. Suppose if an MLA dies, party would field his wife. But that decision is not based on her educational qualification nor her social commitment. She is the wife of an MLA who is no more. They are trying to exploit the emotions of people" (CS2 LSGI7)

These were also reflected within the narrative of few ward members who thought that party does not put much thought into its female candidates. Fair representation of women was never a priority for the party and electoral gains often dictated how they decided woman candidates in elections at all levels.

Double marginalisation of Dalit women within spaces of power

Often female Dalit politicians were the most side lined within party leadership compared to a non-Dalit male politician, who are preferred more. This accrues significance within the case of Village B since left parties have been at the helm of Village B LSGI since more than a decade.

"I had been a party member and this time I stood as a rebel candidate. It's because, I was a party local committee (LC) member and had contested in the elections last term. But, last time no one was ready to stand in that specific ward, it was a general ward and everyone was reluctant to contest against the opposite candidate. The opposite candidate was an independent and he was a people friendly person and have been shuffling between various parties. So, I was sure to lose if I stand against him and no male candidates were ready to stand against him. I knew party made me a pawn, but I was ok even if I lose and I fought against him and I lost by a big margin too. But they had promised me that next time I will be given a fair chance, that was also the LC decision. So, this time when I wanted to stand in the election, party selected someone outside the party even though that ward had 3 LC members including me. As an LC member party should have at least asked me. This vice-president and also one another male party member, they went past my home to the person they selected as candidate and yet they decided not to inform me about that" (CS2 Kudumbasree3)

Interviews with a Dalit woman member who had been a party worker for many years revealed how party preferred male representatives over them. In this current instance, the interviewer met with a previous party worker as well as a kudumbasree member who recently rebelled against the left leadership in Village B. She had been a capable leader and a ward member in the panchayat during the 2010-15 tenure as a CPI(M) candidate in a ward that was not reserved for a woman candidate. However, she felt that she had been treated unfairly by the leadership when she was asked to fight again from a Ward in 2015-20 LSGI elections, where party had prior information of an impending loss. She feels that it was a strategic move by the local leadership to field her so that no male party members will lose their chance. Later in 2020 LSGI elections she was not fielded by the party contrary to what had been promised to her. Despite

her experience as a senior party member as well as an LC member, she feels that she was excluded from the decision-making related to the candidate in her ward.

"I am not interested in political activism anymore as I am really tired of all this after 5 years. As I had told, I have been working as a gramasevak in a different panchayat and I had lots of hope to do something good for the community. I thought there are many talented people including the vice-president and I wanted to make projects that were beneficial for the people. I entered politics with lots and lots of hope, but I never got any support and after a while I was even afraid to talk publicly to an audience. I never got that support, not just from my peers but also from my husband. They never thought that women like me in such a position should be encouraged, and there was never a back support. I initially thought the vice-president was also one among us and he would help in my activities. But he was like an animal, he would always walk around roaring and after a while I got irritated even at his sight, do you get me? If I go to him to talk about something, his attitude was always condescending, that I am just a woman and you stand where you are ought to" (CS2 LSGI1)

The power hierarchy between male and female members within LSGI was evident in the narratives of the Dalit female president in Village B. She felt that as a woman she was always relegated to a lower pedestal when it came to LSGI decision-making. Her experience as a woman representative had only made her weaker and fearful to even face public and express her opinions. The attitude of the vice-president had always alluded to the idea that as a female she was never considered as a peer by the male leadership and ought to be at a lower hierarchy.

4.3.2.3b: Emergence of a strongman leadership within decision-making drawn from the gender and caste institutions in Village B

The gender and caste power structures that existed within the leadership of the CPI(M), had in fact resulted in a unique leadership style within the panchayat. What was evident from the perspectives of various actors was the way in which key decisions of the LSGI being taken by the male non-Dalit president. Both during his tenure as president (2010-15) and during his tenure as vice-president (2015-20) he single-handedly decided the entire activities by the LSGI. He has been a strong leader within the rungs

of the party leadership and is a member of Communist Party of India (Marxist) Area Committee in Village B region. He is a lawyer by profession and has been a ward member since 2008. In 2008 he became a member for the first-time through a by-election and in 2010 term of the LSGI he was appointed the LSGI President by the party. During the 2015-20 term he was re-elected and continued as the Vice-president of the LSGI since the post of President was reserved for a woman candidate. This was evident in his own words, where he felt an authoritarian style was more effective.

"In truth it could be told that I followed an authoritative leadership style…. In a way I believe that rather than a democratic system an authoritarian way is much more suitable for our context. For, in an authoritarian leadership style people will only have to bear the problems of a single person, if at all there is any. However, in a democratic system they will have to bear the problems of multiple individuals which is not good for the community" (CS2 LSGI2)

He himself seemed to believe in an authoritarian style of leadership and had his own convictions for the same. His narratives demonstrated a sense of mistrust in the capability of others in making the best decisions for the panchayat. The justification he had for such a position was that in an autocratic style, decision-making would only have to face the issues of a single person even if it goes wrong. He felt that democratic processes will often suffer from the ignorance of multiple individuals involved in decision making. This specific narrative alludes to his personal opinion that all others other than himself are bound to be wrong and does not serve the idea of good governance.

Strong family clout of the vice-president within left party leadership **sustaining the strongman leader**

A key factor that seemed to work in favour of the LSGI vice-president was also his close relation to senior party leaders which enabled him to rise within local party leadership at Village B. His family ties with one of the seniormost member of the State Committee, CPI(M) gave him the supreme authority over all decisions at the LSGI and local party leadership.

"I was a party member but I am currently suspended from my local committee. I am also the president of my Nair Service Society (NSS) karayogam and party feels that I was responsible for the recent failure of Mr Vice-president in the panchayat elections. Party feels that I did not ask my karayogam members to vote for him. He is very powerful in the party, because he is the nephew of party State Committee member. Also, the elder son of the State Committee member is also a leader in party's Village B Area Committee and an advocate, where Vice-president is also a member. The younger son of State Committee member is a leader is party's local committee in vice-president's ward. Here it's a family run party" (CS2 Community2)

Similar narratives were also observed among community members who found that there is an unfair leadership structure within Village B communist party, mostly run by the family of the vice-president. In addition to his ties with party State Committee member, he also had family members within the leadership of CPI(M) area committee in Village B. This was also a found to have given the vice-president an undue priority party's leadership at Village B.

A priori recognition of male vice-president as de facto LSGI leader due to women reservation

The narratives of ward members who are also members of the CPI(M) party indicates how they perceived the fact that Village B LSGI president position was reserved for women in 2015 term.

"When he (vice-president) contested the LSGI elections in 2015, the position of LSGI president was reserved for women. So, obviously we knew that he will have to step down from the position of president or will have to take a lower position because he will not get anything more than vice-president post. So, it was sure that the panchayat will be led by new women and party thought that it will create a difficulty. The developmental activities that panchayat had initiated already had to be continued, so party asked him to contest again. So, he contested and party made him the panchayat vice-president." (CS2 LSGI5)

As a party it was felt that it would create a challenge for further development of the panchayat since the previous male president would not be able to continue as president.

Hence, informally it was decided within party that though the previous president would continue as vice-president, the decisions within LSGI would still be controlled by him. These indicate how representation of women and women reservation were bypassed by the local party leadership in favour of male leaders through informal ways. These informal mechanisms had also resulted in the vice-president's rise to a powerful position within LSGI owing to the support he received from his party leadership despite his status as vice-president.

Acceptance of gender and caste-based hierarchy as taken for granted by Dalit and female actors sustaining the position of the strongman leader

The male vice-president as the de-facto leader was often a taken for granted position, by his peers within his party. Specifically, so among Dalit party and LSGI members as well as by woman party members.

"No, there was no such issues of a single person deciding everything. Let me say, please don't see it like that. To learn about new projects and to implement it efficiently is something, not all projects that come up cannot be implemented. Take any projects, to conceive it, to implement and complete it 100 percent is not always possible. So, those projects that are beneficial to the community and could be implemented we should learn and try to implement it in the best way. He, as our panchayat vice-president was successful in doing such activities efficiently" (CS2 LSGI5)

The questions on his undue authority over LSGI decision-making was often defended by many LSGI members. There was an overt attempt to project the vice-president as a capable leader, to defend his authoritarian style. However, these taken for granted attitude on his authoritative leadership style was mainly maintained by party members who were below him in the local party leadership, specifically by Dalit and woman members. The justification for his style of leadership was attributed to him being a very capable leader who could envision new projects and implement them after thorough research which are rare qualities. As a result, his leadership style was perceived to be right and the achievement from the Prime Minister was a vindication of his talent and approach to leadership.

"If you ask me about him, he is an advocate, and when an advocate becomes a panchayat member it will be very good… The current LSGI committee will not agree with what I am about to say. All these developments that we see in this panchayat is due to his actions. I am speaking from my experience. He was a person with a clear vision and he has received an award from Narendra Modi. He is that talented. Even if they all evict me from here, I will say that it is all his talent and he is a good person" (CS2 Kudumbasree1)

Nevertheless, these narratives generally also tended to agree to the fact that there was a general dissatisfaction in his leadership style. However, his professional career as a lawyer, and the awards received by the LSGI often served as vindictive justifications for the same.

4.3.2.4 Nature of interactions between actors for decision-making

4.3.2.4a: Lack of space as felt by other LSGI actors in project related decision-making

The major theme that reflected throughout the narratives of other LSGI representatives was the lack of space for them to be an active partner in project related decision-making. A feeling often drawn from the unilateral decision-making style maintained by the vice-president.

"During the last two terms shared decision-makings and discussions were less. As individuals, there have been such faults in certain members. I don't want to name a particular person, but he was the person who led the LSGI. He puts a lot of effort and get things done efficiently and I don't have any complaints in that regard. He had all the qualities, was very smart and did things efficiently. He had the talent to learn about new things and evaluate them properly and was a capable leader. But the failure was that he did not know how to involve and get the ownership of other ward members. So, things started to look like an authoritarian leadership." (CS2 LSGI7)

The authoritarian leadership style was obvious in the narratives of most other LSGI actors. It was felt by many that the LSGI decision-making lacked a democratic nature and projects were unilaterally decided by the ward member who served as the president

and vice president during the 2010-15 and 2015-20 respectively. This was also reflected in how even the president of the LSGI was excluded from taking any sort of responsibility in the functioning of LSGI. Though he was the Vice-president of the LSGI, he unilaterally decided things on behalf of the LSGI. Though he was seen as a very capable individual his leadership style lacked an inclusive attitude with limited room for others' opinions. Casual conversations with LSGI staff demonstrated strong anger among them to his authoritarian functioning. During his tenure, he even institutionalised a penalty system for staff who he thought delayed the provision of timely services to the community. To quote certain members his style of leadership was felt as 'Hitler model' of decision-making.

4.3.2.4b: Lack of space felt specifically by female representatives

Despite being in positions of power including as LSGI president and chairperson of health standing committee of LSGI, women leaders felt excluded. The dominance of male members in Village B was evident within the narratives of female ward members who felt that they were almost always excluded from decision-making spaces.

"For me personally, to be frank in the initial period my personal opinions had a value. Later after a period of first two years from third year onwards I did not have any voice. I am saying very openly and I have nothing to hide. From third year onwards I did not involve much in health decisions. Because there were people who were more knowledgeable than me (sarcastic tone)" (CS2 LSGI3)

Specifically, the female president was never privy to basic financial details related to the various health care projects. She felt that she was never privy to such information nor allowed to partake in such decisions. These narratives clearly suggest to the conventional position of women leaders within the power hierarchy at the LSGI.

Expulsion of female president owing to conflicts with the vice-president

The Dalit female LSGI member who was the president during the 2015-20 term was ousted from her post after a period of 3 years. The main reason for her resignation was cited as repeated conflicts with the vice-president and apprehensions over her political affiliations by the CPI(M) leadership.

"She has been going good with other party members, but towards later years she started having difference of opinions. She started communicating these issues with other political groups who were in the opposition. Based on this there were interventions and within party there were discussions. Even after party asking her to correct herself, she continued with her ways, and finally party expelled her" (CS2 LSGI5)

However, the conflicts that arose due to the power dynamics between both genders were never acknowledged as a source of issue within the leadership of CPI(M). The conflicts between the female president and male vice-president were often branded as her collusion with opposition party members and ultimately ended up in her expulsion from party membership as well as from her position as LSGI president.

Abstinence as ways of opposing strongman leadership style by other members

The strongman leadership style of the LSGI vice-president had also resulted in different degrees of conflict within the LSGI committees. These ranged from certain LSGI members being forcefully ousted from their positions to many others abstaining from decision-making spaces in the LSGI.

"Opinions of others were never respected and even if there are conflicting views, even if they were from same party members, they were not taken for their face value and constantly ignored. So, there were many changes due to such an attitude" (CS2 LSGI8)

"He only includes those people in decision-making, whom he trusts. They need not have any knowledge in the matter" (CS2 Kudumbasree4)

Opposition to the authoritative leadership were also raised by peers from his own party who felt that it was unfair way of decision-making within a democratic constitutional space. However, the nature of conflicts that were evident within these narratives were one of avoidance rather than confrontation within LSGI decision-making. Most of the narratives alluded to how various LSGI members started to keep themselves from putting forward suggestions nor being part of various processes that the president initiated.

4.3.2.5 Key patterns within decision-making related to innovative projects in the LSGI

The panchayat was characteristically evident with its presence of multiple models that were acclaimed at the State and National level. The panchayat is unique given its popular status as a model LSG for others across the State. Through multiple innovative projects achieved the feet of being the first in the country to win a national Public Administration award in 2015 from the Prime Minister. The award was based on a selection of innovative initiatives by the LSG in various sectors including digitalisation of LSG services as well as other citizen friendly services.

The most crucial element that favoured the emergence of multiple unique projects was evidently the aforementioned unique leadership style that existed in the panchayat. In addition to the unilateral style of decision-making, the vice-president also demonstrated certain key personality traits.

4.3.2.5a: LSGI projects and activities as personal projects of the Vice-president

Since he is personally involved in all the projects within the panchayat, the way he perceived the various activities tended to be personal to him and one that lacked a sense of collective effort.

"When I do something it's important for me that the people who stand with me as a team does not face an audit objection. It's not that the officer receives an audit objection, when I am in charge of a project and there is an audit objection it affects me personally. I take it as something that affects my quality, or something that affects my credibility." (CS2 LSGI2)

"Until a project succeeds it's my responsibility and my mistakes. If it fails, I will be responsible and if it succeeds its everyone's success. But, never have I ever made a failed project and due to that the credibility for my words still stands. So, I always know that when I take up such innovative projects the risks associated are always mine. From that standpoint I always try to make it the best project. I think of all aspects from all possible angles so that I never leave the room for criticisms" (CS2 LSGI2)

Rather than viewing projects and activities within the LSGI as a group effort, the narratives tended to be personal efforts. Failures within the projects initiated in the panchayat were seen as his personal failure. One that could be perceived as lax in his personal quality and credibility. His distrust on the abilities of others and his own need to succeed and sense of being credible to all are reminiscent of a Machiavellian style of leadership.

4.3.2.5b: 'Can never go wrong' attitude as the justification for lack of conflicts from others

An interesting theme that stood out within the narratives of the vice-president was how he personally felt as an individual who can never go wrong with his ideas. He always made his decision from a standpoint of having taken the best possible decision which others can never oppose. The lack of resistance from others was perceived as him being right and was unaware of the conflicts that existed within LSGI in the way he decided things. The power he accrued as the decision-maker, drawn out of various social and personal elements in fact obscured him from his external identity as an undemocratic leader.

"I always take up a project and present it at the LSGI committee with a very clear know how. So, when I present it to the LSGI committee I never give others a chance to say no." (CS2 LSGI2)

His narratives on his decisions and ideas always seem to exude with confidence and conviction. They allude to how he perceived himself as a leader and decision-maker who can never go wrong in his decisions for the panchayat. He feels that he initiates project only after learning about all possible issues related to the project and hence can never be opposed by anyone else.

"When I decide to develop a project, I look at it from all possible angles. Even while typing the project document, I myself get involved in it. I never just ask others to do things, like we need an ISO certificate for the PHC and I don't just leave it with the doctor to take it up further. I myself sit down for it, I myself enter the username and password of the medical officer, I myself enter the project details including its financial

details. Since, I write down every detail myself the doctor will not even know what are the various components that are present or not present in the project" (CS2 LSGI2)

The perception of being right always coupled with his lack of trust and capability in others made himself responsible for all projects within the panchayat. The way he developed the projects himself without involving others were seen as positive traits. The projects on health were developed and documented by the vice-president himself and the responsibilities of the medical officer was also completed by him including the personal login details of the medical officer in the Sulekha portal. This personal sense of 'confidence' and 'conviction' were some of the key themes that seemed to enable him to try out new ideas as projects which many often see as risky. His history as a person who has tried out new and innovative projects within Village B and their success made him see as an achiever himself.

4.3.2.5c: Excessive authority over other LSGI institutions

The strongman leadership style within LSGI committees were also reflected in how the LSGI leadership interacted with institutions like Kudumbasree and other transferred institutions.

"Kudumbasree does not have a statute that it should function according to what an LSGI president would want, there is nothing like that in our bylaw. Kudumbasree is an independent organisation. But his perspective was that Kudumbasree should go as per his orders under his authority. We only need president only when we require a support from them, suppose if we want to implement a project we would as "sir we want to implement this project, what shall be done" or regarding the details of the funds. How much our district mission would give us and how much LSGI can support. Only during such instances, we normally interact with the president. But he needs everything to be under his authority" (CS2 Kudumbasree4)

Interactions with two different previous Kudumbasree chairpersons revealed the authority the LSGI vice-president exerted over decisions of the Kudumbasree. It was felt that though Kudumbasree was an independent organisation, in the panchayat it

was forced to function as per the decisions of the LSGI vice-president. This was also seen in the way he went against legal restrictions and implement what he desired.

"There have been many good things, our PHC had got many benefits due to his style of functioning. We could reach first in many areas due to that, we got NQAS, significant improvements in our facilities compared to other PHCs. So that was a great support, but it was his nature, we had positive changes too and negatives too. When I say negative, I mean we never get to have our independent opinions, it was always as per his wishes. If he says that "no it can only be done this way" then there is no other option for us. Even if say it would create difficulties for us, it does not matter to him" (CS2 PHC4)

Similar perspective was also reflected in the narratives of health staff who felt that it was the Vice-president's decisions that ultimately prevailed in the FHC. The staff felt that, they never felt the space to put forward their opinions or challenges as they never mattered in his decision-making related to the health institution. The opinions of the vice-president himself reflected his perception that transferred institutions are under the authority over LSGI leadership.

4.3.2.5d: Attraction to new ideas and teaming with people whom he trusts to realise new projects

Yet another theme that emerged from the interviews were how as a decision maker the LSGI vice-president was attracted to new ideas and his ability to realise them as LSGI projects. He was quick to assimilate ideas that are new as well as team up with people whom he trusted in converting these new ideas as LSGI projects.

"One of our retired Health Inspector (HI) was a good person, before he left, we started the process of ISO accreditation. I had asked him if there are any new ideas, we can do them. He then told me about school health activities, while we met during palliative project management committee, he talked about doing something for the bystanders. It is not just the bed ridden patients but we should also take care of their bystanders, and that was a new idea for me. As part of school health, he had suggested that we should make it better than what we have been doing conventionally. It was he then suggested about the idea of a yoga class for children. Then I had said let's not limit it

just for the children, let the public also have a chance to learn yoga. So, if it is in a public space all of them can participate. So, I said let us take the school compound itself, so all of them including children, their parents as well as public who are interested can also come. So, that initial idea that lets start a yoga project for children which we later developed as a bigger project. In 2011-12 a project on yoga by a panchayat was not even in LSGI guidelines by the State." (CS2 LSGI2)

A most suitable example in this regard was the case of an innovative yoga project by the panchayat in 2011-12 period. Village B panchayat was the first in Kerala to develop a project on Yoga. This innovative project according to the LSGI vice-president was developed from a small thread given to him by the then HI. The initial idea was proposed by the HI as a small yoga activity for the school children, however this was later developed by the then president as a bigger project that can serve the entire people in the panchayat. At the time it was an innovative project and had achieved wide appreciation from across various quarters. Based on this project by Village B it was later integrated as a model project for all panchayats through the State LSGI project guideline.

Multiple other innovations are also reflective of this theme, where the vice-president teamed up with individuals whom he thought are creative. This include the development of the one of the kind plastic shredding unit project in the panchayat.

"Even before Harita Kerala mission guidelines were in existence, we had initiated a plastic shredding unit in the panchayat in 2012-13 period. During 2012-13 when earthworm compost and vermicompost were being distributed, one of our ward members who is also vice principal at a college in Kottayam had suggested that, even though we are distributing these, we need to urgently intervene to resolve the issue of plastic waste unless which it could be a major challenge for us" (CS2 LSGI2)

Based on this idea, in coordination with the ward members, it was later developed as a major project by the president which too was a model for other panchayats in the State. Other projects which too demonstrated this pattern was that of Jagratha committee. Jagratha committee was a key activity that Village B LSGI conducted routinely within the panchayat. It was convened on first Friday of every month and

anyone with a complaint with respect to women and children can come to the committee and seek redressal. This project was also developed when one of the ICDS supervisor suggested about such committees to the president who then realised it immediately.

4.3.2.5e: Power wielded by the VP as an enabler in overcoming challenges within project implementation

A key trait that was evident within the leadership style of the vice-president was his ability to persevere through challenges and his conviction to overcome them. Any challenges that were presented within the course of projects that he wanted to implement was overcome either through creative means or brute force.

"During 2012-13 LSGI guideline did not have any references for a yoga project. But, since the idea came from a PHC staff, we kept PHC MO as its implementing officer, but it was resisted by the MO. To get approval for a yoga project itself was a big thing for us and I had sent it for vetting to the District Planning Committee (DPC). But even after many days it was never vetted and it was kept on hold for more than 20 days. So, I called that doctor and during that time our PHC MO was also a leader of the Kerala Government Medical Officers Association (KGMOA). Somehow the MO himself had called the vetting officer and asked him to keep it on hold. The vetting officer said to me that such a project cannot be taken and will have to wait" (CS2 LSGI2)

The Yoga project that he had initiated in 2012 was met by challenges in terms of opposition by the then PHC MO to act as its implementing officer. The MO had opposed since it was a new project never undertaken by an MO and hence, he was reluctant to take up its responsibility and had also put pressure through KGMOA to decline the project at the DPC.

"I had some quarrels with the vetting officer and finally he said to me that he was new and did not know how to vet such projects. So, I decided to send a team from our LSGI including our technical officer and clerk. I asked them to teach the vetting officer how to approve a new project. I cleverly asked them to take our yoga project as the sample project they need to take, while they teach the vetting officer. So, I asked them to cleverly show him to take health sector, then click next and finally when they click the

enter key a generate option will pop up and finally the option to approve. So, by the time they teach how a project has to be approved our yoga project will be approved. They did exactly that and the doctor did not notice and that way our yoga project was approved" (CS2 LSGI2)

The challenge faced from the vetting officer at the DPC was overcame by the vice-president using his clever tactics. He had entrusted two officials from the LSGI who would go to the DPC to teach the technical process of sanctioning new projects to the vetting officer. According to the vice-president they had successfully sanctioned the yoga project while they taught the vetting process through the Sulekha portal.

Similarly, the challenges he faced from the public health staff in participating with the training sessions on ISO was overcome using his authority as the LSH president. He, had used his authority as the LSGI president in issuing an order to the health staff to be present at a specific time at the PHC conference hall for training purposes. In doing so, he even asked them to keep aside their routine works at the field as he thought the Panchayat did not have much public health issues and can very well be kept aside. Similar instances were also observed against the PHC MO. When he felt that the MO was reluctant to be part of the meetings, he convened at the PHC he had summoned her to the panchayat committee for a show cause. However, when the MO again declined to abide, he decided to move a recommendation of suspension of the MO, to make her fall in line.

4.3.2.6: Project outputs

The following section attempts to locate the various projects vis a vis the various contextual and institutional dynamic specific to the panchayat. The exploration of the project did allude to influence these factors had in the shaping of the projects within the panchayat. Though the various innovative models were in fact found shaped by the contextual needs of the panchayat, they were also influenced by the unique leadership style that existed. The fact that, the male non-Dalit vice-president enjoyed complete authority over decision-making, also resulted in multiple projects that were also disconnected with the local realities. However, they all stood out in the way they were perceived as innovative by the Vice-president in Village B. However, the current

section specifically examined the social innovation project in the panchayat, 'Sayamprabha'. This section therefore examined the nature of roles various actors performed as well as the role of communities within the project. It also tried to examine the extent to which Dalit sections are included/excluded within the social innovation. The details of the project are attached under Annexure B as appendix AXIX

4.3.2.6a: 'Sayamprabha' project as a Social Innovation and why?

'Sayamprabha' as a project to deal a social issue

Any activity to be deemed as a social innovation should primarily meet two key aspects; one the activity remains an innovation and that the innovation attempts to address a social issue by the community themselves. Going by these conceptual understanding of social innovation, 'Sayamprabha' in the current study is considered a social innovation since it's an innovation that attempts to address a social issue within the LSGI region as felt by the key stakeholders. That of the issue of elderly communities and their health needs that are often unaddressed.

"Around 40% of the people here are NRIs and because of that there is an issue of them being living alone. They might not be economically poor and yet they could be alone. Also, the situation could be worse if they are also poor. So, we thought of issues that might be affecting them" (CS2 LSGI2)

"We did the project because we wanted to do something for the elderly here. If we think about this panchayat, many areas here are very interior and rural. So, it's not very developed, so we wanted to do something for them. Many are alone with their children abroad. So, when we considered all these aspects. There are many people living alone here, so it is for them we started such a club here." (CS2 ICDS1)

A common theme that stood out within the narratives on the objectives of the 'Sayamprabha' project was the priority attributed to elderly people living alone. Village B panchayat depended heavily on income from non-residential Indians from the village due to which there is a sizeable proportion of Non-Resident Indians (NRI) in the village. The panchayat had a total of 4902 individuals within the age group of 60-75 years of which 2643 were women and 2256 men. The total population of Village

B panchayat as per 2011 census was 25172, which meant that close to 20% of the population were between this age group excluding those who are above 75 years. The relatively higher number of elderly were also reflected through the presence of a relatively higher number of elderly care homes operating within the LSGI area. As per the information collected from the LSGI actors there are currently 5 major care homes for elderly as well as differently abled individuals operating within the panchayat.

'Sayamprabha' as an innovation to resolve a social issue

The implementation of projects to address the needs of the elderly was perceived by the ICDS supervisor as a commonly unaddressed issue across various other panchayats.

"Even though elderly members raise their needs through working groups, often they are not considered seriously by other panchayats. Such projects are always difficult to implement and to implement a project with all the needed components is often risky too" (CS2 ICDS1)

"In my knowledge in no other panchayat have anyone started such clubs run by the elderly themselves. Though in some panchayats there are namesake clubs not one among them are functional. In my knowledge no other panchayats have tried out such a project before" (CS2 ICDS1)

Hence in addition to being a social issue it was perceived to be an ignored area which the LSGI actors felt had to be addressed in this case, making it an innovative activity. Given the relatively higher proportion of elderly community in the region, the LSGI wanted to have a project that could specifically target their overall physical and psychological welfare.

"Somehow, I was asked to do such a project and I did it and it became 100 percent successful and turned out to be a good project. When people from Kerala Institute for Legal Administration (KILA) came here and observed the project, they found that no one else have implemented such a project and they selected our project for a state award…I have been an ICDS supervisor for the last 20 years and this one of the good projects I have been part of and I am really happy for it" (CS2 ICDS1)

Given the innovative nature of the project, it was also acknowledged by the State government and the implementation officer or ICDS supervisor in this case received the Best supervisor award too in 2019.

As a social innovation aimed at improving primary health care

Yet another dimension within the construct of a social innovation, considered within the current research was the priority attributed to primary health care through a social innovation. In addition to the context of relatively higher proportion of elderly individuals the 'Sayamprabha' project also aimed at dealing with the health of elderly members in the panchayat.

"We thought of activities that can improve the physical and mental health of our elderly citizens. Usually, it was utilised through palliative care project, but that is for bedridden individuals. But not all members above 60 are bedridden, there is a stage before one becomes bed ridden. So how can we improve their health was our thought" (CS2 LSGI2)

The project aimed at the complete emotional and physical wellbeing of the elderly between the age group 60-75 who are not bedridden. The project hence aimed at preventing the occurrence of chronic illnesses that could lead to a sedentary state among the elderly.

"Here there are many individuals who are living alone since their children are working in Gulf. They might have spent their healthy years working in Gulf or as government employees here, if not, they could have been daily wage earners. So, after so many years of hard work after sixty they might be spending their time alone at their homes." (CS2 LSGI2)

A key issue that demanded such an initiative according to the perspective of the Vice-president was the issue of loneliness among the elderly people in the region. He felt that a big majority of elderly could be leading a lonely life without someone to help them. Hence a key objective of the project was to emotionally support elderly people who may be living alone without children. According to the ICDS supervisor the project primarily aimed at the emotional and physical wellbeing of elderly people

through the provision of a common space for them to come together and share their time.

"It's objective, what the government is aiming is to resolve and prevent the abuses elderly people face either from within home from their children or from outside. Because children nowadays do not need their parents when they are old, so they exclude us. Or they will shift us to someplace else like an elderly care home. They will never bother about us after that. So, after that it's the responsibility of the care home to take care of our needs. Countries like America have centres which I think is called red cross who looks after individuals once they are 60 years and above. So, to implement something similar in our country too. So, to address their problems, needs like medicines, food and their protection, this association is for that purpose" (CS2 Dalit community2)

The narratives from elderly members largely resonated with the perspectives from LSGI actors. They felt that through the project they would be supported in their needs related to healthcare like medicines and diet. However, a major theme that stood out within the elderly members' narratives was the idea of a safety and abandonment and the hope that the project would try to address these concerns.

4.3.2.6b: Key actors and their roles within 'Sayamprabha'

Actors from LSGI and their roles

LSGI Vice-President as the most prominent actor and decision-maker

As outlined above, the most dominant actor from LSGI with respect to 'Sayamprabha' project was the LSGI Vice-president. His name appeared throughout the narratives on the project by almost all the actors involved in the project.

"It was with the Vice-President with whom I discussed this first. We used to convene committee meetings and he was usually the most active person in the committee meetings. Decisions are usually taken by him" (CS2 ICDS1)

"It was only because of him we implemented such a project, that I am sure of. No one else will take such a risk" (CS2 ICDS1)

The LSGI vice-president was the first point of contact for the ICDS supervisor when she wanted to discuss about the need for such an activity in the panchayat for the elderly community. She felt that he was a creative leader and was the reason for such a project.

"He (Vice-President) thought that there should be some activity for the welfare of the people here, especially for the elderly members. So, for their welfare, to make their life secure that was the main objective. So, this senior citizen association or elderly club was the first association in India in a panchayat and its name is 'Sayamprabha'" (CS2 Sayamprabha member1)

His involvement as a key decision-maker and his leadership in the project was evident within the perspectives of its implementing officer as well as by members of 'Sayamprabha' project. The project was thought of as his vision for the elderly in the panchayat and the reason for such a project by the leader of 'Sayamprabha' in Village B.

LSGI Secretary as a key support

"After the initial discussions it was me, vice-president and secretary who decided the activities" (CS2 ICDS1)

"Secretary used to come and attend all our meetings, that was a specialty. Normally LSGI secretaries don't attend all the meetings by different implementing officers. But in our case madam used to come for all activities, even to the medical camps. She gave us her complete support and she was there throughout with me in this project" (CS2 ICDS1)

LSGI secretary was found to have played a supportive role in the planning and implementation of the project as felt by the ICDS supervisor. She was a key actor in terms of the initial project planning activities through the support she provided to the ICDS supervisor. It was also felt by the ICDS supervisor that, unlike in other panchayats the LSGI secretary in Village B was particularly supportive even during the implementation of the project through her constant presence in activities like

medical camps. She felt that the positive support provided by the secretary had significant role in the successful implementation of the project.

Limited roles by LSGI President and other ward members

"The first step we took was to convene all LSGI representatives so that we can inform the project idea to all of them. We also wanted to discuss with them so that we can plan how the project could be implemented. So, for this we fixed a meeting of all representatives at a hall in the panchayat and all representatives had come to that meeting. We informed them that we were planning to implement such a project" (CS2 ICDS1)

Once the idea of the project evolved, the first activity that was planned was a meeting of all LSGI representatives to discuss the actual implementation as well as possible strategies for the project. LSGI members were hence made a part of the project planning before its implementation in the panchayat.

"It was always they both (ICDS Supervisor and LSGI Vice-president) who decided things. I was only supposed to sign things and never needed to know anything was the way things were done." (CS2 LSGI1)

"LSGI President used to come to all our meetings. Also, she was the main person who passed information to other members, and I communicated everything to the president. If there is a meeting in connection with 'Sayamprabha', president was the person who communicated things to others, and she came correctly to all meetings and made others attend too. So, we had her total support" (CS2 ICDS1)

Though LSGI representatives were part of the planning processes, their actual role including that of the LSGI president and other ward members seemed to be limited. The narratives on LSGI president and other members alluded to the fact that their roles were limited to their support in functioning of the project rather than them being part of the decision making of the project. The role of president was seen to be one of communication and coordination rather than playing a role in planning of the project.

"Our President was a new person and she did not know things well. Vice-President was really smart and he was also the LSGI President in his previous term. Not only

that since he was the member of District Planning Committee, he knew such things better" (CS2 ICDS1)

This was also reflected in the way ICDS supervisor talked about the role of LSGI president and other ward members in the project. She thought that the president was new and hence her knowledge in such activities were limited. Similarly, though ICDS supervisor perceived that she had the support of all LSGI representatives, her narrative clearly pointed to the role of vice-president the most among them.

Actors from ICDS department

ICDS Supervisor as key champion of the 'Sayamprabha' innovation

"When I got the initial thread for the project, I immediately discuss with people who are close to me. So, in this case I discussed it with the then ICDS supervisor. She was the implementing officer and I discussed with her" (CS2 LSGI2)

"The project report and deciding the name of the project were mainly decided by me and vice-president" (CS2 ICDS1)

The vice-president felt that ICDS supervisor was the first person with whom he discussed the idea when he thought of it. This was also reflected in the way how the ICDS supervisor narrated her role in the project, where she thought she and vice-president discussed the initial idea as well as during the project preparation.

"When Aravind hospital was willing to be part of the project on their own we then tried for their dates. If they are coming all their expenses would be met by them and we did not have any major financial burden. But when all of this was being planned the then implementing officer got transferred. The new person was not that much interested in the project, so then we moved on with other projects" (CS2 LSGI2)

The role of ICDS as a key pillar within the implementation of 'Sayamprabha' project was evident when vice-president thought that the project got stuck when the ICDS supervisor got transferred. He felt that the new supervisor had low interest for the project which resulted in lack of further activities for the project.

Anganwadi workers as implementation partners

The whole project was conceived and implemented as an ICDS project and hence anganwadi centres were the nodal centre for individual 'Sayamprabha' clubs at the grassroot level. Hence anganwadi teachers played a major role in facilitating the elderly clubs at the anganwadi centres as well as provide the needed assistance for the elderly members in coordinating their club activities.

"Along with the LSGI representatives, we had also invited anganwadi workers in the initial planning meeting for the project. It's through anganwadis we are implementing the complete project, so we had also called them for the meeting with LSGI representatives" (CS2 ICDS1)

Anganwadi workers were involved in the project right from the planning phase of the project. Since they were the nodal officers for the grassroot level elderly clubs they were also part of the project planning phase.

"Anganwadi teachers did not personally go for the household survey collection. But they helped us in explaining the forms to the elderly people and the way in which data has to be collected by the elderly members. This help was given to us by the anganwadi teachers" (CS2 ICDS1)

"Anganwadi teachers have the information on the households with members above 60 years in their area. Because they have this information already in their registers. So, this information was provided by the anganwadi teachers to aid the household survey collection" (CS2 ICDS1)

During the initial survey conducted in Village B anganwadi workers played a key role in terms of facilitating the survey activities conducted by the elderly. They provided the members with the needed training to conduct the survey. In addition to the training part, they also provided the needed information related to the household level data available at anganwadi on individuals above 60 in their area. The final collation of the survey data within the anganwadi done by the elderly were also performed by the anganwadi workers.

"Anganwadi teachers too were a major partner in this project. These elderly clubs are normally convened after 3.00 PM, so from 3.00 – 5.00 PM the teachers and anganwadi helpers will remain at the anganwadi to facilitate these clubs" (CS2 ICDS1)

Yet another key role anganwadi workers played in the project implementation phase was to facilitate the anganwadi level 'Sayamprabha' club meetings by the elderly individuals. They played a key role in reminding the 'Sayamprabha' members about the monthly meetings as well as involve in their club activities.

Actors from health sector

Limited roles of FHC staff within implementation

The role of health staff was primarily limited to the implementation phase of the project with little involvement during the project planning.

"Every club was asked to select 5 deserving individuals to be provided with nutrimix powder. This selection was done by a team of actors including club leaders, anganwadi worker, ward member and they also shall be certified by the medical officer too. When we conducted the medical camps the PHC MO had detected individuals with malnutrition and they were also considered. Only those who were certified by the doctor received the nutritional support" (CS2 ICDS1)

"Other than the medical camps they would come if there are any special meetings in relation to the project, only that…specifically if there are any requirements at the 'Sayamprabha' clubs at the anganwadis. If there are any special requirements for these clubs and if they are requested by the anganwadi teachers, they would go there and conduct awareness classes on health either JPHN or the MO" (CS2 ICDS1)

Health staff including medical officer as well as field health staff were involved in activities like conduction of the medical camps as well as to provide awareness sessions for the elderly at the anganwadi. Medical officer from the FHC was primarily involved in certifying individual who they thought required nutritional support so that LSGI can provide them with nutritional support through the anganwadis.

Role of community mostly limited within implementation

Elderly members within the implementation of project

A key aspect for an innovation being considered as a social innovation is how a specific social issue in question is resolved. Often social innovations involve solutions for any given social issue addressed by individuals who are affected by the issue themselves. In the specific context of decentralisation in Kerala, often projects are implemented with LSGIs as authority. However, unlike other panchayat projects the way in which elderly members were partnered with the 'Sayamprabha' project allows it to be considered from the lens of a social innovation.

Need assessment survey of the elderly people by the elderly people

Right from the beginning phase of elderly members were involved within the project

"The issues that the elderly members face cannot be understood through any panchayat committee. This information should come from the elderly people themselves and there should be a team to gauge their needs. Given our current situation staff from the LSGI cannot be entrusted with additional responsibilities. So, we thought it would be best if the elderly people themselves form a team and capture their own needs through a survey" (CS2 LSGI2)

"The household survey was collected by the local club leaders and we had suggested to them that whoever was willing to join can also go for the same. In some clubs they had even split into two or three groups with specific areas assigned to these groups. They did this in various ways…and it was a great success, all the survey forms were properly filled and returned to the anganwadis" (CS2 ICDS1)

The LSGI leadership wanted the project to be finalised - in terms of the various activities to be included in the project - only after a comprehensive need assessment of the elderly people in the panchayat. The key aspect of the survey was also how the decision to entrust the responsibility of conducting the survey to the elderly people themselves. According to the opinion of the LSGI vice-president this was also partly because the LSGI did not have the manpower needed to implement a panchayat level

survey on their own. The various elements of the project were then finalised by the LSGI based on the various needs identified through the survey among the elderly.

Anganwadi level clubs managed by the elderly people

Yet another major aspect was the formation of elderly clubs at the anganwadi centres which were also managed by the members. These clubs were entrusted with the responsibility of selecting their own leadership through a president, secretary and treasurer.

"After the formation of elderly clubs at the Anganwadis we selected of local president, secretary and treasurer for the clubs. So, from among them those who were healthy enough to travel were assigned to collect information in their locality through the household survey. They were provided with the survey forms through the anganwadi teachers." (CS2 ICDS1)

"There were good discussions on the project by involving members from all wards based at the anganwadi at our grama vijnana kendra hall. All its activities were discussed very well by individuals from all 17 wards. These clubs had their own president and secretary and there was also LSGI level president and secretary and anganwadi teacher was its convenor. ICDS Supervisor was its main implementing officer" (CS2 LSGI1)

In addition to the anganwadi level clubs, a higher panchayat level club was also formed with a panchayat level president, secretary and treasurer. The elderly members through such societies and a hierarchical structure had the space to better voice their opinions and needs directly to the LSGI as well as realise them through the project.

4.3.2.6c: Key triggers for 'Sayamprabha' in Village B

Need felt for innovative use of the mandatory elderly care fund by Vice-president

A key aspect in terms of the evolution of the 'Sayamprabha' was the plan fund available for elderly, children and disabled within LSGI. However, the conventional ways in which they were utilised across panchayats in Kerala in fact acted as a trigger factor in the case of Village B in developing such a project. The availability of this

fund and the need to make use of this fund in a more useful way for the elderly felt by few LSGI actors led to the innovation itself.

"Normally 10% of the plan fund earmarked for elderly and children and differently abled are utilised through palliative care projects by most of the LSGIs. Once utilised through palliative care then there is no other tension. It is very clear which projects to be taken or not taken and implementing officers are also safe. So lately there was a notification that palliative care projects will not be considered within this head of funds. So then other panchayats when thought about utilising this fund, many thought of purchasing cots for the elderly. But we showed a lot more involvement and thought about activities that could improve the physical and emotional wellbeing of our elderly community" (CS2 LSGI2)

Championing of the elderly cause by ICDS supervisor

The main trigger for the project was a felt need among elderly community to have projects that could meet their special needs, which were expressed through working groups and development seminars. Based on the narratives, these needs were problematised and highlighted to the panchayat authorities by the ICDS supervisor, which ultimately led the LSGI to initiate 'Sayamprabha'.

"The idea for this project came from our own working groups and development seminars. When we convene panchayat working groups or development seminars, we come across many needs from the part of the elderly members. When individuals above 60 years come to the meeting, they normally write to us their special needs. Needs like they need medicines or an opportunity for them to meet their peers and share a common space. So, all these ideas came from such working groups and development seminars which ultimately resulted in this 'Sayamprabha' project" (CS2 ICDS1)

According to the ICDS supervisor, the basic trigger for the project was the felt need from among the elderly members as well as her commitment to do something for the elderly. In addition to the existing unmet needs of the elderly community, yet another factor was the conventional ways in which LSGIs utilised the funds available for them. As an implementing officer she felt that often the plan funds available for elderly,

children and disabled were utilised by LSGIs mindlessly. Across the State the usual convention was to achieve the utilisation of the plan funds by purchasing cots for elderly individuals which she felt was often not useful for all. She felt that elderly care activities are often a neglected area in most panchayats and strongly felt the need to do something meaningful for them. Hence, a key trigger within this narrative was a need felt by the implementing officer to break the pattern in the conventional utilisation of plan funds and use them for real needs of elderly communities.

Inspiration from elderly welfare policies and innovative models existing in the State

A key aspect to be read along with the ‘‘Sayamprabha’’ innovation in Village B is its uncanny resemblance to the already existing patterns of elderly care projects in the State. In 2018, the Social Justice Department, Government of Kerala, released a policy document under the same name of ‘‘Sayamprabha’’ as part of its larger ‘Kerala Vayojana Nayam’ or Kerala Elderly Policy, 2013. The ‘Sayamprabha’ innovation examined in the study clearly draws inspiration from the stated strategies listed under the ’’Sayamprabha’’ initiatives of the Social Justice Department. Specifically, aspects related to formation of ‘model ‘Sayamprabha’ homes’ for elderly members above 60 for elderly meet and greet in all panchayats. Strategies like provision of free glucometer for elderly, medical camps for them were also some of the similar schemes that were experimented in the ‘Sayamorabha’ innovation in Village B (*Sayamprabha Major Initiatives 2018-19,* 2018).

Yet another way, the ‘‘Sayamprabha’’ innovation seems to have taken inspiration is from already existing and award-winning innovations from other panchayats. The literature review on elderly models in the State suggest to similar elderly care models like the ones in Manikkal panchayat in Thiruvananthapuram District, Kerala. For, Manikkal Panchayat is a recognised grama panchayat in Kerala through its achievements like Swaraj trophy for best LSGI in 2014-15 and second place in the subsequent year for its innovative projects which also included its projects that made it elderly friendly. The innovative elderly care project in Manikkal too, included strategies like elderly survey in the panchayat and formation of ‘Vridha jana sabhas’

or elderly forums, similar to that of the elderly societies under the ‘‘Sayamprabha’’ innovation(*Swaraj Trophy 2014-15- A Case Study of Manickal Grama Panchayat in Thiruvananthapuram District*, 2016).

This was found a key trigger and inspiration for the ‘Sayamprabha’ innovation in Village B, not just for their similarities, but also given the finding in terms of the interactions and engagements between various key actors from both panchayats. The Vice-president, Village B given his key role in CPI(M) party leadership and through his membership in District Planning Board was found to maintain a close relationship with one of the key functionaries at Manikkal Panchayat who historically championed these innovative models. He himself was also affiliated to CPI(M) as well as through his role in Kerala Institute of Legal Administration (KILA) and Kerala Shastra Sahithya Parishad (KSSP). The interaction of the researcher with both these individuals did reveal the close relationship they maintained over the years which also would have inspired the ‘Sayamprabha’ innovation in Village B.

4.3.2.6d: Leadership of ‘Sayamprabha’ project provided by the male vice-president

The examination of the leadership of the project did suggest to a continuation of the pattern of leadership similar to all other projects in Village B. In ‘Sayamprabha’ too, the project was implemented under the leadership of the vice-president as felt by other actors involved in the project.

“Only because he was there, we could implement such a project, that I can vouch for. No one else would have taken such a risk” (CS2 ICDS1)

The ICDS supervisor who was in charge of implementing ‘Sayamprabha’ project strongly felt that the whole project was realised only due to the capable leadership of the LSGI vice-president.

“During the conduction of the medical camps, it was the Vice-president who coordinated all the ward members. He delegated responsibilities of various camp sites to various ward members, delegated the responsibility of arranging food to 4 ward members through a meeting prior to the camps. Similarly, 3 members were given the charge of coordinating with the doctors for the camps, so we never had any

obstructions in the functioning of camps. I only had to arrange the camps and on the day of camps we did not have any issues as he will give charge to people for each and every thing." (CS2 ICDS1)

Her narratives on the leadership of the LSGI vice-president was reflected in the ways in which he organised the medical camps as part of the 'Sayamprabha' project. The project involved three medical camps across three different sites within the panchayat. However, she felt that on the day of the medical camps the leadership of the vice-president helped her vastly in the smooth functioning of the camps. He meticulously delegated individual responsibilities within the projects to various LSGI members which resulted in successful completion of the medical camps for the elderly.

"Some kind of award, I don't know exactly what award it is, and to receive it when our vice-president had gone. It was from there such an idea came that we should start a project called 'Sayamprabha' and that there should be an association for people above 60. Village B is the first panchayat that received an award for this project and the vice-president is the person who started this" (CS2 Sayamprabha member5)

When explored about how the idea of 'Sayamprabha' in its current form evolved through interviews with various actors within the project, the dominant name that emerged was of the LSGI vice-president. The picture that emerged from these narratives were one of a creative leadership and a talented individual who have received national acclaim for the panchayat through his skilful leadership.

The vice-president's ability to overcome challenges as a major facilitator for the project

During the implementation of 'Sayamprabha', the vice-president's narratives reflected how he strategized the whole project so that it does not end up as small project limited by the fiscal capacity of the LSGI.

"Like I told you even though there are multiple components within this project, the LSGI does not have that much of an expense. While we take up some activities from plan fund, we also integrated sponsorship from outside so that it became a big project. So, 'Sayamprabha' is a project like that and in that sense, it was also a pilot project

for the entire State. Now many are learning from this and implementing in their panchayats" (CS2 LSGI2)

"We have a certain amount as LSGIs own fund, but that could not be used up just for the medical camps. Not only that there are many agencies that are ready to involve in charity activities. In our case organisations like Aravind eye hospital was ready to come on their own, so we tried for their dates. When they come for a medical camp all the expenses would be met by them and panchayat will not have any financial burden" (CS2 LSGI2)

A major challenge felt by the LSGI leadership was lack of sufficient funds to implement a good project for the elderly. However, a big proportion of the fund requirements for the 'Sayamprabha' project was met through voluntary contributions. Components like day trip for the elderly as well as provision of spectacles for the elderly were funded using the corporate social responsibility (CSR) funds of Joy Alukkas foundation. So, as per the narratives of the vice-president the whole project was made bigger than what an LSGI could realise was due to his personal clout as a politician which enabled him to attract funds from outside.

4.3.2.6e: Summary of key factors and pathways that led to the emergence of 'Sayamprabha' project in Village B

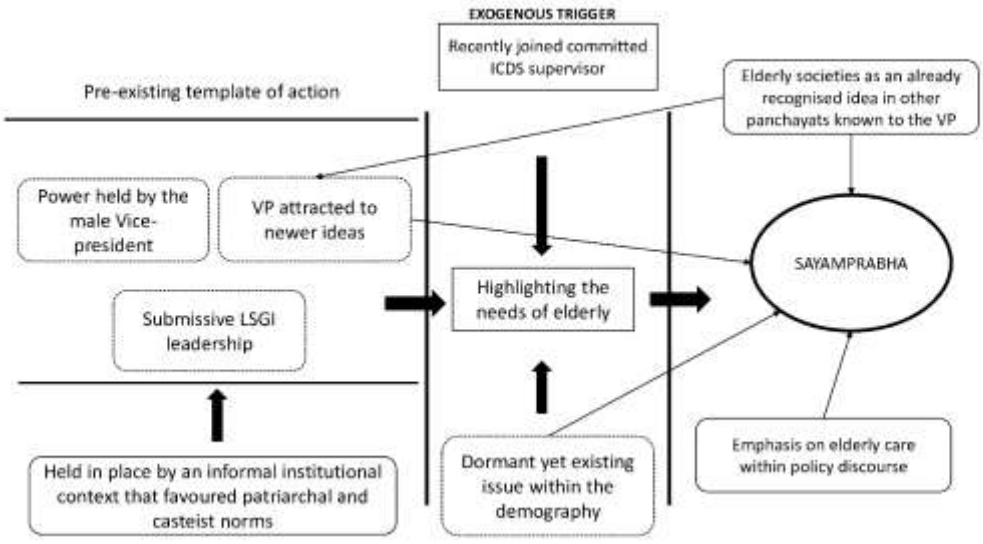
The emergence of 'Sayamprabha' project in Village B could therefore be deconstructed into three key aspects

1. **The unique strongman leadership style that existed in the panchayat:** A strongman leadership style that has been in existence in the panchayat over the last decade. One that was sustained through the strong yet exclusive informal institutions that strictly favoured patriarchal and casteist norms. This meant that the non-Dalit male vice-president was preferred over a Dalit female president by the CPI(M) leadership in the panchayat. This strongman leadership style was rarely questioned or challenged and the ones that did was struck down or expelled from the LSGI leadership structures.
2. **A committed ICDS supervisor as an external trigger:** In the case of Village B, the presence of ICDS supervisor could be located as an external trigger to

the aforementioned leadership structure. The ICDS supervisor through her efforts in championing the causes of elderly in the panchayat and through her ability to convince the vice-president laid a conducive context for a project that could resolve the issues of elderly in the panchayat.

3. **Elderly care societies with participation of elderly as an already acknowledged idea:** A crucial factor that further influenced the emergence of 'Sayamprabha' with its unique nature of elderly partnered approach was also the existence of similar models in other panchayats. In this case, an already acknowledged and rewarded model in terms of being innovative. Also given the fact that, this was a model familiar to the vice-president in fact meant that, elderly care society was a potential choice of action for Village B. This was further made possible also given the unique style of action that the Vice-president has been following over the years. For, he often chose new yet normally perceived as 'risky projects' by other LSGI leaderships, making Village B a popular model across India as well as in Kerala. This along with the policy impetus on elderly care in Kerala ultimately resulted in the emergence of the 'Sayamprabha' as a social innovation in Village B

Figure 4. 3 Representation of key factors and pathways of 'Sayamprabha'



4.4 DALIT INCLUSION WITHIN THE SOCIAL INNOVATIONS EXAMINED

A key area of inquiry within the current research is the dimension of inclusiveness within social innovations for health in village panchayats under the study. The inclusiveness within the current research primarily focuses on the inclusion of Dalit communities. The case studies were also selected in such a manner that they aid the exploration of the dimension of inclusiveness of Dalits within the selected social innovations for primary healthcare. The exploration of inclusiveness of Dalits within the 'Sayamprabha' project was attempted using the framework of Heek's ladder of inclusiveness approach. This framework delineates between 6 different degrees of inclusiveness of marginalised or vulnerable sections within innovations or social innovations in the case of current study. Based on this framework and also informed by the IAD framework the current study has hence attempted to explore inclusiveness of Dalits from a post-structural level of inclusion till their inclusion at the lowermost level or inclusion of intention.

4.4.1: DALIT INCLUSION WITHIN THE PROCESSES OF 'I CARE WE CARE' CAMPAIGN & FACILITATION OF HEALTH NEEDS OF DALITS IN VILLAGE A

4.4.1.1: Background details of Dalits in village A

Based on the census 2011 data, the total number of Dalit population in Village A was 4638 out of the total population of 52417. Based on this information the proportion of Dalits in Village A is around 9% in Village A. However, based on the updated information as per the 'Vikasana rekha' of Village A LSGI, the total population of Dalits was 6034 out of a total population of 61326 (10%). Among the total Dalit population 48% were women.

Table 4. 3 Socio-economic status of Dalits in Village A (SECC, 2011)

Total HH	**Total SC HH (%)**	**HH with at least one govt employee (%)**	**HH with any member earning <10000/m (%)**	**HH with 3 or more rooms with pucca walls and roof (%)**
13904	1351 (9.72%)	116 (8.5%)	117 (8.6%)	476 (35.23%)

Data from the Socio Economic and Caste Census, 2011 suggests to the poor economic context of Dalits in Village A, where a majority household lives within a meagre income.

Table 4. 4 LSGI developmental report, 2017-22 from Village A

Total SC HH	**HH with water scarcity for <6 months**	**HH with non-functional toilets**	**HH with no own home**	**HH with no own land**
1527	600 (39.3%)	8 (0.5%)	99 (6.4%)	115 (7.5%)

A similar picture is also reflected within the developmental report of Village A which portrays the poor housing situation of Dalits within the panchayat. An overwhelming 39% of the Dalit household still lacks access to drinking water for more than 6 months in the region. In addition, there are still Dalit households that lack a functional toilets and large number of households lack an own home or land in the panchayat.

4.4.1.1a: Livelihood and unemployment challenges among Dalits

The interviews with Dalit members of the community suggested to the poor livelihood issues that existed within the community.

"Here people go for different jobs, there are people who do cobbling, who go for coolie work. Women mostly work as domestic aids at homes and many people like us are engaged in NREG jobs. Males are mostly coolie workers and there are also people who go for log cutting or masonry" (CS1 Dalit community3)

The majority of Dalit sections in the panchayat seemed to depend on meagre jobs for their livelihood. Mostly coolie jobs with a minimum income available for them. The field observations by the researcher as part of the case study suggested to the poor conditions of Dalit colonies with crammed housing and congested walk ways. Many houses were old structures and had multiple members of the household living together in small spaces. The members who received government housing support had houses that were only partially completed and yet inhabited. The lack of sufficient livelihood is also reflected as challenges in employment among the younger generations of Dalit communities in Village A.

"Even educated members among us are forced to go for coolie jobs. They go for daily wage jobs in commercial establishments here. They are all well-educated children. At that house (pointing to a house) there is a girl and she has completed B.Ed degree and yet she is going to a textile shop and there are many like her here" (CS1 Dalit community4)

The narratives of Dalit members suggested to the issues of unemployment that existed among Dalit youths in the Panchayat. Many young members of the Dalit community, though had higher degrees are forced to work as daily wage labourers since they did not have enough money to search for and acquire a job. Households who wished to support proper education of their children were forced to take high interest loans adding to their financial burden and many often ended up defaulting on their loan repayments. Lack of economic stability has been preventing many households from

supporting the education of their kids. The community had many youths who were unable to complete at least higher secondary level and hence jobless.

4.4.1.1b: Waste management challenges within Dalit settlements

Yet another issue that Dalit settlements in Village A faced was the issue of waste and its disposal. The lack of sufficient housing space is also reflected as inability to dispose waste hygienically which have been a persisting issue within Dalit colonies.

"We have asked the LSGI to find us a space to dispose of the waste from our area. Now we are throwing waste here and there and in open spaces. Our houses are situated within a small area of 2 cents, so many often burn their waste within their area and many throw the waste in the open. Mostly it is food waste though there is also plastic waste. LSGI is asking us to reduce waste generation and reduce wastage of food, but doesn't all that have a limit. And they also feel that if they allot us a space to dispose waste they fear if it could become a social menace as this is a colony area" (CS1 Dalit community6)

Since a majority of the Dalit households are located within a limited space of less than 2-3 cents, disposal of household waste remains a challenge. Though these issues have been raised repeatedly through different spaces available within the LSGI, there has been no major intervention from their side. This situation has forced most of the households to dumb waste in available spaces or burn plastic and non-plastic waste leading to associated health hazards within Dalit colonies. However, the narratives of the community allude to the reluctance by the LSGI to address the issue of waste in Dalit settlements. Solutions including provision of waste disposal spaces have not been implemented by the LSGI as the Dalit community felt that since it was a colony the authorities perceive that it could lead to further issues.

4.4.1.1c: Water scarcity in Dalit areas

As was pointed out in the LSGI development report, a major issue that Dalit settlements in Village A faced was the scarcity of water. More than 600 households in the region did face drinking water shortage for more than 6 months of the year.

"The most serious issue that we have now is drinking water shortage and it is the most worrying thing for us. One reason for this is because ours is a geographically higher location. So, even if water is supplied to all the 23 wards from the big water tank it does not reach here as the motor is not powerful enough…Though every household have pipe connection now, and many have installed them on their own. But the issue is that water only comes during night hours and to collect it we need to be awake at that hour. So, we normally collect water in bug buckets" (CS1 LSGI5)

Though piped connection is made available in most of the areas within SC colonies, water availability or water pressure remains limited. This has forced the community members to collect water and store them for daily use.

4.4.1.1d: Higher rates of CDs in Dalit colonies

A major issue that existed within many Dalit colonies in Village A was their tendecy to have higher rates of communicable diseases compared to other areas.

"We have many colonies in this panchayat and there is a marked difference in CD cases in colonies compared to others…we have a pattern of higher dengue cases in colony areas. A while back one of the colonies was the key area for dengue in Village A. We had to put a lot of effort to somehow resolve that issue finally. But now it's slowly improving, there is a colony called Manjancodu colony near the corporation area. That is a notorious colony and it is slowly developing now. Based on that colony there is a pattern of higher dengue cases." (CS1 PHC2)

Health staff felt that, Dalit colonies compared to other areas have higher rates of CDs, specifically that of dengue. It was felt that Dalit colonies are often the hub for such cases in Village A. This high rates of CDs in various Dalit colones have warranted prioritised efforts from health staff to control their numbers.

4.4.1.2: Extent of Dalit inclusion within various aspects of 'I care we care' and the facilitation of health needs of Dalits

4.4.1.2a: Dalit inclusion within the objectives of 'I care we care'

A basic level of inclusiveness is the inclusion within the objectives of any social innovation. The exploration of the 'I care we care' campaign and its objectives suggest that a key aim was to prevent the occurrence of communicable diseases in the panchayat. Specifically given the context of covid related lockdown and the constraints on the available health staff to perform responsibilities beyond covid related ones.

Unconscious/partial inclusion of Dalits in the objectives of innovation

The dimension of Dalit inclusivity in the context of 'I care we care' campaign was approached from an indirect angle in the Village A case study. This was done because, the narratives on the campaign and its objectives by the interviewees never explicitly refers to any specific community including Dalits or non-Dalits. Going by the basic premise of the campaign objectives, that is reduction of CDs in the panchayat, it suggests that there were no obvious caste-based exclusions within the objectives of the campaign. Because, as part of the campaign the plan was to survey all households including Dalit households for hygiene related aspects.

Missing narratives of waste and water as a major challenge within Dalit colonies among LSGI actors

Though waste management was a longstanding issue within Dalit settlements and a prominent reason for communicable diseases, they were missing within the narratives of waste issue among LSGI leadership. This was also cited by health actors in Village A

"Colonies have an issue of waste disposal and they currently do not have a system to process their waste. They also do not have a proper space to dispose waste and this is a major reason for health issues" (CS1 PHC2)

Health staff felt that given the high density within colonies as well as limited space available for them for proper waste disposal has led to a higher risk of outbreaks within

Dalit colonies. However, the issue of waste was perceived from a different angle by the LSGI actors. The narratives on waste management as a challenge by LSGI actors mainly revolved around the issue of waste dumping along the main roads within the panchayat region, as well as waste-water outlets along the Killiyar river. Waste and related issues of dumping of waste was seen as an issue that affected the entire panchayat. The idea that it might differentially affect scheduled caste colonies due to their limited housing space was seldom present within their narratives.

Similarly, the issue of water scarcity in Dalit colonies were completely missing within the non-Dalit LSGI leadership in Village A. They were mentioned only by the Dalit LSGI president and by the Dalit ward member and the remaining interviewees never mentioned water as an issue in the panchayat. On the contrary the narratives tend to suggest that LSGI has done everything for the water requirements for the members of the Dalit community in the panchayat.

"We have done everything for the scheduled caste communities. We have provided home maintenance funds, funds for roofing. We constructed toilets for them to prevent open defecation, we are providing them free electricity. We gave them free water connections, and gave them water tanks. We gave cots for bed-ridden patients, palliative care and everything. Even then all their funds are not being completely utilised" (CS1 LSGI2)

There was a sense of total complacency among these narratives as if LSGI has done everything that could be done for the Dalit community. There was a sense of achievement that even after doing everything possible for them the funds for SC are still under-utilised. These narratives by non-Dalit LSGI leaders subtly tend to establish a strong binary of 'we' (non-Dalits) and 'them' (Dalits). Reading from such a binary position is the dominant theme of 'Benevolence shown to the Dalits', suggested by the words 'we have given them', giving them everything for 'free'. Such perspectives on Dalits are in a way are obfuscating the actual issues faced by Dalits among the non-Dalit communities and leaders including the issue of drinking water shortage among Dalit settlements.

Disconnect between objective and the strategies adopted to meet the objectives

However, the very objective of the 'I care we care' campaign being prevention of communicable disease, the strategy adopted to achieve the objective in Village A was a universal cleaning drive. This suggests a larger disconnect between the disease and their determinants in the panchayat. Because in Village A, what was unique was the obvious link between the incidence of communicable diseases and Dalit colonies. The narratives among health staff in Village A suggests to the differential rates of communicable disease incidences among Dalit and non-Dalit areas.

"We have some 2 to 3 colonies here, IHDP colony, harijan development colony. Also, there are some in maruthoor, then there is manjancodu colony. The main issue in these areas is a difficulty to dispose of waste, and there is an issue of water too. So, in these areas we give specific attention to reduce water related issues. Because, due to water shortage they store water in containers and that leads to mosquito breeding and also dengue incidences." (CS1 PHC1)

They felt that Dalit households had a longstanding issue of waste management, water shortage and differential rates of CDs compared to non-Dalit areas within Village A. These points to the obvious challenges that exists in Dalit settlements in Village A when it came to prevention of communicable diseases. Public health staff too felt that some Dalit colonies in the panchayat had higher rates of CDs in Village A.

However, such a differential rate of CDs and its determinants in Dalit settlements were missing within the narratives of 'I care we care' campaign by GPK and LSGI leadership. The issue of waste as well as communicable disease were perceived as a general issue and ultimately fails to acknowledge the specific experience of Dalits in Village A. The issue of waste was mostly seen as dumping of waste along public roads and in water bodies by LSGI actors. Though a challenge in its own right, they however largely exclude the Dalit communities' experience in dealing the same issue in terms of lack of space to dispose waste as well as limited availability of drinking water.

"We have asked the LSGI to find us a space to dispose of waste from our area. Now we are throwing waste here and there and in open spaces. Our houses are situated

within a small area of 2 cents, so many often burn their waste within their area and many throw the waste in the open. Mostly it is food waste though there is also plastic waste. LSGI is asking us to reduce waste generation and reduce wastage of food, but doesn't all that have a limit. And they also feel that if they allot us a space to dispose waste they fear if it could become a social menace as this is a colony area" (CS1 LSGI5)

This disparity between Dalit and non-Dalit households in terms of basic infrastructure to handle waste as well as maintain hygiene was also obvious through the scoring pattern within the campaign.

Table 4. 5 Scoring pattern of Households based on Phase I survey for cleanliness in 'I care we care'

	Ward numbers	Number of HH with least hygiene score (2 stars)	Number of HH with most hygiene scores (5 stars)
Wards with the greatest number of Dalit HH	11, 20, 21	94	629
Wards with least number of Dalit HH	1, 2, 14	48	772

Though the exact caste status of the households could not be identified, the data on hygiene score of individual households after phase I survey was available. Based on the aggregate of number of stars assigned for households in each ward it could be suggested that wards with maximum number of Dalit households had almost twice number of least stars (2 stars) than the wards with minimum number of Dalits. Similarly, the number of households with most stars (5 stars) were also less in wards with maximum number of Dalit households in Village A. These tend to suggest the poor housing status of Dalit households compared to non-Dalit households in Village

A. Also, as evident from the narratives of health staff above, the issue of waste disposal within Dalit colonies have been a longstanding one and yet without much initiatives to address them by the LSGI.

Hence, while being included and considered as part of the household surveys, they are also being excluded as a group that might warrant priority action by the LSGI. By adopting a universal strategy common to all households irrespective of the social location, Dalits are in a way kept outside from the larger discourse on hygiene and communicable diseases in Village A. Hence, the nature of inclusiveness within 'I care we care' could not be termed as a conscious inclusion but rather as an accidental or partial inclusion by the LSGI, GPK and health leadership.

4.4.1.2b: Extent of Dalit inclusion within the utilisation of 'I care we care'

A higher level of inclusion when it comes to inclusion of marginalised communities and innovations are the way in which they are included within the consumption of innovation and its benefits. Consumption in the case of 'I care we care' could be seen as the inclusion of Dalit households for survey and other community driven activities through the campaign.

Exclusion of certain Dalit colonies from phase II and phase III survey

Given the campaign objective of reaching all households as part of the aim to reduce the occurrence of communicable diseases, Dalit households were included as a key section within "I care we care'. All Dalit households were included in the phase I survey by community level volunteers. However, exploration into the various key activities as part of the campaign including phase II and III survey indicated an exclusion of Dalit colonies.

The phase II and III surveys were exclusively conducted to determine the households that had the best scores based on the 'Aardra bhavanam' concept of the health department. As part of the survey, they had applied a questionnaire that also included various additional components including diet, lifestyle, mental health along with environment hygiene. The households for phase II and III were selected based on the

scores received during the phase I survey of the campaign. Only those households with maximum stars (5 stars) were selected for the later surveys by health department staff.

"We did not give such a priority to colony areas and besides doing such an activity based at colonies was also impossible. The government's policy itself is to reduce colonies in the state. So, the idea was to identify households that maintained maximum hygiene within their existing space and resources and for that we can also include some colonies. There are some colonies that maintain at least some level of cleanliness. But in some colonies, it is impossible for us to survey, scoring for them is not possible and it is not a living situation that we can encourage too. So, we only took other households, such colony areas were excluded and it is also the policy of the government too. But we had conducted all other activities including phase I survey, but they fell too low in terms of their scoring." (CS1 PHC2)

Senior health leadership perceived that a survey like 'Aardra bhavanam' was impossible to be conducted in certain colonies in Village A. It was also felt that some colonies had very poor living conditions and they were excluded from the phase II and III survey as it would be a sort of encouragement of such spaces if they were considered for scoring. It was also justified by stating that the policy of the State government was also to reduce colony spaces and hence excluding them was only natural for a survey like 'Aardra bhavanam'. Hence, some Dalit colonies in Village A that were deemed to be very poor were excluded as part of the Phase I and III 'aardra bhavanam' survey by ASHAs and field health staff.

4.4.1.2c: Extent of Dalit inclusion within the impact of 'I care we care'

A key level of inclusiveness within innovations is the ways in which marginalised sections are included in terms of how they are impacted from the innovation. Though the usual sense of impact tends to be the assessments in terms of improvements that beneficiaries of any given project achieve in the long term. These could also be improvements in productivity or welfare for marginalised sections. However, impact inclusion could also be assessed in terms of equity, where sections that need prioritised attention receive better availability of the benefits of innovation.

Approaching the ‘I care we care’ project from an equity perspective, in the context of inclusiveness assessment in Village A suggests that its impacts were exclusive to Dalits. To be an innovation that would have provided an impact that was inclusive for Dalits, it had to have components that targeted Dalits and their issues in Village A. The perspectives of LSGI and GPK failed to acknowledge the issue of waste disposal, shortage of drinking water and constrained housing among Dalit settlements. All of which have also been a frequent cause for dengue and other communicable disease outbreaks within Dalit colonies. To be read along with this theme is the narrow perspective that maintenance of ‘hygiene and cleanliness’ as the go to strategy to prevent CDs in the panchayat. In the context of Village A and specifically for Dalit households, strategies like maintenance of clean surroundings remains largely parochial in preventing communicable diseases. They fail to acknowledge the larger level determinants of CDs like availability of facilities to dispose waste, continuous piped supply of drinking water, housing infrastructure and the strategies needed to address them. The question that whether Dalit settlements in Village A with these longstanding limitations can maintain clean surroundings was missing from the larger picture of the ‘I care we care’ campaign.

The perspective of improper waste management and communicable diseases as a common issue within the panchayat and the blindness to Dalit experiences resulted in a blanket strategy generic across the entire panchayat. This meant that there was no strategy that targeted Dalits nor their housing issues within the ‘I care we care’ campaign. In addition to this, they were also actively excluded from being even surveyed during the phase II and III ‘Aardra bhavanam’ survey. Hence from an impact level, Dalits in Village A were doubly excluded from the ‘I care we care’ innovation when compared to their non-Dalit counterparts.

4.4.1.2d: Extent of Dalit inclusion within the processes of ‘I care we care’

To be inclusive in terms of the processes of inclusion means that the marginalised sections are also part of the innovation at its various levels. These include being included in the initial conceptualisation, designing of various strategies and implementation of the innovation. Yet another way in which process inclusion could

be explored is the way in which marginalised sections are included in terms of their status while being part of the innovation process. This could mean exploration into the aspects like whether they were informed and consulted during the initial planning phases, whether they were collaborated during the innovation processes. Finally, to explore whether the innovation had an empowering role for the marginalised sections and whether they were actually in control of the innovation activities.

Dalit presence during the conceptualisation, designing and implementation of 'I care we care'

The exploration into the initial planning phase of 'I care we care' project did suggest to the presence of Dalit individuals. The two key members who were part of the initial planning of the 'I care we care' campaign in Village A were LSGI president as well as Health Standing Committee (HSC) chairperson from LSGI. These two individuals belonged to a Dalit women background and were active partners in the initial phases of the innovation as was evident from the narratives of GPK leadership.

Yet another way in which Dalits were included in the processes of 'I care we care' innovation was through their participation as volunteers and ward members, as well as members of Kudumbasree. As these sections were active partners during the implementation phase of the 'I care we care' campaign. Given the significantly higher proportion of Dalits in Village A, they were invariably a major presence within Kudumbasree units in the panchayat, as well as through their presence as members of HPT. This meant that Dalits had a key role in the successful implementation of the campaign.

Dalit leaders with limited control within the processes

However, what was also relevant within the analysis of Dalit inclusion as well as their presence in the various phases of 'I care we care' campaign is the nature of such involvement. Though the planning and development phase of the campaign had Dalit presence, the extent of control they wielded was largely limited in Village A. The two women Dalit members in their position as LSGI president and HSC chairperson was only facilitated through the legal mandate of reservation for Dalits and women in LSGI

representation. The narratives of Dalit HSC chairperson allude to the way how reservation is the only way that enabled Dalits to have a fair representation in Village A.

"Reservation is important, because it's not just that only big people…it is not enough that only others get a chance in the LSGI. They (Dalits) will also have their own ideas and they should have the opportunity to come and say that in the panchayat. So, my personal opinion is that reservation is important, otherwise they will not get seat here" (CS1 LSGI3)

The fact that reservation was the only mechanism that enabled Dalit politicians to get a chance at representing people, also meant that their power within such spaces were similarly low. The issue of caste-based side-lining was a repeated theme within the narratives of Dalit representatives within decision-making spaces in Village A. Yet another revealing aspect was the differences between the perspectives of Dalit and non-Dalit actors in their perception of Dalit issues in Village A and how they got reflected within the design and implementation of innovation.

"Waste is a major issue in colonies, drinking water is also an issue. Though there are many households with their own well, there are many areas that entirely depend on piped water connection" (CS1 LSGI1)

The Dalit women president was the only person that acknowledged the issue of waste, drinking water as well as housing from the angle of Dalits among all the interviewees from Village A LSGI. These were however missing from non-Dalit LSGI leadership as well as within the narratives of GPK leadership. The way in which the 'I care we care' campaign was finally structured alludes to the power dynamics of actors in its decision-making based on caste and gender. The development of a blanket strategy for the entire panchayat as well as the exclusion of Dalits in the implementation suggest to the limited control Dalit leaders had in shaping up the various components of the innovation.

4.4.1.2c: Structural exclusion of Dalits within LSGI discourses and decision-making spaces

Yet another axis of inclusion, is one of structural inclusion which tries to explore the extent to which marginalised sections are included within larger discourses and structures in Village A LSGI. The argument being, only a structure that is inclusive of marginalised sections can conceive and develop innovations that are truly inclusive for them in its real sense. As part of the Village A case study, the researcher had attempted to explore how the larger discourses among LSGI actors as well as GPK and health staff and related activities are inclusive for Dalits.

Reluctance to acknowledge caste as an axis of marginalisation

A key theme that was evident within the larger discourses on marginalisation in Village A was the reluctance among LSGI and GPK leadership to acknowledge caste as an axis of marginalisation.

"It is not possible to classify marginalised sections in Village A into a defined set of categories. If you look that way, Village A is a panchayat with very few scheduled tribe communities. But there are more scheduled castes here and there are people who are suffering or facing backwardness. Same way there are also people who we normally call forward communities based on their economic situation are also facing backwardness and also many other difficulties. All I am saying is that we should not just take one criterion for backwardness but consider multiple criterions. So, there will be sections with economic, social or other kinds of backwardness." (CS1 GPK1)

There seemed an obvious attempt to dismiss caste as an axis of marginalisation, but at the same time equalise it with the idea of economic backwardness within the narratives of senior GPK leadership. This could be seen as a continuation of the historical stand of communist parties in India who have been maintaining the view that economic class as the dominant axis of marginalisation in any society. Caste as a possible axis of marginalisation was never acknowledged even within the narratives of key LSGI actors with a Dalit identity. In a way, the real-world exclusions faced by Dalit

communities were reflected as exclusionary discourses on marginalisation, dismissing their struggles and lived experiences in its entirety.

Dalits as economically poor and as a health hazard

The perspectives on marginalisation among health actors displayed a major deviation from that of the LSGI actors in terms of how they included Dalits as a group that required priority

"The most important issue in colonies is drinking water shortage, they don't have drinking water there. Due to this they will collect water from wherever it is available and store it in containers. This will often turn as breeding sources for mosquitoes and that's how dengue is spreading here" (CS1 PHC2)

Almost all the narratives of health staff on drinking water issue within Dalit colonies were directly linked to the issue of dengue in the panchayat. This alludes to the way how health actors tend to limit the issue within the angle of Dalits as mere health hazards. This could be read along with the longstanding issue of CDs in Village A and the need felt by the health staff to bring it under control. The result is the open acknowledgement of an otherwise silent issue – as in the case of non-Dalit LSGI actors – since it poses a threat to the FHC staff in terms of higher case load. Dalits and Dalit colonies often emerged within the narratives of health actors almost exclusively in connection with the number of CDs in the panchayat. These in a way suggests how Dalits and Dalit colonies are perceived as mere health hazards by the health actors in Village A.

However, a major theme even within health narratives were the similar perspectives on marginalisation based on economic lines. Health staff viewed Dalits as a priority group given their low economic status and resultant poor living situation and poor hygiene which often have been a risk element for CDs in the region. Such an articulation of marginalisation was also evident among field health actors like ASHA volunteers who positioned Dalit communities as economically poor sections requiring prioritised action.

Dismissal of Dalits as a marginalised section

The dominant discourse of economic poverty as the only axis of marginalisation was also accompanied with a sense of dismissal of the Dalit experiences in the region. Almost all the interviewees tend to dismiss Dalits as a marginalised section and consider them as privileged compared to non-Dalits in the region.

"Today they (Dalits) are number one in our panchayat. Be it economically, socially or in basic infrastructure. If we see their houses, we can clearly understand it. But, if the houses of forward communities are in dilapidated conditions, we are not able to give them any benefits. But since they (Dalits) have all the benefits and are less in numbers their people receive benefits even if they have received once." (CS1 Kudumbasree1)

The prioritised allocation of funds by the State and Central government over the years for scheduled castes was perceived to have made them well off and perform better than others. Some key LSGI actors felt that governments have been doing more than enough for Dalit communities over the years and LSGI finds it difficult to spend the complete amount allotted under Special Component Plan (SCP) funds due to it.

"They (Dalits) don't have any major health issues here. In fact, they are all now better than us. Because we have been taking enough awareness classes through kudumbasree and all." (CS1 PHC6)

Grassroot level health actors like ASHAs considered Dalits as better-off in terms of health indicators compared to non-Dalits, despite key health staff's opinion that they were at higher risk of CDs in the panchayat. Similar views were also observed among LSGI actors and perceived that Dalits are largely well-off since given the welfare schemes and economic benefits available from the government. Many key LSGI actors thought that they must consider all individuals equally without any preferential treatment to any specific groups including Dalits. The aforementioned narratives on Dalit communities by LSGI and health actors tend to equate the struggles of Dalits and non-Dalits based solely on economic poverty. These indicate the lack of acknowledgement of caste as an axis of social marginalisation and a reductionist view

of Dalits as economically deprived. The priority attributed to colony areas by health actors could also be discerned as a perspective drawn from such an approach to marginalisation, that are blind to the historical and societal axes of marginalisation endured by Dalits. In a way these ideas of equal treatment of all could only add up as a double burden to historically oppressed communities.

Victim blaming of Dalits

The dominant discourse on Dalits in Village A was also shaped in terms of how they end up blaming Dalits for their situations. Senior LSGI actors felt that they are a difficult community and were impossible to convince.

"No matter how much we go and call them they will not come for gramasabhas and they will go for their private needs. Then they will start blaming us in public that they have not received anything. There is a limit for us to try and change someone, no? (Smiles sarcastically). We are calling them our maximum. Once people have signed in the minutes of gramasabhas nobody can do anything." (CS1 LSGI2)

The perception was that Dalit communities have enough welfare mechanisms that they are uninterested in attending gramasabhas to avail their benefits. Here too, the blame for lapse in the utilisation of funds allocated for Dalits are being shifted to Dalits themselves and their lack of interest in attending gramasabhas to avail the existing funds. Similar narratives were also reflected among health staff.

"In colonies education status is very low and they are all socially backwards. Crime rates are high among them and they see everything from such an angle. They don't behave like civilised people and they only see and respond to things from their perspective…Reservation for Dalits have brought about a positive change now. Because, previously they were a difficult community to influence. Even if we tried some sort of educational activities for their behavioural change we were not successful. We could only influence them once we started getting members from among them." (CS1 PHC2)

The narratives on Dalits among health actors also seemed to include a sense of victim blaming and they were perceived as culturally prone to negative health behaviours. They found them as a group who are not amenable to awareness and education and difficult to manage with their anti-social behaviours given their poor economic status. Scheduled caste sections were perceived as a section of the community uninterested in hygiene and preventive health behaviours. They felt that the solution to the issues of scheduled caste was through better education and awareness building measures. Again, these narratives were completely devoid of an acknowledgement of the historically accumulated social and economic burden faced by Dalit communities. Perspectives on SC representation too reflected these ideas on Dalits, where representation of Dalits in LSGI was perceived as something that enabled effective health services among Dalits. Since they are a difficult community to inculcate positive health behaviours, having members from their community better help in disseminating needed awareness. Hence, their narratives on SC reservation within LSGI were reduced to mechanisms for positive health delivery among Dalits rather than one of social justice.

Under-representation in positions of power and in LSGI spaces

A key theme that emerged from the interviews with Dalit leaders as well as Dalit community members was the exclusion they have been facing when it comes to positions of power.

"We too desire for a fair representation in power, we also desire that people from among us should rise up. SC people have been actively working in political parties and we also raise this issue in party committees. But they always say that they can only do what the higher party leadership decides…we too want education, employment and positions of power." (CS1 Dalit community7)

They feel that they are almost always side-lined within their political organisations as well as in LSGI representation by all political organisations. They feel that it is important to have Dalit leaders in positions of power for the community to improve. Chances at better positions were perceived by Dalits as positive enablers for the

community to have pride and be an inspiration for others too in their community. Given this, there is a sense of frustration among Dalit members that only reserved seats are allotted to Dalits and non-reserved wards are exclusively represented by non-Dalit members every time. But such demands are often not acknowledged within political organisations including left parties. Though they feel that their non-Dalit ward member has been very committed to their needs and requirements, they believe that it's a political gimmick to ensure Dalit votes. Such exclusions have resulted in instances where Dalit leaders exit from their political party and aligning with other parties to get a LSGI representation. It was felt by the community that major political organisations and communities believe its derogatory to be represented through a Dalit member and this they feel have been preventing them to field a Dalit candidate unless it's a reserved seat.

Failure within LSGI discourse to perceive Dalit representation from a social justice perspective

This was also reflected within the narratives of non-Dalit LSGI leaders, who felt that being represented from a Dalit community was not really necessary. They feel that Dalit or not the welfare schemes are allotted based on guidelines and hence their lack of representation within LSGI was never an issue.

"Even if some wards are reserved for Dalit members, benefits that are given to people are considered equally for all wards. So, even if we give an SC person a seat in a ward, or increase the number of SC members at the time of giving benefits we consider all equally. In my ward even if I am not a Dalit member, I can give everything to the people. So, it is not necessary that we need a Dalit representative to achieve something additional." (CS1 LSGI4)

The idea of representative justice for Dalits was absent within these perspectives and conceives it from a narrow perspective of a legal requirement to be followed. Yet another perspective on Dalit representation was the way in which it was conceived as a requirement only in Dalit predominant areas.

"In some of our wards if there is an SC reservation it would be difficult. Because, we don't have a sufficient SC population here." (CS1 PHC7)

These perspectives on Dalit reservation within LSGI echoed a casteist approach where it was felt that they shall be given representation only in areas where there is enough Dalit demography. However similar line of argument was missing about the idea of a non-Dalit member in a Dalit predominant ward. In a way these implied that Dalits shall be limited to the representation of Dalits only even within LSGI spaces.

Under-representation of Dalits in various committees of LSGI

The underrepresentation of Dalits was reflected even within other LSGI decision-making spaces too, where the proportion of Dalits were significantly low as shown below.

Table 4. 6 LSGI working groups and their Dalit presence in Village A

Sl No	Name of the committee	Total strength	Number of Dalits
1	Public administration and finance working group	24	1
2	Agriculture working group	13	0
3	Animal husbandry and dairy working group	12	0
4	Regional economic development working group	16	0
5	Poverty alleviation working group	12	2

6	Social justice working group	12	0
7	Women development working group	18	1
8	SC development working group	25	2
9	Health working group	18	1
10	Water and sanitation working group	26	2
11	Education working group	18	0
12	Public infrastructure working group	29	2
13	Biodiversity working group	12	0

These indicate the proportion of Dalits in various working groups constituted as part of the LSGI project planning and implementation. Ironically even the working group for SC development had only 2 Dalit members out the total 25 members. Similarly, the working group on social justice did not have even a single Dalit member in it. The low representation of Dalits within these LSGI working groups indicates the systemic exclusion that they experience within the region.

In addition to these, the larger developmental discourse on Dalits were also limited to perspectives like improving their situation through welfare schemes related to agricultural projects or provision of livestock, poultry amongst others. Ironically the nature of these welfare schemes itself tend to position Dalits within a limited idea of developmental schemes, which could itself be seen more or less driven by notions of caste and caste-related vocations. These narratives clearly miss out the social exclusion

faced by Dalit communities over the years leading to lack of positions within power structures. It also tends to diminish the importance of upward social mobility available through such positions and most of all is devoid of the idea of justice through fairness of equal opportunities.

4.4.2: DALIT INCLUSION AND FACILITATION OF THEIR HEALTH NEEDS THROUGH 'SAYAMPRABHA' IN VILLAGE B

4.4.2.1: Status quo of Dalit communities in village b

As per the census 2011 data, Village B has a population of 25172 individuals. Village B is also one of the village panchayats that has a relatively higher proportion of Dalits at around 15.36% (2011 census) higher than the state average of 9.5% and the district average of 14%. Dalit demography was also a key area of interest within the current study given their history of social exclusion within Kerala as well as nationally.

Table 4. 7 Socio-economic status of Dalits in the region, Village B (SECC, 2011),

Total HH	**Total SC HH (%)**	**HH with at least one govt employee (%)**	**HH with any member earning <10000/m (%)**	**HH with 3 or more rooms with pucca walls and roof (%)**
6680	1079 (16.15%)	108 (10.0%)	93 (8.6%)	274 (25.4%)

Based on the available information from the 2011 Socio economic and caste census, the proportion of Dalit households in the panchayat was around 16%. The data also points to the poor availability of basic infrastructure and livelihood within the community.

4.4.2.1a: Poor livelihood and living conditions

A key theme that emerged from the interviews and with Dalit members as well as field level observations was the relatively poor living conditions and livelihood that

persisted in the village. One of the major challenges that Dalit communities face is a chronic cycle of poor economic stability, unemployment and social exclusion. Majority of the Dalit community members depend on low paid daily wage jobs as their main source of income with few members working abroad in gulf countries

"*We are all poor people, most of us go for daily wage jobs and are very poor. Some of us have gone to gulf for jobs. We have been hanging on like this...we go for jobs like painting or masonry"* (CS2 Dalit community4)

The most accessible income source for Dalit women were NREG related activities or that available through their local Kudumbasree units.

"*Here most of the kudumbasree members are Dalit women……. after government has implemented poverty eradication through kudumbasree there have been positive changes, previously it was really bad. After the floods our kudumbasree got sufficient loans without looking the financial status of the kudumbasree unit. Government has really helped us during our difficult times when floods occurred and we are obliged for this help"* (CS2 Dalit community5)

The poor economic conditions were obvious within Dalit settlements which had dilapidated housing conditions or houses that are partially complete and are situated within a limited space of 2-3 cents. Many families still do not own a house and dwell in rented spaces.

"T*here are around 225 households here and many of them still do not have own houses. And they have not received any support yet from the local government"* (CS2 Dalit community6)

Unemployment

Economic impoverishment has also been affecting the educational status of many young members within the community. Most of the members felt that they were unable to support the education of their children and as a corollary a growing demographic of Dalit youths are unemployed too. They felt that even educated members often found it difficult to land in good jobs due to the lack of social support they had.

"*Among us there are many with MA and BA qualifications, but none of them will ever get a job as a teacher. They will only get a daily wage job at the school and no one amongst us has a permanent government job"* (CS2 Dalit community6)

4.4.2.1b: Social exclusion based on caste in Village B

The community felt that caste is a live issue and often the treatment they receive from non-Dalit sections have been inhumane. The frustration among community borne out of their caste status was reflected in how they viewed their social reality too.

"People like us are not even considered as humans, they just come here seeking vote. Otherwise, people within this area from that road till this colony are seen condescendingly by others. They haven't even repaired the roads in this area since years." (CS2 Dalit community8)

The social exclusion faced by certain Dalit colonies were also reflected in how their areas were demarcated. The community members interviewed during the case study felt that even their area was devoid from having a proper name. Their colony was just known as a 'settlement colony'. Though the area had a name to begin with, was later changed and the name was given to another area. They felt that they are not even acknowledged by the LSGI as a proper colony.

"*We came here 27-28 years back and our colony had a name back then. But now the name of our colony has been given to another area nearby. Now our area is just called a settlement colony and does not even have a name"* (CS2 Dalit community3)

Exploration of what constituted a colony to be deemed as 'settlement colony' was unknown to most of the LSGI actors. However, these 'settlement colonies' come with their own stereotypes attributed to them by people in power which makes them see the issues within these colonies as extreme and difficult to solve. They are perceived as areas with poor social cohesion and with a proclivity to anti-social behaviour.

"Colonies are of two types, conventional colonies where people have been living for long. They have close ties and even if there are small issues, they will be resolved within one or two days. But settled colonies have people from different places. They don't have any blood relations among each other, nor do they have any commitment

to anything. They are like independent cabins. They only have their own issues. They will have limitations in mingling or separating from the society. They can get separated to any extent, but mingling has limits. So, because of this the problem they have in such colonies are totally different." (CS2 LSGI2)

The community felt that lack of education, employment combined with the ill-treatment have resulted in a large segment of Dalit youths being misguided into substance abuse and alcoholism. As a consequence, many of the Dalit youths have been caught up with negative activities including theft.

"When our kids see this exclusion, they lose their morale to go up in their lives. In reality none of our kids aspire for progress, they don't have the inspiration to seek education and they are just failing" (CS2 Dalit community4)

"Our kids after an age they are reluctant to go for further higher studies. May be up till plus 2, they are not even interested in a minimum education for themselves. There are issues like this among us and we really need progress here"

"*In our area there is an issue of substance abuse, in the nearby areas our children are always caught for issues related to theft and others. There are issues like that here"* (CS2 Dalit community4)

These have been further fuelling the dominant stereotypes about Dalits as a community with a proclivity to alcohol and substance abuse.

"*In some colonies, their youths are interested in roaming around in new bikes. When enquired further they are all involved in small drug dealing activities. These bikes cost around 1.75 lakhs, but father will be a daily wage earner and mother will be involved in 'thozhilurappu'. So, when investigated they are drug dealers and they need such good bikes to travel fast and these mostly happen in settlement colonies"* (CS2 LSGI2)

4.4.2.1c: Lack of LSGI projects that could benefit Dalit communities as felt by them

The negative stereotypes and caste drawn exclusion were reflected in the region is limited projects that aimed at the welfare and improvement of Dalits in Village B. Members of Dalit community felt that LSGI have excluded the needs of Dalit sections

in terms of the projects in the region. It was perceived that LSGI was only interested in high tech initiatives rather than the real needs of the community. They sarcastically referred to various high-tech projects like Wifi installation at the LSGI, solar projects as being too far away from their reality. Demands including a community library which Dalit youth can access were not considered by the LSGI and even the property allocated for a library were used for other purposes.

The Dalit neighbourhoods which the investigator approached as part of field research were found to be without sufficient water supply. It was reported that though the LSGI have laid pipes, never have they received water through those pipes. Yet another instance was the non-functional lamp post within the area that never functioned even once after it was installed. The community also reported that even the roads in the region were due for repair since many years. The frustration in the voice of the community members were too obvious when they felt that they had no one to support them other themselves. They felt that even the wells that have been dug in the area were done by their own members who worked as NREG members. The narratives alluded to a deep sense of frustration borne out of the systemic exclusion at the hands of LSGI institutions. Many members did not possess even homes with proper roofs and felt that they are forced to live out this reality without any hope of coming out of it.

4.4.2.2: Extent of Dalit inclusion within various aspects of 'Sayamprabha' and the facilitation of health needs of Dalits

4.4.2.2a: Dalit inclusion within the objectives of 'sayamprabha' in Village B

As was observed from the field visits to many Dalit colonies, the socio-economic profile of Dalits in Village B was evidently poor, with relatively poor housing and employment status of the community. Despite such social situations and even being a key demography in Village B, the narratives on the objectives of 'Sayamprabha' never seemed to include Dalits as a priority group.

"Among the elderly people there are people who are economically well off as well as those who are not so. However, just because they are economically well off does not mean that they are emotionally healthy. Because for most of them their children are

abroad in America or Gulf. They are somehow trying to shift them to elderly care homes or given their current situation they are forced to call the neighbour to help them video call their children abroad. (CS2 LSGI2)

A major priority that seemed to emerge within the objectives of 'Sayamprabha' was attributed to elderly members who had their children working abroad, and have limited support at home. These narratives were often repeated within the interviews with key LSGI actors involved within the project in Village B. However, they never acknowledged Dalit elderly nor their poor socio-economic situations compared to the priority attributed to elderly sections with better economic situation but with no domestic support.

"Yes, we have sections within elderly who we feel that should be given some priority, like elderly individuals who only have a girl child, or those who do not have children, or widowed women. We have many such elderly members in these categories and they are being given priority. Also, elderly individuals who have no one to take them out, also people who are very poor. We selected such people for distributing nutritional support through the project. All our selected individuals are based on such criteria, though we say that all are included under this project there are people who really need it. So, they are being prioritised and even those who were taken to our tour was also done similarly" (CS2 ICDS1)

When explored for sections that were given priority within the project, they key criteria suggested by the implementing officer of the project, elderly from Dalit sections never figured in her narrative.

"No! we never looked for such criteria like elderly from scheduled caste or tribe nor whether they are from general sections. Now, even within scheduled caste there are people who are rich, so we should not see like that" (CS2 ICDS1)

Meanwhile when specifically probed for the issue of Dalit elderly, she felt that the project never delineated their beneficiaries on the basis of caste as if it was wrong to do so, as she immediately negated the idea of Dalits being given a priority. She also felt that, such a prioritisation was irrelevant as members from Dalit sections are now rich and well off.

"Elderly who are scheduled caste or tribe we don't see like that, they don't have any special priority. All are considered equal in this project" (CS2 Sayamprabha member1)

Even the narratives of the president of the 'Sayamprabha' project in the panchayat who himself belonged to a Dalit caste felt that there is no such delineation within the project. He felt that all are considered equal under the project.

4.4.2.2b: Dalits and their utilisation of 'Sayamprabha' project

Yet another axis of inclusion explored within the research was the way in which Dalits were part of the various activities and benefits of the 'Sayamprabha' project. Based on the information collected from the ICDS department staff including ICDS supervisor as well as from anganwadi workers, the 'Sayamprabha' project in Village B has 27 elderly clubs at the anganwadi level. These anganwadi based elderly clubs have their own leadership with a president and secretary selected by the club members themselves.

Table 4. 8 'Sayamprabha' club attendance and caste and gender details of the members

AW No	President	Secretary	Club attendance	Females	Males	Dalits (%)
1	Non-SC male	Non-SC male	7-8	1-2	6-7	1 (14%)
2	Non-SC male	Non-SC male	15-20	16-18	2-4	0
3	Non-SC female	SC male	8-10	6-7	2-3	2 (25%)
4	SC Male	SC female	15-20	8-10	5-8	12 (70%)
5	SC female	SC female	25-30	25-28	2-5	22 (81%)
6	Non-SC male	SC male	10-15	8-10	2-5	5-8 (58%)

7	SC female	SC female	18-20	12-14	6-8	13-14 (68%)
8	SC male					
9	SC female	Non-SC male	10-12	8-10	2-3	1 (9%)
10	Non-SC male	Non-SC male	20-25	18-20	3-5	7-10 (36%)
11	SC male	Non-SC female				
12	SC male	SC male	18-20	10-12	6-8	15-17 (84%)
13	Non-SC female	Non-SC female	13-15	9-10	5-6	0
14	SC male	Non-SC female	14-15	11-12	3-4	7-8 (64%)
15	Non-SC male	Non-SC female	14-15	9-10	5-6	4-5 (29%)
16	Non-SC male	Non-SC male	7-8	5-6	2-3	6-7 (85%)
17	SC male	Non-SC female	19-20	13-14	6-7	15-17 (84%)
18	Non-SC male		18-20	12-13	6-8	6-7 (31%)
19	SC female	SC female	20-21	17-18	2-3	16-17 (80%)
20	SC female	Non-SC male	15-16	6-7	6-7	14-16 (100%)
21	Non-SC female	Non-SC female	11-12	8-10	3-4	7-8 (63%)
22	SC female	SC male	18-20	15-16	4-5	10-11 (52%)

23	Non-SC male	SC male	23-25	18-20	5-6	15-17 (66%)
24	SC male	SC female	20	10	10	12-15 (65%)
25	SC female	SC male	18-20	14-15	5-6	15-16 (78%)
126	Non-SC male	SC female	20-22	15-16	6-7	5-6 (25%)
130	Non-SC female	Non-SC female	14-15	10-11	4-5	0

Out of the 27 elderly clubs in Village B under 'Sayamprabha', 15 or more than half of the clubs (55%) are headed by a Dalit president and 12 clubs had a Dalit member as its secretary. In addition to this, the president of 'Sayamprabha' project in the panchayat was also headed by a Dalit elderly member.

Yet another theme that was evident from the attendance of elderly members during the monthly club meetings alludes to significantly higher involvement of Dalits during such activities. Based on the general participation of Dalits within the club activities, it was found that close to 60% of the participation within the 'Sayamprabha' clubs were by Dalit elderly individuals in the panchayat.

Table 4. 9 Proportion of Dalit membership in the Sayamprabha clubs in Village B

AW NO	CLUB ATTENDANCE	DALIT MEMBERS	PROPORTION OF DALITS ELDERLY IN THE AREA
1	8	1	11%
2	20		0%
3	10	2	
4	15	12	6.4%
5	30	22	90%
6	15	5	27%

7	20	13	40%
8			
9	12	1	3%
10	25	7	11%
11	25	18	67%
12	18	15	53%
13	15	0	0%
14	15	7	12%
15	15	5	47%
16	8	6	39%
17	19	15	35%
18	20	7	23%
19	21	16	81%
20	15	14	26%
21	12	7	11%
22	20	10	24%
23	25	15	35%
24	20	13	26%
25	20	15	30%
126	22	5	10%
130	15	0	1%

Yet another observation was in the relationship between club participation and the proportion of Dalits in the anganwadi area. Based on the approximate participation details of elderly individuals in the 'Sayamprabha' clubs, in wards where there were higher proportion of Dalits in their population the clubs had relatively higher participation compared to areas with a smaller number of Dalits. This also alludes to the interest and participation of Dalits in 'Sayamprabha' project compared to their non-Dalit counterparts in Village B. This was also evident within the narratives of few anganwadi teachers, when explored about the nature of participation within the 'Sayamprabha' clubs.

"When they convene, mostly people from general section are people who have jobs or people who have members in good jobs. So, they have a perception that institutions like anganwadi are for poor people. I have tried my best to change such an attitude, I have been giving awareness class for all sections about anganwadi activities in my area. But the general perception is that 'oh anganwadi is for the poor'. When we go an invite people from general sections, they will say that yeah, we will come, but participation is still high among SC individuals. Then some will say that their children will scold them if they don't see them at home or when they know that they have gone to the anganwadi as if they don't have anything better to do. But there are also people from general section who will ask their parents to go, but it's mostly people from scheduled caste. Because I feel people from SC will have a perception that only if they go for such activities will they get any benefits from the panchayat" (CS2 AWW1)

"If you ask why other sections' participation is low, I don't know why. But when we call them for meetings and all they often say that they cannot come. Also, our anganwadi is within a Prathyaksha Raksha Daiva Sabha (PRDS) colony and they always come very actively. PRDS is a very active organisation and people in them are also very active and that is also seen in their participation in our anganwadi activities too" (CS2 AWW3)

The narratives of the anganwadi workers too indicate the increased participation of Dalit members within the 'Sayamprabha' activities as they are mostly poor and are in need of support from the LSGI.

Yet another overlap within this theme was the way in which how anganwadi workers felt that people with lower socio-economic conditions often attended more in 'Sayamprabha' clubs. Since Dalits remained within an intersection of poor social economic condition as observed from the field visits, most of the poor individuals who attended the 'Sayamprabha' activities are also Dalits.

"When we go to certain economically well-off area within the panchayat, there they will already have senior citizens association among their elderly members. So, when we go there, they are of the attitude that they don't need such projects for them and we

already have our own associations. So, in general economically well-off people are less interested in this project" (CS2 Sayamprabha member1)

"In most wards it is like that, it's mostly scheduled caste people who participate in this. People who are somewhat big never joins with such projects, like those who are rich they never participate. Only people like us who are economically weak participate in these activities. For the big people these are never an issue. But they are in the 'Sayamprabha' list and they will know all the details. They are ready to collect all the benefits and they will know all details and they will also ask us" (CS2 Sayamprabha member3)

It was felt by the president of the 'Sayamprabha' project as well as other Dalit members of the project that economically well-off individuals are generally less interested in participating in the project in Village B. So, in general the participation within the 'Sayamprabha' activities is generally from Dalits and poor non-Dalit sections in the panchayat with limited participation from elderly individuals from a rich background.

4.4.2.2c: Inclusion of Dalits within the level of utilisation of benefits and impact through 'Sayamprabha'

In addition to the increased participation of Dalits within the project, they were also the group who benefitted most from the project as felt by the anganwadi workers.

"Currently in my anganwadi 5 members are being provided with nutrimix powder. They are given to the neediest 5 individuals who does not have any other means like, who have no one to look after, parents with only a daughter, similarly individuals who are really weak. In my anganwadi there is someone who does not have any children and there is an elderly woman with only a daughter. Within this three are from scheduled caste, one is a Dalit christian and only one from general section" (CS2 AWW4)

"The provision of nutritional powder is a very big support for them. I know many of them are using our powder as the main breakfast meal, many have told me that. They are poor and are unable to even buy wheat flour and cook for their breakfast and no doubt for them it's a great support" (CS2 AWW5)

"I feel most of the people who receive benefits are from scheduled caste" (CS2 ICDS1)

A common pattern that emerged from the narratives of anganwadi workers and the ICDS supervisor was the way in which it helped Dalits in receiving the nutritional support from the project. In most of the anganwadi areas Dalits were a major beneficiary of the nutritional support provided through the project.

"In my anganwadi hearing aid was provided to two individuals and they both were from scheduled caste. One was an elderly woman and received it through the 'Sayamprabha' project and she was in our Below Poverty Line (BPL) list. That mother had 5 daughters but there was no one to look after her" (CS2 AWW7)

"Cot was to given to a family of an elderly mother and her daughter. Their entire house was washed off in the floods including the roofing sheet. It was within a paddy field and they were from scheduled caste, so she was a very poor woman" (CS2 AWW3)

Similarly, the provision of other schemes within the project like provision of cots, hearing aids too have had a major impact in the well-being of Dalits in the panchayat. This was possible as they were beneficiaries of these goods in in many anganwadi centres through the project.

Since Dalits were a major demography within these activities it has also impacted them positively.

"These clubs have been really beneficial for them and through them we can easily know all their needs. Two three women had asked me about walking sticks, similarly it's a great space for them to share time together during evenings. I feel it is a very productive project and they have been saying that to me too" (CS2 AWW4)

"They have been having much improvement in their emotional well-being. It's a space where they can share their feelings and issues. They will be idle if they remain at their homes alone and they have been telling to me that they feel very happy when they come to the anganwadi. Once we had conducted stage competitions for them, we could really see the excitement in them like they were small children. They sang songs which they

had learned from their childhood and it was so good to see them dance with lot of excitement" (CS2 AWW4)

In general, it was felt by the anganwadi workers that the club activities and other project activities like arts competition have had a significant impact in the emotional well-being of the elderly in the panchayat. These elderly groups have opened up newer space to share their needs, their emotions which would can translate as improved well-being among them too.

4.4.2.2d: Inclusion of Dalits within the processes of 'Sayamprabha'

A key dimension of inclusion is the idea of including the marginalised sections within the various processes of any innovation. The current research explored the 'Sayamprabha' project during its various phases, the role of various actors to map the inclusion of Dalits within the various processes of innovation.

Limited involvement during project conceptualisation and designing

A key pathway through which Dalits were excluded within the initial conceptualisation and planning, was through the obvious exclusion of the Dalit Panchayat president within them. The two key actors who primarily contributed within these activities were the non-Dalit male Vice-president and the ICDS supervisor.

"Initially me and the vice-president sat together and thought of the survey. We prepared a survey form and informed the anganwadis to form the clubs and the conduction of the survey. All the details of the survey form like what shall be identified, the basic status of the elderly, any other relevant needs were all decided by us" (CS2 ICDS1)

The initial discussions and planning regarding the projects were limited to two main actors, LSGI vice-president and the ICDS supervisor. These included the initial idea for the 'Sayamprabha' project, planning of the project components including survey and finalising the details of the survey form as well as naming of the project.

"The next activity we did was to inform all the LSGI representatives. We called a meeting of all representatives so that we can inform them about the projects as well as discuss with them the future actions within the project" (CS2 ICDS1)

Once the initial planning was completed between the ICDS supervisor and the vice-president, the second process was the meeting of all LSGI representatives and anganwadi workers to inform them about the project and plan the possible strategies through the project. Though other LSGI members including the Dalit president was part of this phase, it did not leave much room for them to have a creative partnership within the planning of various activities. Besides, during these initial planning and brainstorming sessions elderly community was also not involved by the LSGI in any manner. Hence, by extension Dalit elderly and their role too was missing in terms of the initial conceptualisation and design of the project.

Collaborative role of Dalits

The first instance of elderly members being part of the project process was the anganwadi level meetings convened by the anganwadi workers. This is also the phase where Dalits too became part of the project activities initially. This was through their role as anganwadi level club leadership as well as having a Dalit member as the president of the 'Sayamprabha' at the panchayat level.

"The issues that the elderly members face cannot be understood through any panchayat committee. This information should come from the elderly people themselves and there should be a team to gauge their needs. Given our current situation staff from the LSGI cannot be entrusted with additional responsibilities. So, we thought it would be best if the elderly people themselves form a team and capture their own needs through a survey" (CS2 LSGI2)

"We surveyed each and every household. This is ward number 12 and, in this ward, we went to all household where there are people above 60 years. We went to every house and enquired about their issues" (CS2 Sayamprabha member1)

Yet another way elderly and Dalit elderly were made part of the processes of the project was through their collaboration with the LSGI in the household survey. Since

Dalit members were also a major part of the anganwadi level club leadership, they too were a crucial part of the survey activities.

Consultative role for Dalits

Once the survey was completed, the next major activity in which the elderly was collaborated was the discussion on the survey findings. These activities enabled the members of the 'Sayamprabha' clubs to further raise their needs through such spaces within the project.

"After the survey and anganwadi meetings, we invited all the committee members from the 27 anganwadis for a larger general body meeting. There we reiterated the project details and informed them about the formation of 'Sayamprabha' clubs. We announced that we are planning for the improvement of the physical and mental well-being. Through the initiative as panchayat projects, we are planning medical camps for you" (CS2 LSGI2)

Before the conduction of the medical camps, the elderly members were again invited for a larger meeting at the panchayat, which included all the committee members of the anganwadi level clubs. Through this meeting the information related to the medical camps was given to the elderly by the LSGI leadership.

"During the general body meeting of the 'Sayamprabha' committee members someone had told. 'We need not just eye care camps, many have dental issues, so it would be good if we could get dentures.' Then ICDS supervisor told they have a program called Mandahasam by the social justice department. So, they could collaborate with that project and dentures could be provided to them" (CS2 LSGI2)

Through the general body meeting, elderly members had the opportunity to raise their needs like dental care which were then transformed as components of the 'Sayamprabha' project. The dental needs of the 'Sayamprabha' members were met through collaboration with Social Justice Department through their dental program called 'Mandahasam'. Similarly, events like 'Sayamprabha' arts competition were also evolved out of the discussions between elderly and LSGI leadership. Clearly these

activities suggest towards the consultative role elderly specifically Dalit elderly in the panchayat had in terms of shaping up the various components of the project.

4.4.2.2e: Perception of being empowered through inclusion within the processes among Dalits

As was discussed before, Dalit elderly were also major section within the 'Sayamprabha' leadership both at the anganwadis as well as at the panchayat level. Almost 55% of the club leadership as president was by Dalit elderly in the project and 44% clubs had a Dalit member as its secretary. These allude to an empowering role the project could have had to a certain extent among them in terms of having a stake in activities that could influence their health and well-being. The narratives of Dalit members of the project often pointed towards a sense of ownership and authority they felt they had within the project.

"Now there is a committee at the district level, so after that it is slightly difficult for any financial corruption within the project. They cannot now easily embezzle the funds for the elderly. Since there is a district level committee involving district collector, so if we have some issues or difference of opinion, we can present before them our concerns and they will immediately investigate" (CS2 Sayamprabha member4)

"We had received hearing aids, three of them was given. Our ward received one and other two was given to ward 11. But all three was allotted to us but we did not know about it and so we only got one. We did not have much information about it, but we are supposed to know and legally they should inform us, that is the rule now." (CS2 Sayamprabha member3)

There was a perception among Dalit 'Sayamprabha' members regarding issues of corruption in the management of funds for elderly through the project. However, they felt that after the project has initiated there is a committee at the district where they can present their grievances and seek immediate redressal for them. Similarly, after the formation of clubs and groups under the project, there is a heightened sense of ownership regarding the various benefits that are available through the project. Dalit elderly who was also leaders of anganwadi clubs felt that they should be informed about the various schemes through the project now.

Lack of control by elderly as well as Dalits in the project decisions and financial aspects of 'Sayamprabha'

Though elderly in general and Dalit elderly in specific were key consultative and collaborative partners in the 'Sayamprabha' project, largely they had limited control in the decision-making related to the project. These were evident through the interviews with various elderly members involved in the project, specifically among the Dalit elderly.

"Normally this project is intended for us to give us the space to let the LSGI know our needs. So, on some occasions they ask us to meet at the panchayat. During the meetings the committee members will present our needs, like such and such unit needs such and such things. These are all financial matters and they will agree to them in public and will never say no. These may come at some point in the future or they may also not come and many have never been given also. The president there will or authorities there will say that they will give us this and that. It's all just rhetoric and we will never get anything" (CS2 Sayamprabha member1)

The narratives of Dalit 'Sayamprabha' members including members who were presidents of 'Sayamprabha' clubs alluded to lack of trust in the project and its benefits. It was felt that most of the benefits announced through the project are mere rhetoric and many are yet to be given. These in a way indicate to a lack of any say in terms of realising the actual project and its benefits by the 'Sayamprabha' members.

"They had told us about provision of spectacles, that too was a clever strategy by them. The 'Sayamprabha' president informed us about spectacles. But suddenly one day they told us that by tomorrow noon we should be present with our eye readings with doctor's certificate! Meaning they are saying this today at 12 PM that we should bring our reading by tomorrow 12 PM! This was told us by the balavadi teacher. No, I am asking you, if someone has a genuine interest in giving us, they would have informed us much before. Are we sitting here with readymade reports? many did not get because they did not have the money to pay for their travel to and from the hospital to get a reading for their eyes. Will someone give us a report if we suddenly go and ask them for one? (CS2 Sayamprabha member5)

The narratives of Dalit 'Sayamprabha' members were replete with instances within the project where they did not have any control in the key activities. It was felt that activities like tour for the elderly or provision of spectacles were arranged without any consultation or feedback from the club members. They felt that lack of proper planning and consultation has resulted in many Dalit members failing to access the benefits available through the project. When asked about the various details including the number of beneficiaries within the project, the president of the 'Sayamprabha' project felt that he is not privy to all those information yet. He felt that even after repeated requests to share the details of the project ICDS supervisor has not provided him yet that information. The Dalit president of the 'Sayamprabha', also did not seem to know the exact funding related to the project, as he seemed to think that 'Sayamprabha' was a centrally planned and sponsored project. He felt he did not have any say in the activities as it is implemented through the block LSGI and hence the decision-maker for all the activities under the project is only by the LSGI. He felt that there is a general dissatisfaction among club leaders at the anganwadi that the project president nor the clubs are privy to any details regarding the exact funding of the project and their utilisation. These narratives allude to the general lack of control among the elderly within the project in terms of deciding the activities nor how the finances shall be managed within the project.

4.4.2.2f: Structural exclusion of Dalits in village B

Innovations could only be structurally inclusive, if they emerge out of structures and systems that themselves are inclusive in its nature. The argument being, often systems that are not inclusive can only generate innovations that are only temporarily inclusive or may end up being shallow in terms of its inclusiveness. Hence to develop structurally inclusive innovations, it is also important that their core organisations, their relations and culture that constitute an innovation system are inclusive in their outlook. Hence a key area of the current research was also to explore how various actors at the LSGI and other transferred institutions perceived marginalisation and also how they saw the Dalit situation in the panchayat.

Invisibilisation of caste as an axis of marginalisation

The study explored about the sections of communities who could be considered as marginalised or sections that required prioritised support among various LSGI actors. A key theme that emerged from the interviews was how caste was missing from the narratives as an axis of marginalisation in Village B.

"Definitely, there will be marginalised sections in all panchayats. Like all other communities there are racially segregated people in our community too. Like people who does not have homes, people who are living alone, elderly with no one to take care, so such marginalised sections are there in our panchayat" (CS2 LSGI2)

LSGI vice-president who was one of the most dominant actors in terms of decision-making at Village B never acknowledged Dalits as a marginalised community in the panchayat. His narratives on the list of marginalised sections failed to recognise Dalit communities within them who he felt required priority.

"Yes, there are people who needs prioritisation and we always make sure that such people get what they deserve. People who have low income, we assess such people based on their income. So, we give the first priority to those who have very low income. We have a list of such hierarchy to be used in the gramasabha. So, the person with the lowest income will get the first chance, then the next will be given the second chance." (CS2 LSGI3)

Similarly, the health standing committee chairperson – key actor in health decision-making in the LSGI - felt that income was the key aspect that needs to be considered while prioritising LSGI projects. According to her the most prioritised by the Village B LSGI are people with the least income and yet her narratives too never acknowledged caste as a source of marginalisation.

"There are no major sections that need prioritised attention for health as we don't have much scheduled tribes in our panchayat" (CS2 PHC2)

"I feel that there are certain sections who should be given priority. As I said before there are poor people who are enlisted under 'Ashraya' scheme and for many of them

there is a situation where they are not able to buy the medicines they need" (CS2 PHC3)

The interviews with key health staff too reflected the views of LSGI representatives in terms of their idea on marginalisation. According to the health inspector (HI) of the FHC, priority for health care is required only for scheduled tribes and they were very less in Village B. The JHI felt that people who are very poor are one of the key marginalised groups that existed in the panchayat.

These narratives on marginalisation largely tended to ignore or invisibilise caste as a source of marginalisation. As was evident from the field visits and with the interviews with Dalit community members, they remained one of the poorest sections in Village B. Despite the fact that LSGI actors acknowledge economic poverty as an axis of marginalisation, its overlap with caste in Village B was missing within their perspectives on marginalisation. This was also evident in the case of 'Sayamprabha' too, where Dalits never figured as a section who might gain from a prioritised attention within the project.

Tendency to diminish the struggles of Dalit communities

To be read along with the caste 'invisibilisation' are the subtle attempts at dismissing the realities of Dalits and Dalit settlements. The LSGI actors tried to paint a positive picture through their narratives that Dalit settlements have improved over the years significantly and there are no major issues that affect them currently. Many felt that most of the members now have their own homes and almost all the households have water availability. These narratives strangely attempted to portray that Dalit households have good living conditions despite the fact that almost all of the Dalit households had only daily wage earners.

'Victim blaming' of Dalits for their conditions

A second theme that emerged from the interviews was how Dalit sections themselves were positioned as the source of their own poor situations in general. A sense of victim blaming was evident within the narratives on the Dalit question in the panchayat by key LSGI actors including non-Dalit and Dalits too.

"Be it scheduled caste reservation or reservation of women they only see it as an opportunity to get into a position as an LSGI member. Beyond this perspective, they don't realise that they are in that position due to reservation and hence they should work more to improve that area. They never have such a consciousness and not that they are prevented from having it also. In which panchayat committee will you see a member selected through SC reservation intervening creatively on SC issues" (CS2 LSGI2)

Often the rhetoric of reservations as good and shall be maintained are soon followed by perceptions of reservation as a benevolent mechanism. Hence it was perceived that Dalits should have the 'capacity' to 'make use of such opportunities' for the betterment of their own society. It was felt that despite reservations Dalit LSGI actors fail in focussing their attention to the problems of their community and they 'lack' such a consciousness.

"Scheduled caste community does not have the strength to raise their needs now. They are reluctant to speak about issues that are for an overall societal development in general. They are not speaking about because of their subservience to many other issues. They are bothered that if they speak about issues, it may harm such and such individuals. So, they should raise to a level where they can boldly say about their needs, or at least their elected members should do that. Such elected members are always interested in speaking about the issues of their ward in general, they never speak about the issues of scheduled castes. They are not thinking from such a perspective, some may do it. They have their own organisations by the scheduled castes, these organisations should improve such thinking in them" (CS2 LSGI7)

These narratives allude to the notions that only Dalits shall work for Dalits and as if the development of Dalit communities was never the prerogative of non-Dalit LSGI actors too. By maintaining such an argument, they are in general trying to exclusively shift the blame of the poor social situation of the Dalits on to the Dalit community and their representatives. The feeling is that they are not bothered about their development or not conscious about their role in the community and the improvement of their own community, which ultimately results in their poor social conditions. Yet another way

of victim blaming was through the maintenance of an argument that their issues are unaddressed because Dalits are not vocal enough in mainstreaming them. It was perceived that though there are various Dalit organisations none of them are vocal enough about their issues. Similar to 'oorukoottams' in tribal settlements Dalits too need such spaces to voice their demands. However, such a narrative miserably fails to recognise the relevance of gramasabhas within LSGI and their relevance in understanding the needs of the community. And when reminded about gramasabhas, it was felt that their opinions lacked the strength to be considered as mainstream issues. These perspectives are in fact the exact representation of how the current structure keeps obfuscating the structural exclusions of Dalits by shifting the blame on to the victims themselves for not being 'loud enough'.

Ironically, the narratives of a Dalit ward member who was also a long-term communist party member considers the poor situation of Dalits from a taken for granted attitude.

"The perspective that Dalits are treated differently in communist party are only the view of some people. We should see party from a broader sense and also those within the party only then we can understand it. I have such an opinion on this matter. I am from a Dalit community and I contested the elections for the first time and I don't have any bad feeling in party not giving me a seat earlier. A feeling of being lower is only because we think it is so. Every community will have its own negatives in all areas of it. It will also be in politics as well as in various social groups, and they cannot be changed all at once." (CS2 LSGI5)

Though he feels that there is some degree of casteism within any political organisation, he feels that it is quite natural to have those. Within the same narrative he wishes away the casteist structures as something that is only residing in the minds of Dalit individuals and their feeling that they are lower to others. The general blame here too is placed on Dalits for their lower ranks within party as something drawn from the feelings of Dalit and not a real issue. Despite being a long-term party member and was only given a chance at LSGI elections since his ward was reserved for Dalits, he maintained this view and feels that it was not a problem at all.

These narratives reflect the lack of acknowledgement of actors within positions of power in understanding the Dalit question as a mainstream developmental question. And how the current realities of Dalits are in fact shaped exactly out of such structural exclusions they have been facing throughout their history. Besides there is also a lack of understanding of tools like reservation as a means for social justice or representative justice. Hence by positioning Dalit reservation as a tool for better addressing the conditions of Dalits, it is in fact side lining the Dalit developmental question.

Negative stereotypes attributed to Dalits

"In some colonies, their children from this generation have been observed to be roaming around using costly motorbikes. When we collected information on it we could learn that they are all associated with drug related business. They will be using bikes that cost around 1.75 lakhs, but their father is a daily wage labourer and mother goes to 'thozhilurappu' (NREGA). So, they need costly bikes to go fast and these are very common in settlement colonies" (CS2 LSGI2)

Coupled with the victim blaming are also the popular stereotypes of Dalits and their proclivity to negative health behaviours including alcoholism, substance abuse and other tobacco products. These too were found to be attributed to the lack of self-respect the community had within themselves due to their poor living conditions. It was felt that their lack of education was a key cause for such habits and it was also felt that they 'lack the consciousness' that education is important and that it could emancipated them from their poor situation. And the reason for such lack of consciousness were strangely attributed to the existence of welfare mechanisms like reservations making them have a 'taken for granted' attitude

"They don't need big things they just wish to subsist and only need the minimum requirements for education and daily food. These are their main issues and they don't have big expectation like they want to be an IAS officer or something. Their needs and dreams are always small" (CS2 LSGI3)

It was felt that their dreams too are always limited and small with better housing, water, electricity and minimum livelihood to sustain their family. They were pictured as a

community devoid of any aspirations beyond the bare minimum required for mere existence. The narratives of non-Dalit actors were rife with subtle condescension and references to how Dalits were lower in the social hierarchy and yet never treated as such and are 'considered equal'. It was also strange to note that the narrative of certain actors even excluded Dalits from the Hindu fold. Within the narratives of many actors, they were positioned as a third category of SC and not Hindus and Christians.

Exclusions within positions of power

All these exclusionary and negatively stereotypical discourses on Dalits and their social situation were also translated as exclusion of Dalits within positions of power at the LSGI. In general, the representation of Dalits in Village B LSGI have been historically limited exclusively to the seats reserved for Dalits. The interviews with LSGI actors did suggest to the local convention of classifying LSGI seats by the political parties into two main categories; SC seat and general seat. Since, certain number of election seats in every panchayat are randomly allotted to Dalits by the government as per constitutional norms, they are by mandate allotted to Dalit candidates by every political party. Since, such a system existed, the term general (non-reserved) seats locally meant that it is a ward 'reserved' as de facto for a non-Dalit member.

As per reservation policy the number of seats reserved for Dalits is based on the proportion of Dalits in any Panchayat. According to this, 3 random wards are always reserved for Dalits in VILLAGE B . However, going by this logic the representation of Dalits seemed relatively better in Village B at the outset. Because, during the 2015-20 term Village B panchayat had 6 Dalit candidates in the LSGI which are three additional seats beyond what was reserved for Dalits. These were;

Table 4. 10 Dalit representation in Village B

Total number of LSGI members	**Total number of Dalits in the LSGI**	**Number of Dalits from unreserved seats**

17	6	3

This suggests an apparently fair representation of Dalits at the outset. However, from the interviews with Dalit community members it could be discerned that two out of the three reserved wards in Village B comprised of a population that did not have Dalits as a major demography, which are ward 1 and 2. Hence it was only politically advantageous to field Dalits in the wards that had significant Dalit voters though they were unreserved, ward 9, 10 and 13.

"Ward 10 is an area that is mostly scheduled caste colony, it is a colony area also called as poothakkuzhy colony. If we examine that ward as per proportion of population it is mostly scheduled caste. And these colony residents are also party people so they would have asked for a candidate among them strongly. In ward 9 and 13 also our people and they have a majority there, it is due to that there are scheduled caste members in these general seats" (CS2 Dalit community3)

Hence in the case of Village B the larger proportion of Dalit community together with constitutional reservation policies did by coincidence had an indirect positive impact on receiving a fair share of representation within LSGI. However, the interviews with Dalit LSGI actors as well as previous LSGI representatives did point out to these exclusionary ways within political parties. It was felt by certain actors that often they are fielded in seats which had poor prognosis of electoral victory.

"Let me ask you, why are these political party leaders saying that no Dalit can contest from a general seat?! I want to know that. I am asking why are they looking for caste in a general seat, I want to know why it is so" (CS2 Dalit community1)

Exclusions were also echoed by members of the Dalit community who felt that left parties have historically failed to give their party workers a fair chance of representation. They felt that they have been reduced to mere vote banks in the eyes of the powerful. They were just foot soldiers for various political organisations to be used as supporters at their political events. Though the area had significant Dalit proportion, it was felt that not even once have any political organisation given a ticket

to any party member from their community. In one of the wards where the interviews were conducted, every time a member from outside the ward is fielded as a candidate as a convention. During 2015-20 term of the LSGI CPI(M) had fielded a woman candidate from an 'elite' community who was not even familiar with the region. This happened despite many members from their community were active members of political organisations. Similar narratives were also observed from Kudumbasree actors too. It was perceived that, had there not been reservation it would have been impossible for Dalits to occupy leadership positions in Kudumbasree, like being the chairperson of Community Development Society (CDS).

Systemic exclusion of Dalits from Dalit specific LSGI projects

Yet another theme that emerged from the case study exploration was the systemic exclusion of Dalits within LSGI projects. These were evident within much accoladed projects in Village B including 'Village B rice' and the 'Avees Café' project. The Village B rice project was a paddy farming project initiated exclusively for Dalit kudumbasree members during 2017 in collaboration with Kudumbasree in VILLAGE B . However due to the involvement of the LSGI leadership, the project was also extended to few non-Dalit members too. Initially the project had a membership of 8 Dalits, 2 converted Dalit Christians and 6 non-Dalits. The project started with a Kudumbasree loan of 15 lakhs initially from 2 separate banks as well as with the support of small kudumbasree loans taken personally by all members.

"Most of the Dalit members in the project has left it, only the secretary is now active remaining all left. There was no income or revenue from it, don't we need money to live? Its not just the flood sir, the project has significant financial loss and there are bank loans involved" (CS2 Dalit community5)

Though the project started off well, it soon met with glitches due to lack of know-how which resulted in wastage of large amounts of rice due to improper storage. Challenges also arose in 2018 when floods hit Village B which too resulted in loss of money within the project. Though the project had planned for a daily income for all its members, recurring financial losses over the years had made it impossible to receive a steady income for its members. This had resulted in many members dropping out of the

project, all of them ironically Dalits. As of 2021, the Village B rice project that started off as a Dalit project currently has only 2 Dalit members out of the 6 members. The project leadership too is currently held by non-Dalit actors only with the position of secretary allotted to a Dalit actor. Though, she too was threatened of ouster since she had rebelled with CPI(M) for not providing a ticket in the recent LSGI election. It could be discerned that the exclusion of Dalits in this case was more or less predisposed owing to their fragile living conditions shaped by the social location of caste.

Similary Village B panchayat also had a project called Avees Café, which too was initiated by the LSGI in collaboration with Kudumbasree. The project was a small restaurant outlet that sold steam cooked snacks along the highway. This project too was conceptualised as a Dalit specific project of Kudumbasree managed and run by Dalit members. The project has been running well until 2020 when Covid-19 pandemic occurred during following which it was converted to a community kitchen under the Village B LSGI. However, during this period due to conflicts between the Avees Café leadership with the LSGI vice-president, the Dalit secretary of the project was removed from the project.

"Sir, this is the case everywhere, always they show the face of Dalits to receive funds and then distribute it to non-Dalits. By showing scheduled caste they will start a project, and by midway when the project starts running well or even if it fails, we will be removed from it and they will appoint others, that's it" (CS2 Dalit community4)

Presently the project is headed by a non-Dalit member appointed by the vice-president. The decision of vice-president was defended by him since the project is currently community kitchen and not the Kudumbasree café project. Again, this too was an instance of Dalit project reconstituted under the leadership of non-Dalit members.

A third project which could be seen along with the above discussed project is the plastic shredding unit initiated by the LSGI and run by Kudumbasree members. The project as discussed before was one of the many innovative projects in Village B that received much media attention. This project too was operated by Dalit Kudumbasree members exclusively. The project involved cleaning of the plastic waste collected by Haritha Karma sena at the shredding unit by its members. After cleaning the plastic is

shredded using a shredding machine installed at the facility. The project had started in 2012 and has been running successfully as of March 2021.

"Only in the plastic shredding unit project there has not been a major reshuffling. Also, who will handle waste other than us (smiles sarcastically)." (CS2 Dalit community6)

However, the attrition of Dalit as seen in Village B nor removal of key leaders involved in the project was never observed in this project. Interviews with Dalit community members felt that it would not happen since dealing with waste have always been entrusted with Dalits everywhere. They felt that no other community members would be willing to operate the shredding unit since it is obviously a dirty task.

5. DISCUSSION

Kerala's ambitious 'Peoples plan' campaign marked its 25th year of implementation in the year 2021. The decentralisation process devolved substantial transfer of powers and financial autonomy to LSGIs that has enabled them to initiate projects that could address the needs of their local communities (Balan et al., 2014b). Healthcare, specifically primary healthcare has been a key area of intervention within the ambit of village panchayats in Kerala. This has invariably resulted in a slew of unique and innovative healthcare projects in Kerala over the course of these years. Despite this, there have been limited attempts to explore the various innovations currently underway in the State, specifically for primary healthcare. Though, the government of Kerala has instituted various awards to identify good LSGIs, innovations and their exploration remain a lacuna in the State. Yet another area of interest in the context of the current research is the Dalit question and the ways in which 'People's plan' campaign has engaged with it. Specifically, from the perspective of social justice and equity with regards to Dalit inclusivity in LSGI projects in Kerala. This research is therefore an attempt in this direction, to try and fill the existing research gaps with respect to LSGI level social innovations and the examination of Dalit inclusion within them.

The study could unearth key information regarding how larger discourses on primary healthcare prioritise and mainstream a medicalised idea of primary healthcare. One that maintains a narrow view of social determinants as well as role of communities within them. Also crucial was the inability of policy discourse on primary health care to acknowledge the health disparities among Dalits and therefore exclude them as a marginalised social group. The second level analysis undertook an in-depth exploration of ongoing social innovations for primary healthcare in village panchayats in Kerala. This enabled the exploration of how social innovations emerge within panchayats and the role of various factors in shaping these social innovations. The findings suggest that the emergence of social innovations of primary health care was overdetermined by a slew of factors. However crucial among these were the political affiliation of the LSGI as well as the interactions among LSGIs that prioritise certain mode of actions. The influence of larger policies was also crucial in determining their emergence. However, these social innovations continue to reflect the medicalised idea

of primary health care as well as their views on community partnership and marginalisation. The result was obviously relegation of community's role as implementation partners and exclusion of Dalits. One of the key strengths of the current study as is its rather deliberate bias towards the realities of the oppressed sections, specifically that of Dalits in contemporary Kerala. Going by the existing realm of research on primary healthcare and decentralisation in Kerala, this study is one of the first to explore the idea of social innovations and Dalit inclusivity. Hence, the findings from the current study have key policy level implications with respect to the implementation of primary healthcare and decentralisation projects in Kerala.

5.1 DIALECTICS BETWEEN LARGER DISCOURSES AND DISCURSIVE PRACTICES OF LSGIS IN THE STUDY

This section specifically aims to discuss the key overarching discourses that influenced and shaped priority setting as well as the nature of social innovations examined. Evidence suggest that though ideas of equity and social justice are often talked about within healthcare, decisions on healthcare are still influenced by dominant social discourses (Blanchet Garneau et al., 2019). The findings from the current research too clearly suggest how the various perspectives and world views of dominant actors at the level of LSGI does in fact shape the project outcomes including the nature of social innovations for primary healthcare. The evidence from the current study points to three major interconnected themes within the discourses that influenced and shaped the priority setting within LSGIs and thereby also shape the social innovations. These are;

5.1.1: A MEDICALISED AND APOLITIZISED IDEA OF PRIMARY HEALTH CARE WITHIN STRATEGIES THAT AIMS TO MOVE BEYOND THE SAME

The findings from CDA of policy discourses on primary health care innovations suggest the detrimental role of pervasive ideologies in shaping ideas on health care. Though there clearly existed a committed intent on the part of the government to revive the health system, it continues to carry the burden of an ideology that arguably is shaped and driven by a neoliberal ideology on health care, one that prioritise curative care over others. This also suggests a continuation of a global pattern wherein reforms that intended to move away from market-oriented health care also continued to carry

the burden of neoliberal tendencies within them. These include the popular experiments from the Latin American countries popularly called Latin American Social Movements (LASMs) which are also termed under the moniker of 'Postneoliberal' health care reforms. These reforms were mounted as a challenge and alternative to the hegemonical neoliberal regimes and structures that marked the history of Latin American countries till then. These reforms championed by the political left sought to address the widening social inequalities sustained under neoliberal systems, specifically within the realm of public health care in the region (Chris Hartmann, 2019; Sánchez & Polga-Hecimovich, 2019).

However, a caveat that often followed the postneoliberal shifts in the Latin Americal countries was the persistence of neoliberal rationalities within policies that attempted to challenge the same. The experiments in the Latin American regions too were argued to have failed in completely assimilating the ideas of social medicine concepts of health nor completely rejecting neoliberal paradigms of health (Hartmann, 2016). The policy level discourses on primary health care innovations in Kerala too suggests a similar patterns within them. Though as a policy, the State openly commits to its promise to move away from a market-driven idea of health care, it too fails to completely shrug off the neoliberal influences within its ideas of primary health care. The tension between health as a basic human right and public good versus health as a commodity were evident within the policy level discourses in Kerala.

5.1.1.1: Dominance of curative care discourse within strategies aimed at comprehensive primary health care

The Aardram mission for health care in Kerala was evidently vocal about its commitment to the idea of strengthening primary health care through its emphasis on comprehensive primary health care and social determinants of health. However, the policy itself as well as the narratives of policy level actors remains largely counter-intuitive to the social determinants vantage point envisaged under the principles of primary health care. The overemphasis of primary health care innovation discourses on secondary prevention and curative care among health and LSGI actors in Kerala could be argued to have been driven by a neoliberal idea of health. For, within

neoliberal discourse, the idea of health is largely watered down to individual-centric, biomedical models of curative care (Hartmann, 2016). Hence, it only becomes natural to perceive primary health care innovations as shaped around the prevalence of diseases as well as disease screening strategies, one that comfortably fits within the biomedical and curative care rationality. Reading along with this is the dominance of the discourse that favours infrastructural improvements as primary health care innovations in Kerala. A perspective on health primary health care that is biased towards curative care by extension requires the services of an expert from a facility that has the sufficient infrastructure to aid its delivery. The continuation of such discourses also seems to extend within the larger level policies on health including the 2017 National Health Policy in India as well as ones that exist globally too. For, they too reflect within themselves this larger tendency of being governed by the neoliberal discourse on public health ("National Health Policy Reflects Conflict Between Public Health and Neoliberalism," 2017; Sater De Andrade, Resende Carvalho, Freitas de Oliveira, & Ravelli Cabrini, 2020).

The secondary prevention and curative care bias expressed within the policy level discourses on primary health care were also reflected within the case study panchayats too. Both Village A and B were evident for their priority attributed to projects that aimed at strengthening the patient care services and facilities through their primary health centres. Both the panchayats spend significant budgets on ISO certification as well as Kayakalpa accreditation of their PHCs. Improvement of human resource at these facilities were too a major area of intervention including provision of additional doctors, pharmacists and lab facilities. The social innovation from Village B, 'Sayamprabha' was particularly evident for this bias towards primary health care within the study. The survey tool used for 'Sayamprabha' initially had some hints towards a comprehensive approach to primary health care. This was evident in terms of the information gathered around the social location of the individual, family details including income, living condition, educational status amongst a host of other details. However, one of the most crucial strategies within the 'Sayamprabha' project was its priority on screening camps for NCDs and provision of free medicines through the camps. Also were its strategies like provision of spectacles and hearing aid for those

who required them. Clearly these strategies were clearly derived out of a felt need among its community and fills a unaddressed health gap in themselves. However, no strategies were developed around the information on social location, living condition and educational status apart from the fact that they were used to find the beneficiary for distribution of benefits including free hearing aid, cot etc. The fact that little effort has gone into other strategies for primary prevention and health promotion speaks about the dialectic relation between larger discourses and social practices of primary health care in the State.

5.1.1.2: Apolitical and sanitised views on social determinants

Social determinants were one of the most invoked concepts within the policy level discourses on primary health care in the study. However, their failure to move beyond a reductionist and apolitical view of social determinants is a common pattern that has been prevalent within public health discourse in the study. This too reflects the much too common neoliberal idea of poverty that is exclusively driven from an individualistic level. Such perspectives of poverty deal with an individual who is poor and move on to explore the individuals' character and the biological, racial and ethnic backgrounds that made them poor. However, this endeavour completely backgrounds the analysis and exploration of various class relations, social power structures that determine outcomes like poverty at a larger level. There is always the relentless attempt to locate the individual and their economic status from an empirically quantifiable approach (Hänninen, Lehtelä, & Saikkonen, 2019).

On one level Aardram mission's primary health care narratives put forward a vision of a truly holistic approach to health care by invoking social determinants including the provision of safe drinking water and clean surrounding amongst others. However, by maintaining a reductionist and narrow approach to social determinants, it simultaneously obfuscates within the same narrative the larger disparities within the distribution of social determinants within various social groups in the State. Such a discourse on social determinants also lacks acknowledgement of various historical social structures that shape the unequal organisation of community groups and the disparities within the distribution of resources within them (Raphael, 2006). This could

be of much significance given the context of Kerala, where there exists ample evidence on growing inequalities among various social groups both in terms of health as well as access to various social determinants of health (Thresia, 2007). The overall development paradigm of the state is evidently riddled with large structural inequities driven by caste, gender, ethnic status and economic class. All of this has invariably translated as persisting inequities in the distribution of health outcomes among various social groups in the state (Thresia, 2014).

The reflection of these discourses was evident within the social innovation case studies too. Both the social innovations examined demonstrated this pattern of dilution of the idea of social determinants. The 'I care we care' innovation in its approach to preventing communicable diseases, clearly aimed at the issue of environmental hygiene and sanitation. However, the limitation within the project to problematise the issue of poor living conditions within Dalit colonies meant that many Dalit colonies were excluded in the later phases of the project. Though the project could be seen to have aimed at hygiene as a determinant of health, the societal dimension of hygiene and sanitation on health was totally lost on the project. The 'Sayamprabha' innovation too, failed to acknowledge the issue of Dalit elderly and how they could be exasperated through historical and structural dimensions of caste. Though the social locations of caste and gender were captured early on in the project, little were they used to curate the innovation around these aspects and their impact on distribution of health across the community.

5.1.1.3: Relegation of communities as beneficiaries and implementation facilitators

Often invoked theme along with that of social determinants was community participation within primary healthcare discourses in Kerala. Community partnership was repeatedly seen as a mandatory construct when talking about primary health care innovations. The patterns in health discourses globally too suggest to a similar proliferation of ideas related to communities being positioned as the locus of healthcare services (Komporozos-Athanasiou et al., 2018). However, ideas of community participation equated as their role as responsible beneficiaries, as resources

for program implementation and as the ones to ensure transparency suggest to a reductionist view of democratic participation within policy discourses. This diluted view of community participation alludes to a neoliberal perspective of community participation as *Responsibilisation*, which largely recontextualise communities and individuals roles as being responsible for public tasks (Schinkel & Van Houdt, 2010). Though the policy places community as an active partner, the duality of communities and experts continues to persists and are also made evident. Primary healthcare programs within such ideas are still drawn from the experts and the role of communities is limited to the realisation of a given political project (Komporozos-Athanasiou et al., 2018). The role of communities within the policy discourses currently in Kerala too fails to internalise the concept of communities as active co-producers of health and rather limits them within the lowermost pyramid of program implementation. These allude to the looming tensions within primary healthcare policy, one between the felt need to include communities as active partners and the neoliberal tendency of a reductionist views of community participation currently in the State.

The in-depth examination of the two social innovations too alluded to such a pattern of community partnership within them. Both the social innovation projects were evident in terms of significant community partnership. However, the actual nature of this partnership, or the extent of autonomy they had within these projects were rather limited. In both these projects the major role communities played was mostly around the implementation of the project. Particularly so, in the case of 'I care we care' where the only role community level volunteers had was during the conduction of the household survey and hygiene promotion activities. Little role did voluntary teams like 'Health promotion teams' had in terms of conceptualising or planning phase of the activities. This was also the pattern within 'Sayamprabha' in village B, where elderly teams were mostly used to conduct the elderly survey. Though there were 'Sayamprabha' clubs at the level of anganwadis, these clubs had limited role in planning of activities within the project. The executive members of the 'Sayamprabha' including the panchayat level president of the elderly club clearly had no say in the routine activities of the project. The idea of decentralisation though laid the foundation

for an idea of pro-active role of communities in local activities, the realisation of these themes continues to remain aspirational. The social innovation projects examined clearly hints to a larger pattern of top-down models of decentralised governance, that largely pass off as community partnered and decentralised. One, that is also strongly present within the popular discourse on decentralised projects for primary health care across the state.

5.1.2: UBIQUITOUS NATURE OF CASTE UNSPEAKABILITY ACROSS POLICY DISCOURSE AND SOCIAL PRACTICE OF PRIMARY HEALTH CARE INNOVATIONS IN KERALA

The policy discourses on marginalisation in Kerala in the current study was also characterised by a blindness to Dalits as a marginalised social group. However, the aspect of Dalit blindness is rendered curious given the acknowledgement of aadivasis and coastal community as marginalised within the same policy discourses. The simultaneous presence of certain social groups as marginalised yet unacknowledging Dalits warrants the need theorise the issue of Dalit invisibilisation. One that moves beyond the paradigms of neoliberal tendencies within social determinants to the ones that could also accommodate the question of Dalits from an Indian context. It is in this context the study discusses the theme of caste as an unspeakable idea within policy discourses in Kerala.

5.1.2.1: Recontextualization of untouchability as caste unspeakability within policies

Evident within the policy discourses on marginalisation in the study was attempts to shape the narratives on marginalisation by carefully avoiding the question of caste. The policy narratives were characteristically evident with an ominous reluctance to even mention the word caste or scheduled castes related to discourses on marginalisation. The marginalisation narratives in the current study almost exclusively existed along the axes of biomedical markers of age and sex, access to drinking water and hygiene. The references to marginalised social groups too were drawn from the reductionist ideas of geographical location like Aadivasis and coastal communities in this case. The palpable urgency to dismiss any reference to caste within

marginalisation discourses within the current study allude to a conscious or unconscious yet strong repugnance towards discussions on caste.

Sociologist Satish Deshpande in his thesis of castelessness in India, argues about how the various historical legal and policy decisions on the issue of caste and reservation have shaped a new 'common sense' of caste in India. He argues that the word caste is almost often immediately reinterpreted as 'lower castes' within the collective discourses. This also has parallels to similar recontextualizations within other universal categories of gender and race. Gender is almost often construed as women from a conventional patriarchal common sense and race as people of colour from a white supremacist sense (S. Deshpande, 2013).

The reductionist logic of caste as 'lower caste' has significant relevance in the current study since dismissing caste also by extension suggest to the exclusion of Dalits themselves as a marginalised social category. Through the avoidance of discussions on caste, there is an uncanny resemblance of the Brahminic logics of purity and impurity being carried over to the realm of social discourses on health and by extension exclusion of Dalits. An evident contempt to even have a discussion about caste among the ruling elites subsequently lead to the existing caste blindness within policies. This is in line with 'Social Nausea' argument by sociologist Awanish Kumar, where he argues that Indian policy today suffer from the potent combination of social isolation backed by the regressive notion of Brahminical caste and that of social nausea of elite castes towards utterances of caste and Dalits. The result being the inability of public policies on health to effectively address the real issues of the masses in India (Kumar, 2020).

5.1.2.2: Anti-Dalit narratives within LSGI structures and practices of primary health care innovations

The issue of Dalit exclusion within the social innovations examined was also drawn from the repugnance to the idea of caste within the narratives of LSGI and health leadership in the study. For, both the LSGIs within the case studies either remained blind to the issues of caste or was dismissed as an axis of vulnerability. One that is also drawn from a similar pattern within the larger discourse on primary health care in the

state. Unlike the realms of policy making which is far separated from the day-to-day realities of governance and people interaction, LSGIs are active sites of communication exchanges and conflicts. This is relevant in the current context, for the issue of 'social nausea' or unspeakability of caste as evident within policy discourses though are not completely absent, it also becomes necessary within LSGI spaces to deal with Dalit and Dalit related issues as a mandate. This meant that, caste remained as a live issue that has to be dealt with on an ongoing basis within various realms of decision-making at the level of LSGI. This opened up a new space, that was evidently casteist yet the expressions of which ranged from outright rejection of caste-based exclusions to condescension and blaming attitude towards Dalits. However, what was evident was the ubiquitous presence of humilatory and anti-Dalit narratives that was dominant within the LSGI discourses within the study.

5.1.2.2a: Caste as an 'anachronism' in modern day Kerala

Yet another dimension of caste dismissal within the study was also the overlapping of the idea of caste dismissal with that of the ideologies of political left. Given the political milieu of both the village panchayats selected for the case study being dominated by the LDF, there was an evident and overt attempt to dismiss any social categories beyond that of economic classes within the narratives on marginalisation. Caste was seen as a non-issue by leadership of both village panchayats in the study. This is reflective of the history of Marxist movements in India and their continuous attempts to generate a class consciousness exclusively on economic criteria (Prakash Karat, 2011).

However, the reference to the class categories dominant within left political leadership in this case shall not be perceived from a neutral pro-poor outlook that accommodates all social categories irrespective of their social locations. The operation of economic class categories is also driven by the conscious or unconscious anti-Dalit sentiments pervasive within the non-Dalit ruling class within the LSGI. From this vantage point, it becomes rather easy for them to dismiss Dalit marginalisation by conveniently referring to their 'universal' and 'pro-poor' political stance. A commonly appearing theme was the assumed notion that Kerala is a 'modern', 'progressed' society and that

caste is an anachronism in contemporary Malayali society. The rather famous quote by Dr Baba Saheb Ambedkar where he called the communist leadership in India as a bunch of 'Brahmin boys' resonates within these views on caste in contemporary left leadership in Kerala (*What Dr. Ambedkar Said about Communism and Communist Parties - Velivada - Educate, Agitate, Organize*, 2016). Often this has come at the cost of dismissing as well as negative stereotyping of all forms of identity politics that has emerged in the country as essentially divisive (Das, 2020).

5.1.2.2b: Dalits as the 'most preferred' beneficiaries for all welfare schemes

A frequent hue within the Dalit humiliatory discourses are the ways in which Dalits are placed as the preferential beneficiary of all the welfare schemes available through LSGIs. That, Dalits are the most benefitted category section for any government when being considered for the provision of any schemes in Kerala. There existed a seeming contempt within these narratives driven by the notion that Dalits are 'stealing' away all the benefits that the non-Dalits too 'deserve'. Often made evident through the sarcastic remark that, 'now we are more deprived than them'. This is in line with the popular notion of Dalits as 'sarkaar ka damaat' or the 'sons-in-laws' of government argument, as they receive much benefits based on their caste locations (Guru, 2011). These remarks are simultaneously derogatory as well as borne out of the contempt towards Dalits as being the beneficiaries of public schemes funded by the public. Experiences of humiliation and contempt faced by Dalit students during instances of their receival of educational scholarship also reflects a similar picture that is common to the psyche of non-Dalits in relation to Dalits and welfare schemes available for Dalits (Pramod, 2020). Parallels to these are also discernible from the attitudes of non-Dalits towards the idea of reservation for Dalit candidates within LSGI representation in the study. Constitutional reservations for Dalit members to LSGIs were also perceived as a means of backdoor entry for ill qualified and talentless politicians. These arguments also presents an uncanny resemblance to the 'merit' argument raised by savarna categories towards caste based reservation to educational institutions and government jobs (Subramanian, 2015; Vijayan, 2017).

5.1.2.2c: Invented logics of differences

A third yet not so subtle approach to Dalit humiliation is through the overt stereotyping of Dalits followed by the blaming of Dalits for their poor conditions. The interviews with non-Dalit members within the caste study are replete with rather bland stereotypes including that of alcoholism, abuse of drugs as prevalent among Dalit members. These are also then used again as the very cause of the Dalit situation today. That 'due' to their proclivity to negative behaviours and due to the no questions asked 'subsidies' and 'reservation' they have become a 'lazy' crowd. They 'do not wish' to get proper education nor good job, because they have everything freely available. They are portrayed as a crowd that does not have the 'courage' to speak out, which has also added to their misery. Clearly there existed an almost evident urgency in demarcating the Dalits and the non-Dalits within these narratives and these fault lines are drawn using the negativity attributed to being an alcoholic and drug abuser.

These rather newly drawn fault lines could be argued as the changing dynamics of practicing caste today in India, albeit a forced change since the conventional practice of casteism – overt practices of untouchability and remaining within their hereditary vocations - are fast waning under the pressures of modern liberal democracy. The changing realm of social lives within modern societies and the evident lack of demarcation of people as a savarna or Dalit has made Brahminical caste system to seek out newer yet modern forms of untouchability. It is here one can draw from the theories of Slovenian philosopher Slavoj Žižek and rather eloquently explained by the Indian academician Anilkumar Vijayan around caste in contemporary India. Vijayan rather succinctly recontextualise Žižek theory of the 'unbearability of sameness' and the 'logics of difference' into his theorisation of modern-day untouchability and meritocracy. It is argued that, although savarnas within modern liberal spaces cannot overtly practice casteism, they invariably find it unbearable to find that there is no tangible difference between them and the impure Dalits. Hence, to break this sameness, it is important for them to find subtle logics of invented differences that can demarcate between them and Dalits (Vijayan, 2017; Žižek, 1994). This is relevant to this current study context, since these invented stereotypes around Dalits are in a way the attempts to draw the line between *them* and *us*.

5.1.3: RECONTEXTUALIZATION OF DECENTRALISATION AS BENEFIT DISTRIBUTION MECHANISMS

A third theme that ran across the realm of discourse and the discursive practices of LSGIs in the study was that of welfarism. An idea that LSGIs as a mechanism of distributing welfare benefits for communities. The thematic analysis of primary health care innovations among health and LSGI functionaries did allude to this tendency to perceive them as provision of free medicines, dietary support, economic support. This was also a recurring theme that emerged within the explorative case studies of the two panchayats in the study. For, the various health related projects including the social innovations examined suggested to this pattern. Literature on Kerala decentralisation too suggests that historically LSGIs have been governed by the idea of welfare distribution, a persistent feature within PPC in Kerala. Though the People's Plan Campaign rolled out in 1996 to fulfil a promise what sociologists call 'the liberal economic promise' made in the wake of the crisis the State witnessed in its economic status. One that promised basic citizen's rights of land ownership and provision of basic services in terms of health, education amongst others, all of which saw a stark decline post the land reforms in 1970. Later studies on Kerala's decentralisation does suggest to a failure in achieving these objectives in terms of real people participation within various aspects through decentralisation. What was mostly achieved was the provision of basic needs through the LSGIs, one that was dominated by distribution of individual level welfare benefits (Devika & Thampi, 2011; N. D. G. Nair, 2000).

This has in fact resulted in a popular perception towards panchayats as mechanisms for provision of various benefits and has largely limited its ability to actively involve citizens as producers of any sort. This larger perception of LSGIs is evident in how LSGIs utilise their funds. A larger share of welfare funds available for LSGIs are mostly utilised for the distribution of individual level benefits in Kerala (Devika & Thampi, 2011). Both the panchayats in the study did have multiple projects that were drawn from this idea of welfare distribution including free medicines for poor elderly members, financial support schemes for poor patients with chronic diseases. The community in both these cases were reduced as a group that shall be catered through various welfare schemes. Specifically in the case of 'Sayamprabha' project, though it

had elements of societal involvement in terms of elderly society it too was largely dominated by the idea of welfare provisions. The project started off as an idea to delegate power to the elderly through elderly association, it largely was caught in the trap of welfarism. The key elements of the 'Sayamprabha' project suggests this continuum of welfare pattern, including provision of free nutritional supplements, free medicines, free hearing aids amongst other for the elderly community in the panchayat. The narratives of elderly members included in the project too alludes to how the community perceive the project. The experiences of 'Sayamprabha' members were replete with terms like 'anukoolyam' (benefit), 'gunam' as if the project was intended to provide something to them. The idea of taking ownership of the activities for the elderly, by the elderly was sorely missing within the narratives of elderly too in the panchayat.

5.2: A 'NON-DIVERGENT INSTITUTIONAL RESPONSE' PERSPECTIVE TOWARDS SOCIAL INNOVATIONS

The two social innovations for primary health care examined through the case studies dis present key parallels across various factors that led to their emergence as well as in the nature of these innovations. This section specifically aims to theorise both the emergence of these social innovations as well as their specific nature in terms of Dalit exclusion/inclusion. A key analytical construct that would be used to undertake the theorisation of social innovations would be that of institutional theories and comparing and contrasting them with existing literature on the same. By using this strategy, the research aims to shed light on the key salient institutional dynamics that laid the context for the emergence of these social innovations. The study also tries to bring out the key points of departure that the existing social innovations present with the accepted theories on social innovations.

Institutional theories have enabled a deeper understanding of social innovations through their ability to better explain the evolution of social innovations using the foundational construct of institutions. This has been specifically enabled by the theories of *institutional entrepreneurship* that enables the explanation of the radical changes often associated with emergence of social innovations within various contexts. Institutional theories on social innovations in comparison with other

theoretical strands on social innovations foregrounds the role of various actors, their positions and interactions as interdependent entities within a given institutional context. Emphasis is also given to the consideration of various contextual rules, norms and values and their existence as socially constructed and negotiated by the actors within a given context (P. J. DiMaggio & Powell, 1983; Jensen & Fersch, 2019; van Wijk et al., 2019).

However, in light of the evidence available from the two social innovation case studies, a thesis, the current research intends to propose is the idea of social innovations as *non-divergent institutional responses* and not so much a radical institutional change. However, this is counter-intuitive to the existing theories on social innovations as well as innovations, often considered as *divergent institutions* and sometimes termed as radically different institutions (van Wijk et al., 2019). Before such an idea is proposed, it is necessary to layout the key foundational dynamics in relation to institutions and social innovations are laid out and discussed.

5.2.1: SOCIAL INNOVATIONS AND INSTITUTIONAL ENTREPRENEURSHIP

Insights from the foundations of institutional theories has largely provided a reinvigorated impetus to the study social innovations globally. A major breakthrough for such trajectory was laid through the groundbreaking work on institutional theory by DiMaggio in 1988. Through his seminal work he introduced the concept of institutional entrepreneurship which sought to reintroduce the concept of agency within individual actors within the larger schemes on institutional analysis (P. DiMaggio, 1988). This largely went against the earlier works on institutions that mostly tended to diminish the role of individual agency within ideas on institutional change. The earlier theories attributed emphasis on extraneous shocks as a key factor that mostly triggered institutional changes. The idea of institutional entrepreneurship opened up a new and powerful explanation of institutional changes that is also simultaneously endogenous in its origin (Leca & Boxenbaum, 2008).

Institutional entrepreneurship discusses about the significant role of individual agents within an institutional context to affect institutional change. It introduces the idea that individual actors through their sustained efforts can overcome institutional barriers and

introduce larger level institutional change. DiMaggio characterises institutional entrepreneurship as the organised efforts of individuals backed by sufficient resources which can ultimately contribute to changes within the institutional structures and thereby introduce newer institutions (P. DiMaggio, 1988). This posits an idea of the power vested within individual agents operating within a given institutional context to ultimately change the institutions against its basic nature of stasis (Leca & Boxenbaum, 2008; Seo & Creed, 2002).

Social innovations research too have had its share of influence from the larger institutional theories to adapt the concept of institutional entrepreneurship. Recent advances within social innovations largely builds on this idea of institutional entrepreneurship as a powerful analytical tool to explore and explain the emergence of social innovations (Jensen & Fersch, 2019; van Wijk et al., 2019). These literatures draw from the idea of both endogenous and exogenous forces of institutional change. Endogenous as in, institutional entrepreneurs, and exogenous as in external triggers that lays the conditions for the change demanded by the entrepreneurs. The exogenous triggers could be an array of factors including financial constraints, environmental changes amongst others that presents themselves as a challenge to the existing ways of institutions. However, these exogenous factors despite their significant influence are limited in their ability to guide the exact direction of institutional change. This direction and guidance are in fact provided by the endogenous forces of institutional entrepreneurs with their unique characteristics including their reflexivity, capacity to think in new terms and their ability to easily adapt to newer ideas (Jensen & Fersch, 2019).

5.2.1.1: Institutional entrepreneurship and paradox of embedded agency

The pioneering works on institutional entrepreneurship rather daringly introduced a theory of institutions that is also imbued with the idea of an entrepreneurial world view embedded within itself. They emphasised on the entrepreneurial activities of individual change makers to deliberately leverage their power and resources in an attempt to transform their institutional context. They argue that the idea of institutional entrepreneurship reintroduces the ideas of power, agency and interests within analysis

of institutional change (Garud et al., 2007). Although owing to its immediately intuitive logic that could explain change in terms of innovations, the idea of institutional entrepreneurship has never been without its share of criticism too. The most insurmountable one came in the nature of the idea of 'paradox of embedded agency'. The logic of institutional entrepreneurship though effective in its explanation of institutional change could never really resolve the ever-persistent structure versus agency debate and the challenges that came with it (Holm, 1995; Seo & Creed, 2002).

The critics of the embedded agency of entrepreneurship has long questioned the rather disembedded view of individual agency, which backgrounds the powerful influence of institutions on actors and their behaviours and their power in sustaining status quo (Phillips & Malhotra, 2008). Largely the concerns raised by the critiques of institutional entrepreneurship and the source of power that enables individuals to effect change still remains unresolved. By emphasising on agentic superhuman capabilities of entrepreneurs without contextualising them within their immediate socio-cultural environment, the theory risks being reductionist. A reductionist view of simplifying organisational and institutional structures as mere linear derivatives of individual efforts (Abdelnour et al., 2017).

5.2.2: DEPARTURE FROM THE IDEA OF 'INSTITUTIONAL ENTREPRENEURSHIP' WITHIN THE SOCIAL INNOVATIONS EXAMINED IN THE STUDY

The current research on social innovations does in fact has significant take aways from the critiques of institutional entrepreneurship in terms of the how embedded agency can affect radical institutional level changes. Despite the social innovation literatures' take on institutional entrepreneurship as a key factor within their emergence (Jensen & Fersch, 2019; van Wijk et al., 2019), the current study too suggests otherwise. A key argument raised by the critiques of embedded agency and institutional entrepreneurship is the inherent inability of 'embedded actors' to feel the need to change the existing ways and work towards an alternative. Particularly so in the case of dominant actors, since they draw their very power from existing institutional norms, and therefore are rarely motivated to seek alternatives or changes and are conditioned to the existing normative processes (Greenwood & Suddaby, 2006).

It is in this context the study intends to discuss further, the role of power within institutional work and how it is related to the current research on LSGIs and social innovations. The idea of institutional work refers to the roles played by various actors within an institutional context that are aimed both at continuity of institutions as well as changes within it (Lawrence & Suddaby, 2006). Deeply embedded within this is the idea of 'power' attached to ideas as they ultimately decide how actors would behave and interact, and accepting and acknowledging various informal practices that are accepted equally by the group they are also part of (Schmidt, 2017).

5.2.2.1: Institutions and power

A key interconnecting link between institutions and its long-term sustenance is the idea of power. Because institutions, be it formal or informal is only relevant as long as it is able to exercise its relevance as a prescriptive system for the actors involved within a decision-making space. Hence, institutions are relevant in only as much it is successful in achieving a sustained adherence to it by various actors, organisations or societies in the way it dictates their nature of interactions and behaviours including their beliefs (Hughes, 1936). But a key factor that distinguishes institutions are its power to limit transgressions beyond its prescriptive limits by the involved actors, organisations and societies. And this is where the key link between institutions and power emerges. Because, institutions are only relevant in its ability or power to also institutionalise counter active measures for avoiding actors transgress its limits. These sanctions are socially constructed and systematically and repeatedly evoked that can successfully disincentivise actors or organisations to break the conventional practices of institutions. Hence, institutions are vastly different from other social structures in its complex interconnections of power and its repeated invoking as control systems that sustains it over time (Greenwood et al., 2017). An idea of power that closely resembles the Foucauldian concept of power. One that is omnipresent in all social relations and practices and ultimately influences everything by its mere presence (Foucault, 1977a; Lukes, 2005).

5.2.2.1a: Power and its manifestation as informal institutions in the context of decentralised governance

Though structures like decentralisation holds vast potential to strengthen grass root level democracy, the implementation of formal or legal rules have often remained limited in its ability to achieve complete adherence specifically in the context of developing countries (Bardhan, 2002). Formal rules may fail in providing the needed incentives to achieve sustained adherence to them by the local actors. The result is wide variations in the degrees of success achieved by different local governments even under similar conditions and common legal frameworks. The answer to these differences lie in the concept of informal institutions and the power wielded by them to interact with or substitute ineffective formal institutions (Fridy & Myers, 2019; Horowitz & Palaniswamy, 2010; Pal & Wahhaj, 2016). The significance of informal institutions in bringing out large variations within decentralisation landscape in India suggests that a limited focus on the formal structures are at best partial explanations of the existing policy outcomes (Ban & Rao, 2009; Horowitz & Palaniswamy, 2010; Palaniswamy & Krishnan, 2008).

Specifically, in rural settings, it is commonplace to have informal practices that incentivise exclusions of community groups based on their caste status. Similar patterns also exist along the lines of gender, where women are bound by patriarchal norms often limiting their involvement in decision-making processes even if they remain part of the formal LSGI structure (Ashwani, 2017). Evidence on decentralisation experiences from India have showed that devolution of authority has resulted in local elites capturing power at the cost of the poor and marginalised in the country. Hence, more often than not informal institutions rooted through the power drawn from caste and gender matter more than the formal institutions or legal rules in India (Harriss, 2001; Johnson, 2003; Rajasekhar et al., 2017). The power wielded by non-Dalit male LSGI actors and the overt exclusions and marginalisation faced by Dalit female actors within decision-making spaces speak about the nature of power in the two case studies. This is in line with the broader trends within LSGI decision-making in Indian contexts and the hegemonical position of informal institutions shaped by power-relations drawn out of the social locations of caste, class and gender.

In both the village panchayats explored within the current study, the power wielded by male politicians also sanctioned by their political organisations, led to the evolution of informal reservations of male as a counter measure to the formal reservation systems. This was also similarly played out in the case of caste reservations too, where non-reserved wards were informally reserved for non-Dalit politicians within both the panchayats. The patriarchal and casteist norms within political organisations as well as society at large meant that powerful non-Dalit males often had the final say in decisions. A manifestation of power that functions as a more powerful alternative to the formal structures and authority in any given space (Hickson et al., 1971; Mintzberg, 1984; Thompson, 1956). This is a notion of power that is made systemic and is affected through routine and sustained practices that ultimately facilitates the domination of certain groups over others, without the dominant group necessarily the one to establish them or maintain it (Clegg, 1989; Foucault, 1977b; Greenwood et al., 2017; Laclau & Mouffe, 1985). This is assumed to be relevant given the social context of deep-rooted casteism and male-dominated decision-making spaces in India. Substantial evidence on decentralisation points to the fact that constitutional provisioning of representation for Dalit communities has not been translated as real autonomy within the LSGI decision-making processes in India (Inbanathan & Sivanna, 2010; Sukumar et al., 2019).

These patterns of power distribution along the lines of gender within the case studies could be seen as a continuation of the larger discourse on women leaders within LSGIs in Kerala are perceived. The history of introduction of women into electoral politics in the context of LSGIs has in fact been a significant milestone in Kerala during the mid-1990's. However, the ushering in of women in decentralised governance was not without its caveats in Kerala. Researchers argue that the idea of gender mainstreaming in the State and the later discourse on women LSGI leaders was in fact shaped by the very nature of its initial conceptualisation. The process of induction of women leaders in the State was made possible through the mechanisms of reservation and specific fund heads like women component plan. However, the very nature of these mechanisms largely saw women as subjects or passive recipients of capacity building measures by the government. They failed to see women as independent agents with an active role to play in political decentralisation. The idea of women within

decentralisation was hence largely limited to women as governmental category for provision of benefits. Such a perspective on women and women politicians resulted in a system of LSGIs that sorely lacked enough room for independent decision-making by its women leaders (Devika, 2019).

It is also argued that the entrance of women into the space of decentralisation resulted in the reconstitution of these power structures along the lines of patriarchal norms. As a result, women in politics of LSGIs were seen through the new lens of a 'feminine' agency and skill sets, one of compassion and love to the community. Hence, largely for women politicians the line was drawn between competitive politics and as their role as a 'feminine' leader. These have in fact reflected across the realm of LSGIs as hostility to women leaders who were assertive and the general inability of decentralisation to accept women as a political group(Devika & Thampi, 2011). The status of women leaders in the current study area too does not prove otherwise and could be seen as a continuation of the gender stereotypes that exist at a larger level in the State.

5.2.3: NATURE OF LSGI INSTITUTIONS IN THE CURRENT CASE STUDY AND HOW THEY FACILITATED COMMUNITY PARTNERED PRIMARY HEALTH CARE INNOVATIONS

The explorations of the various formal rules related to project development including innovations that guides the LSGIs in Kerala, as well as the informal rules and norms within the two case studies, does in fact allude to the institutional contexts within the study settings. The formal rules and guidelines that currently exist in the state, as discussed before leaves enough room to LSGI leadership to define and develop innovative projects as deemed necessary by them. Therefore, there is an evident flexibility within the formal rules that guides the development of innovative projects in the State. The formal policies and guidelines as suggested by the State Planning board members suggest that the State wanted to encourage more innovative projects by the LSGIs by keeping the legal restrictions to a minimum. In addition to the formal rules on innovations and LSGI projects, the State government as well as national governments through formal policies also encourages better participation of women and Dalits within LSGI spaces. In acknowledgement with the historical trends of

marginalisation faced by Dalits, the Kerala Panchayat Raj act, 1994 formally mandates reservation of Dalit seats within LSGI elections based on their proportion within the population (The Kerala Panchayati Raj Act & Rules, 1994). The formal rules also mandates a similar reservation system for women representation within LSGIs, through a statute that mandated at least 50% of the seats to be reserved for women candidates in local body polls (Buch, 2009). Going by the formal institutional context, the LSGIs in the State clearly intends to encourage active participation of women and Dalits within LSGI decisions.

However, the exploration of the social innovation cases as well as the LSGI decision-making dynamics suggests a totally different picture. The conventional yet powerful patriarchal and caste norms that the formal policies intended to overcome through statutes does in fact continue to persist within LSGI spaces in newer and recontextualised forms. The formal policies of reservation for women and Dalits though are being followed by LSGIs, informally non-Dalit males owing to the patriarchal and Brahminically driven power structures hegemonically occupied the decision-making spaces. These were also evident through the informal reservation system for men and non-Dalits in unreserved or general seats in the LSGIs examined in the study. Though general seats are not formally reserved for any specific caste or gender, in the LSGIs examined as part of the study, general seats were almost exclusively reserved for non-Dalit males, with some exceptions. The positions and roles of LSGI actors in terms of their gender and caste were clearly marked and established. The subordination of women and Dalits within the LSGIs in relation to non-Dalit males were evident through their conditioned behaviour and acceptance of the taken for granted hierarchy that existed within the LSGIs. This is in line with the institutional maintenance work often performed by the less powerful actors to sustain the dominance of the powerful and acting accordingly (Currie et al., 2012; Labelle & Rouleau, 2016).

The subordinate actors owing to their institutional position as being lower in the hierarchy is often argued as less embedded than their dominant counterparts. Given their relatively low embeddedness, they are also the ones who are more prone to try and achieve disruption that are aimed at resolving the inherent contradictions within

their immediate institutional context (Creed et al., 2017; Smets et al., 2012; Smets & Jarzabkowski, 2013). Parallels to this were evident through the disruptive efforts yet unsuccessful at achieving any institutional change from the part of Dalit women LSGI members in both the case studies. Dalit women politicians were at the forefront in terms of confronting the leadership structure occupied by non-Dalit males within left political organisations through their frequent rebellions and shifting of political affiliations. However, these disruptions were also managed and resolved through the exercise of power vested within the institutions through the ouster of rebelling members by the dominant actors. This follows the accepted pattern of institutional sanctions or the mechanisms through which overt departures from the taken for granted ways and norms are immediately counteracted by the institutions themselves (Jepperson, 1991).

The institutional power arrangements in terms of key decision-makers within the LSGIs in the study is also followed by the accepted ways of project conceptualisation. This meant that the convention of trying out community partnered projects in Village A and the ability to try anything new by the male Vice-president was a given. In the case of Village B, the vice-president's affinity to innovative ideas and the existence of community partnered models in LSGIs known to him made 'Sayamprabha' the way it is today. These community partnered ideas through their presence as the dominant idea among the powerful within the LSGIs are also then discursively realised as local healthcare projects. This tendency of mainstreaming the ideas of powerful was also reflected in other areas too. The projects never delineated in terms of how it prioritised any section of the population, except for its considerations of economic class categories, popular within left politics. Both the village panchayats through their projects as well as within the social innovations acknowledged economically poor as the exclusive social category that deemed prioritisation. A yet another corollary of these conventions within implementation of LSGI projects within the case study was the exclusion of Dalits as a social category and their only inclusion as part of projects that were implemented universally within the LSGI area.

The nature of these informal institutions largely fit in with the concept of 'exclusive institutions' as theorised by Yaroslav Startsev. Startsev proposes a profiling of

institutions based on three themes and thereby locating them within an institutional spectrum, with completely exclusive and completely inclusive institutions at either extreme of it. The location of the institutions within this spectrum depends upon the degree of severity of its rules and norms under the three themes of 1) discursiveness 2) accessibility and 3) exit costs. Based on this an exclusive institution is characterised by its relatively high non-discursive rules, high access barriers and high exit costs (Startsev, 2005). The non-discursiveness suggests to the presence of various rules and norms that are barely spoken about. These rules are largely tacit and exists within the minds of the actors as mutually agreed upon ideas. The taken for granted ideas of the authority of non-Dalit male leaders within the LSGIs though are never spoken are very much an accepted norm as was observed in the study. Except for the actors who rebelled, these were never spoken about even by Dalit and female members as a possible axis of power within their LSGI context. These LSGI institutions are also uniquely characterised by their high access barriers, specifically in terms of how difficult it is for Dalits and women members to be accepted as part of the LSGI by their powerful counterparts. To be part of the decision-making process in the context of LSGIs examined in the study translated as, to be accepting of the existing hierarchies in power, and for those in confrontation with it, entry to the system remains highly inaccessible. The access barriers are often realised through the powerful position held by non-Dalit males within left parties and how they use this to bottleneck the growth of those who are in conflict with their positions. A Dalit or a women LSGI member who agrees to be part of the LSGI institution are therefore limited in their ability to exert any form of authority or choice over the decisions of their more powerful male non-Dalit counterparts. Similarly, the informal LSGI institutions in this case also demonstrate high exit costs associated with it, any disruptive change that is in stark contradiction with the routine ways are dealt with strongly. The expulsion of the Dalit representative from her position as LSGI president does suggest to the high exit costs that are associated with breaking the institutional ways in the LSGIs examined in the study.

5.2.4: 'INSTITUTIONAL CONTINUITY' AS A LIMITING FACTOR FACILITATING THE TRUE PARTNERSHIP OF COMMUNITIES & EXCLUSION OF DALITS AND WOMEN MEMBERS WITHIN THE SOCIAL INNOVATIONS EXAMINED

A commonly attached attribute to social innovations that adopt institutional theories to explain change is the idea of institutional change, often invoking the superlative adjective of being a change that is often profound (Poonamallee et al., 2020; van Wijk et al., 2019). The resolutions to the problems addressed by social innovations entails 'radical changes' within the institutional context that surrounds the innovation. So much so that, these changes had to achieve an institutional embeddedness to be qualified as social innovations (Moulaert, 2009; van Wijk et al., 2019). Through their adoption of institutional theories including that of institutional entrepreneurship, it is often argued that social innovations achieve this radical change within institutions through the agentic efforts of institutional entrepreneurs (Jensen & Fersch, 2019).

In line with the literature on social innovations it does point to the influence of various external factors as well as the role played by endogenous actors in the evolution of social innovations examined. The external factors in this case, the changes in the bio-physical contexts did in fact point to their significant role in the emergence of the social innovations within the two case studies. The changing dynamics of elderly proportion in the demographic as well as emergence of a pandemic situation and the threat of communicable diseases clearly presented themselves as extraneous triggers in both the grama panchayats. These aggravating challenges meant that LSGIs had to adopt and innovate to surmount these barriers that pose a threat to the health of the local communities (Jensen & Fersch, 2019). However, the similarities of the social innovations examined in the study with the contemporary literature on social innovations rather strangely ends with their similarity in terms of exogenous triggers.

The findings from the current study fails to presents a picture of innovations in line with an institutional entrepreneurship and radical institutional change. On the contrary the social innovations examined in the study rather strangely exhibited a pattern of 'institutional continuity' or an evident lack of any visible change within them. The social innovations examined in the study lacked the presence of an endogenous change

agent in terms of an 'institutional entrepreneur'. An idea of an institutional entrepreneur as an agentic actor whose efforts ultimately result in radical change within their institutional context. This does not suggest that there were endogenous actors who contributed in the development of social innovations in the study. The argument here is also not an attempt to shape a reductionist view of the various actors who in fact worked towards the emergence of social innovations examined in the study. In fact, the attempt is to argue that the social innovations examined does not present itself as an institutional change emerged out of the agentic actions of an entrepreneur so to speak. For, these social innovations were not really characterised by any radical disruption in terms of how both the LSGI institutions operated before and after.

The social innovations examined in fact also owed their emergence largely to the coordinated efforts of the already dominant actor(s) within the LSGI rather than through the efforts of an institutional entrepreneur. These innovations rather emerged out of the genuine commitment expressed by the aforementioned dominant actors within the LSGIs to try and address an issue that they felt affected their local community and their ability to innovate. However, even while doing so the LSGIs were characterised by an evident continuity in its institutional status quo in terms of the conventions around decision-making as well as in its implementation. The social innovations examined in the study reflected the already existing patterns around project conceptualisation and implementation in the LSGIs. Specifically in terms of limiting the scope of community partnership at the level of implementation. They also continued to exclude Dalits in both cases and exclusions of Dalits and female representatives within decision-making processes. They were conceived and shaped by non-Dalit male leaders in both the panchayats with minimal participation by larger community as well as women and Dalit LSGI members. Though they had communities as partners it never extended beyond their historical role as facilitators of implementing the ideas of powerful, non-Dalit males in this case.

The way in which dominant actors within the LSGIs in the current study continued to be the champions of innovative activities is in line with the literature on institutional theory as well as those that critique institutional entrepreneurship arguments. For,

dominant actors within an institutional context are less likely to be agents that seek to achieve institutional change. They are also less likely to see beyond the existing discourses and routines and are also conditioned to routine normative processes (Greenwood & Suddaby, 2006). This also in a way explains why the observed change or the social innovations in the current study failed to break away from the conventional patterns that already existed around routine projects in their panchayats. This includes their continuing the pattern of equal treatment of all and as a corollary a failure to give any sort of priority to Dalits through these social innovations. Given this argument some key question in this context would then be, how did the social innovations come into being within these two grama panchayats? And what makes these case study LSGIs unique or different to others that they resulted in these innovative projects?

5.2.4.1: Stronger consolidation of power structures leading to easier translation of ideas of the powerful into real projects

A theoretical premise the current study turns to, to aid the explanation of the emergence of the social innovations within the LSGIs examined is the idea of power. These include examination of the idea of power as a structurally oriented entity that predetermines the nature of interactions between various actors (Carstensen & Schmidt, 2016). Carstensen and Schmidt discusses about three categories of power as a structurally oriented concept, these are 'compulsive or coercive' power, 'structural' power and 'institutional' power. The idea of power, as 'compulsive' is the expression of power where some actors (individual or group) owing to their access to material resources can exert absolute control over others and also shape their actions as well as circumstances. Normally a form of power that is shaped out of material resources and differential relation to it by different actors (Barnett & Duvall, 2005). A second idea of power, as 'structural' deals with the role of power in shaping structured relations through creation of subjects and subjectivities who are accepting of the structures around them and act accordingly without compulsions. A very common application of power as a structural idea is that of Marxism, which conceptualised capitalism as a structural power, that placed various classes in specific hierarchies based on their relation to resources and power and thereby shaping how they normally interact and think based on their class locations (Carstensen & Schmidt, 2016; Poulantzas, 1982). A

third perspective on power is the idea of power as an institutional force, specifically in its form as formal and informal institutions and how they translate as power and control of some actors over others within various contexts (Barnett & Duvall, 2005).

The second form of power, where power functions as a structural force is of specific relevance in the current study context. For, both the panchayats and their LSGI decision-making spaces were largely characterised by left politics as a dominant power structure. The hierarchical organisation of LSGI leaders based on their gender and caste locations were clearly marked and followed from the dominant structure of CPI(M) and left in general in the State as well as in other parts of India. Though left in general has been vocal about women's right and feminist politics, largely they have remained as rhetorical narratives by the left in the country. Specifically CPI(M) in India has repeatedly failed to give sufficient representation for women and their active participation within its party structures and marked by patriarchal power structures (Santha, 2015). This is also similarly reflected in CPI(M)s position in regards to the caste question and Dalit representation within it. In its more than 55 years of existence, never has CPI(M) politburo, the top decision-making body of the party given representation to a Dalit leader and with minimal women presence ("The CPI(M) Can't Evade Gender and Caste Questions," 2018). The two LSGIs governed by CPI(M) examined in the current study did follow this larger trend in how they organised themselves, taking for granted the hierarchical organisation of actors within the party based on gender and caste line. Here CPI(M) as a party acts itself out as a structuring force thereby also shaping the natural roles and responsibilities expected out of its members. This theme aligns itself with the idea of power as a structuring force, with clearly marked boundaries of power and expected roles around its subjects in relation to each other.

This is crucial within the LSGIs examined in the current study, for a key theme that was characteristically evident within both the villages were the relatively stronger consolidation of left politics. Both these LSGIs were at the time of the research historically and powerfully controlled by LDF alliance, specifically by CPI(M). Village B have been under LDF rule since a decade and Village A have historically been governed by LDF since the inception of Peoples plan campaign in Kerala. This

meant that there is a much more robust crystallisation of power structures and hierarchisation of LSGI members. Non-Dalit males rose to powerful and dominant positions by design leaving ever so slight space for their less powerful counterparts to be in a confrontational role within the LSGI decision-making. This also meant that the ideas and decisions of non-Dalit male leaders within both LSGIs met with little conflicts from others and achieved a smooth translation from ideas to real life projects.

In both the cases, the social innovation ideas were evidently championed by the dominant actors based on their worldview and either had complete support or complete absence of conflicts from their peers in its planning and implementation. In Village A, the Dalit female president took for granted the authority of Grameena Padana Kendram and felt that their presence can only benefit the LSGI and its project. This meant that, 'I care we care' campaign conceptualised by GPK had the complete support of the LSGI leadership and smooth transitions from an idea to actual project. However, in the case of Village B the authority held by the non-Dalit male Vice-president was a de facto position granted to him by CPI(M) leadership. The Dalit female president and his other fellow LSGI members though had difference of opinion in his style of leadership, could never mount any resistance to his ideas and projects. For, his authoritarian and unilateral decision-making was the accepted convention within the LSGI, which was also sanctioned by the local party leadership, which meant that the projects and activities he desired could also easily translate as LSGI projects in the panchayat.

5.3: THE SIMULTANEOUS INCLUSION/EXCLUSION OF DALITS AND AMBIVALENCE OF 'SOCIAL INNOVATIONS' EXAMINED IN THE STUDY

A crucial dimension often included within the definitions of social innovations within literature is its focus on being participatory and its ability to address long standing issues within health (*Social Innovation to Transform Health Care Delivery*, 2020). This emphasis on the objectives of the social innovation as a solution to address real needs of the community has remained a persistent pattern within the literature around it. It is often projected as a solution or attempt to address 'wicked' problems within a given society (Rittel & Webber, 1973). Though the concept of social innovations has

historically evolved and shaped from the influence of diverse theoretical backgrounds, a key theme that continued to remain as a crucial component of social innovations was its affinity to be 'just' in comparison to the existing processes and solutions (van Niekerk et al., 2021). Also crucial is the emphasis social innovation literature attributes to the idea of participation and inclusion. The ability of social innovations, while addressing long standing and unaddressed issues to be simultaneously participatory and socially inclusive as a process specifically for marginalised and neglected social groups (Howaldt & Schwarz, 2010; Marques et al., 2017; Moulaert et al., 2014; Neumeier, 2012; van Niekerk et al., 2021).

Notwithstanding the emphasis of social inclusion and the idea of social innovations as a plausible solution for wicked health problems, the exploration of the social innovations in the current research points to the contrary. The two social innovations examined in the study, though have been implemented and realised from a participatory model does exclude Dalits both as a partner as well as a target community. Dalit LSGI representatives were in fact completely excluded within the planning processes of the 'Sayamprabha' innovation by the powerful in Village B. Though not completely excluded in Village A, the participation of Dalit LSGI president and HSC chairperson were observed to be limited to mere formality with minimal room for any contribution within its processes. The examination of the two innovations in terms of their objectives too suggested to a similar exclusion of Dalits in both the panchayats. The 'Sayamprabha' innovation though conceived as a project to address the needs of elderly, completely excluded the ideas of marginalisation based on caste. Similar exclusion of Dalits was also observed in the objectives of 'I care we care' in Village A, which also went on to exclude Dalit households from the actual implementation of the project itself. Does this then mean that, these innovations, being exclusionary to Dalits does not qualify themselves as social innovations?

The exclusionary status of the innovations examined in the study, thus points to the question of whether they qualify themselves as social innovations. Therein also lies the ambivalence of the innovations examined, being simultaneously social innovations and not social innovations at the same time. For, these social innovations were conceived within the panchayats by the LSGI leadership, who genuinely wanted to

address a health issue that they felt demanded urgent action and was also realised in a manner that they thought was truly participatory. The 'Sayamprabha' innovation though did not acknowledge Dalit experience nor prioritise them did in fact benefitted Dalits as part of its implementation. Similarly, the 'I care we care' project was in fact implemented with the idea of prevention of CD outbreaks which was a real problem faced historically by the LSGI. Given this standpoint and in the background of Covid lockdown the panchayat leadership considered all households for a community partnered hygiene drive. Hence, from the standpoint of the LSGI leadership, both these innovations did in fact attempted to address a social need as perceived by them and in the process was realised with complete community partnership. Though not acknowledged as a priority category and despite their exclusionary processes, these innovations do stand to benefit and also impact the wellbeing of Dalits in the long run albeit indirectly. This was more evident in the case of Sayampabha where Dalits were in fact the most benefitted from the project. In the case of 'I care we care', the project in fact covered many Dalit households during the initial rounds of activities suggestive of possible health benefits that could accrue in the future. Does this unique nature of the innovations, not outright or deliberately exclusive of Dalits then simultaneously qualify these projects as social innovations?

5.3.1: LIMITATIONS OF INCLUSION-EXCLUSION BINARIES IN EXAMINING SOCIAL PROCESSES

Herein we turn to the ideas of social exclusion and inclusion and the limitations in pitting them against one another in contrasting binaries as a problematic stance. For ideas of inclusiveness and exclusions are largely seen as two exclusive categories, often defined by their property of people or groups falling outside or within a defined process or limit (Mascareño & Carvajal, 2015). The often-followed corollary of this dichotomous stance is the almost exclusive attribution of all positive adjectives to the concept of inclusion and exclusion being the exact negative opposite to it. On, the contrary modern-day societies are often characterised by various groups and individuals being simultaneously included and excluded and a resultant blurring of the dichotomy between themes of inclusion and exclusions. Understanding complex social processes through the straitjacket of inclusion and exclusion as two distinct binaries

will only mask the varying shades of exclusion and inclusion in operation within these processes (Mascareño & Carvajal, 2015; McCampbell et al., 2021). Hence, adoption of the social exclusion theories without acknowledging its implicit dualism, often comes at the cost of failure to recognise the caveats within the idea of inclusion itself. The ways in which inclusion can themselves be problematic in terms of how it masks unequal distribution of power, and the ways in which it may disempower certain sections (Hickey & du Toit, 2013).

5.3.2: THEORY OF 'PASSIVE INCLUSION' THAT GENERATES SOCIAL INNOVATIONS THAT ARE EXCLUSIVE FOR THE UNDERPRIVILEGED

This section attempts to build the case for a new theoretical position that could sufficiently explain Dalit inclusion termed 'Passive inclusion'. One that is strong enough to explain the simultaneous exclusion and inclusion of Dalits within the social innovations examined. This is being argued here using the famous taxonomy of exclusions elucidated by Amartya Sen. In his paper on social exclusion, deprivation and poverty, Sen proposes four different categories of exclusion; Constitutive, Instrumental, Active and Passive exclusions based on how they relationally constitute deprivation and poverty. Constitutive exclusion occurs when the exclusion itself is a form of deprivation. For instance the inability of an individual or group to freely interact with others be an active part of the community can constitutively shape impoverishment (Sen, 2000). Examples of this could be found in the deprivation of persons ability to read or write or his or her inability to be part of the labour market due to physical disability (Joseph, 2014). Instrumental exclusions are those which by their mere presence is not an impoverishment, but has the potential to cause impoverishment. An example that Sen suggest for such an exclusion is being landless, which in itself is not impoverishing. But the lack of land ownership has the ability to prevent individuals from having better opportunities by economically and socially (Sen, 2000).

A second group of exclusion categories are Active and Passive forms of exclusion. Active exclusions are deliberate forms of exclusion, often exercised by the powerful to purposively exclude others from gaining a certain objective. Examples of this could be found in the prevention of citizenship status to immigrants which can ultimately

lead to various forms of deprivation. Passive exclusion in contrast are rarely purposive and is often the result of social processes that are themselves exclusive in many ways (Sen, 2000). An example for this would be the persistence of illiteracy, even when as a country we have policies that aim at free primary education for all children (Joseph, 2014). The development of these categories of exclusion by Sen were done with the primary intention to explain the relational effects of exclusive social processes causatively constituting deprivation and poverty. Though the social deprivation of Dalits is beyond the ambit of the current study, the present attempt is to borrow the categories of exclusions presented, and adopt them to theorise the nature of exclusion of Dalits within the social innovations in the current study. Hence, the attempt is not so much the theorisation of Dalit deprivation, as it is to the complex ambivalence of inclusion and exclusion shaped by the interplay between formal and informal institutional structures within the LSGIs.

The key pattern that could be observed in the social innovations in the current study is one of partial presence of Dalits at the level of decision-making process as well as a contextual role at the level of their implementation. These ideas of partial and contextual are crucial here, specifically because both the LSGIs had Dalit members as LSGI presidents and therefore were in a formal position of power and yet they remained inconsequent in shaping the innovations. Similarly contextual presence of Dalits is also evident in terms of their unconscious exclusion from the objectives of the social innovations and yet being part of its implementation and partially benefitting out of the innovations. Of importance here would be to juxtapose Sen's categories of Active and Passive exclusions in theorising this unique nature of Dalit presence within these social innovations. The concept of active exclusion in the current context fails to completely theorise the current observations, for, even though there are patterns of active exclusion of Dalit LSGI members from decision-making spaces, the social innovations do not end up in complete nor any deliberate exclusion of Dalits within its implementation or from being benefitted. Similarly, though there are elements of passive exclusion, in terms of the non-deliberate exclusion of Dalits within the actual objectives of the social innovation, the concept fails to accommodate the active exclusion of Dalits within decision-making spaces in the LSGIs examined.

5.3.2.1: 'Passive inclusion'- a form of exclusion facilitated by namesake inclusion of Dalits

Therefore, building from the categories of active and passive exclusion, the current study proposes the idea of 'Passive inclusion' as a theoretical category of exclusion to understand the pattern of Dalit presence within the social innovations in the study. Within this concept, the idea of inclusion is far removed from the positive connotations attributed to inclusion as well as from the dogmas of conventional duality of inclusion vs exclusion. Here inclusion as a passive process is argued as a negative concept that ultimately serves to exclude certain sections. The nature of exclusion of Dalits in the study settings are termed passive inclusion because, their exclusion is in fact being strangely facilitated by their very presence or 'inclusion'. Their informal yet actual experiences of exclusion gather legitimation exactly due to their namesake presence in positions of power within LSGI facilitated by formal rules of Dalit representation. The persistence of informal conventions justified by patriarchal and casteist power structures ensures that they are limited within their capacity to effect change in actual decision-making processes. However, these informal structures largely remain clandestine and veiled by the more visible yet powerless formal rules in place.

The idea of passive inclusion, also accommodates the contextual inclusion of Dalits despite their exclusion from the actual objectives of the innovations. The presence of Dalit participation within both the innovations despite exclusive structures were largely facilitated by mechanisms beyond the agentic control of Dalits in the current study settings. Specifically owed to their larger numbers within the local population as well as by their deprived status and thereby falling under the lower economic class, one preferred by the dominant discourses that shaped the local projects. This meant that any LSGI projects or social innovations within the LSGI is by default bound to involve Dalit sections, despite any deliberate intent from the LSGI leadership themselves. Again, what is crucial here too is the ability of the social innovations examined to easily pass off as not completely exclusive and even inclusive, due to the presence of Dalits within various processes of innovation implementation. The result being, presence of social innovations for healthcare, that is blind to the actual realities of Dalits and yet provides a haphazard respite for their issues. However, these projects

under the garb of innovation also fail to acknowledge the disparities and differential distribution of health determinants between Dalits and non-Dalits and thereby facilitates to sustain over time the health inequities between these groups. Hence, by being passively inclusive these social innovations by their inherently exclusive power structures, hides as well as further shape and create health inequities among Dalits.

6. CONCLUSION AND RECOMMENDATIONS

The findings from the three different phases of the research brought out some key and relevant findings pertaining to the practice of primary health care innovations and by extension primary health care in the state. The analysis of the existing policy level discourse on primary health care innovations does suggest to the existence of a medicalised idea of primary health care. One, that is urgent to prioritise strategies and

actions that favoured early detection and curative aspects of primary health care. This along with a rather myopic view on social determinants come at the cost of limited action on preventive, protective and promotive aspects of primary health care. The policy discourse failed to conceive the full potential of the agentic actions of communities within primary health care innovations. They also remain unaware of the disparities in health outcomes and the differential distribution of basic determinants across social groups in the state. Within the policy discourse, caste either remained a non-issue or something that was reluctant to be spoken about within the policy realm. The result was an evident exclusion of Dalit as a vulnerable social group in terms of primary health care policy settings in the State.

The emergence of community partnered primary health care innovations however, were in fact determined by the unique political and bio-physical attributes of the panchayats, the history of People's Plan Campaign. In the case of 'I care we care' there existed a political history of community collaborated action within its panchayat that set the conventional path of action for the LSGI leadership. In the case of ''Sayamprabha'', community collaboration was in fact influenced also by the existing elderly care policy in the State as well as through similar strategies emulated elsewhere in the State. However, the extent of the scope of community partnership in both panchayats did reflect the existing policy discourse on community and their roles within primary health care innovations. Though community had substantial roles within both the innovations, their actual roles were limited to that of implementation facilitators in both social innovations. The emergence of these social innovations however also suggested to the existing milieu of caste and gender dynamics prevalent at the grass roots in the State. For, both the case studies were characterised by their strong political leadership marked by equally strong patriarchal and casteist norms. This had ramifications on two fronts; one, the easier translation of ideas into real life projects, that often came at the cost of marginalising women and Dalit LSGI members. Two, given the gender and caste-blind norms, these innovations also suffered in terms of problematising health care issues from an equity lens ultimately leading to exclusion of Dalits.

There existed a clear dialectical link between the emergence and nature of primary health innovations in the village panchayats and the larger policy discourse on primary health care in the state. Though the specific nature of the social innovations were invariably shaped by the unique socio-political and economic context of the panchayat, they too were limited by their narrow vision towards primary health care. The 'Sayamprabha' innovation in specific suffered from the early detection and curative care bias on primary health care. The idea of social determinants and by extension inclusiveness was significantly limited within both the innovations examined. Within 'Sayamprabha', elderly members were prioritised based on economic status while being completely blind to the role of caste and the intersection of caste and poverty within the panchayat. The access to the 'Sayamprabha' benefits among Dalit elderly was therefore purely coincidental in nature. The 'I care we care' project at the outset commenced with the problematisation of health determinants like hygiene and sanitation and its impact on communicable diseases in the panchayat. However, despite its commitment to resolve the issue of determinants of health, it too completely failed to problematise the issue from the perspective of caste. Though Dalit neighbourhoods continues to remain within poor sanitary conditions, the project not only failed to reconcile with the fact, but also ended up excluding many Dalit households in the process.

The inclusion of Dalits within the processes of social innovations was largely aided by their relatively larger proportion within the local demography of the villages. They remained key partners in terms of making the social innovations successful, as they were one of the most active groups in implementing the projects within the panchayats. However, the informal exclusion and side lining of Dalit LSGI members from having a meaningful role in decision-making related to health projects were also reflected in terms of how Dalits, in general, benefitted from such projects. The social innovations for primary health care, though did not purposively aim at Dalit exclusion, were marked by its inherent lack of awareness about the realities of Dalits within the local communities. Based on the findings, the primary health care practices in the state requires a multi-pronged strategy to achieve the ideals of comprehensive primary

health care. One that is truly comprehensive, rooted in democratic agentic action of local communities as well as socially just and equitable for under-privileged sections.

6.1: PRIMARY HEALTH CARE POLICY

The concerns that existed within the primary health care innovation policy discourse were of three kinds – a curative care bias and a sanitised views on social determinants, a gap in terms of viewing communities as active partners within primary health care delivery and thirdly exclusion of Dalits as a marginalised social group.

6.1.1: INTRODUCING A DISCURSIVE SHIFT BY REVISITING THE AARDRAM POLICY ON PRIMARY HEALTH CARE

The findings from the study suggest the bias that exist across the health system including within the policy in terms of its unfair emphasis on curative dimensions of primary health care. While it may be impractical to expect or achieve a sudden system level shift towards comprehensive primary health care at an ideological level, we feel that it would be relatively easier to introduce this shift at the policy level to begin with, given the renewed political commitment by the Government of Kerala towards Comprehensive Primary Health Care brought in through the Aardram Mission. While critical of the Aardram mission, the current study does not aim to diminish the significance of the attempts to rejuvenate the existing primary health care system. The Aardram mission also merits applause given its emphasis on comprehensive Primary Health Care as the strategy to achieve its goal of strengthening the public health system. However, for a policy that openly commits to the ideals of social justice and health equity, it is imperative to have a clear acknowledgement of the existing gaps and a roadmap in terms of how it envisions to overcome them. However, in the wake of such policy reforms, these limitations can only serve to sabotage its own goals. For, they stand to risk the opportunity to adopt and implement a broader vision of primary health care that is socially just and committed to the goals of equity. There is an urgent need to restructure the existing primary health care policies to be truly committed to the ideas of primary health care as envisioned through Alma Ata and Astana Declarations. This requires an equal attention within the existing policy towards actions and strategies at a local level by including preventive, promotive, protective

aspects of primary health care. This would also, therefore, involve adopting a comprehensive view on health determinants that can problematise the differential distribution of health determinants across axes of caste, class, religion and geographical locations of social groups.

6.1.1.1: Promoting the role of local communities as active partners for primary health care within policy

Relegation of the possibilities of communities as pro-active agents to the level of implementation facilitators and beneficiaries runs against the basic idea of primary health care itself. By being blind to the agentic potentials of community in devising innovative primary health care activities at the grass roots, existing policy discourse further shut themselves out from the possibilities of co-generating equitable and just primary health care actions. Moving beyond the conventional views of communities as beneficiaries or implementation partners to strategies that raise local communities to the level of active decision-makers are necessary. The achievement of this in the social practices of primary health care would only be possible, until and unless there is an overt acknowledgement of the same within the larger policy discourse in the state.

6.1.1.2: Acknowledging caste as an axis of health vulnerability in the State

Urgent action is also imperative to reconcile the historically generated health disparities across social gradients, specifically among Dalit sections in the State. The achievements of which can only be made possible through primary health care strategies that begins itself by the acknowledgement of the same. However, the existing policy discourse neither problematise the issue of health disparities nor is aware of the widening gaps in health outcomes between Dalits and Non-Dalits. It is vital that the existing policies on primary health care engages with the question of caste and how they shape health outcomes in the State. Caste and caste driven health disparities shall be emphasised within newer policies so that, they receive the needed attention that it deserves. Only from an open acknowledgement and repeated emphasis can the existing practices of primary health care at the grass roots too start engaging with the same.

6.2: SOCIAL PRACTICE OF PRIMARY HEALTH CARE INNOVATIONS

We believe that the first step in attempting to realise change at the grass roots obviously begins through changes at the level of larger policy level discourse as mentioned above. However, we also believe that bottom-up strategies are inadvertently much more complex and does not render itself easy to be amenable through formal rules and regulations. Therefore, some of the recommendations that we feel can make a gradual change in the practice of primary health care innovations are;

6.2.1: DEVELOPING A DATABASE OF NOVEL PRIMARY HEALTH CARE STRATEGIES IN THE STATE

One of the primary challenges experienced during the current research is the lack of a system that documented novel practices of health projects by various LSGIs across the state. This was one of the key bottlenecks that impeded the in-depth exploration of the primary health care landscape in the state. The only digitised portal by the Government of Kerala that allowed locating LSGI projects is the Sulekha, which does not include any data regarding the exact nature of the project (health or non-health) as an external researcher. Though People's Plan Campaign over the last 25 years of implementation have witnessed multiple models of novel primary health care strategies, currently there has been little effort in documenting them. This prevents the scope for any kind of meaningful assessment of these strategies as well as learn further from them by the system. One of the first step towards facilitating meaningful learnings is, therefore, establishing a system to document various historical and ongoing models of new health projects across various village panchayats in the State. This would enable a comprehensive database of primary health care strategies, that could then be subjected to further exploration and analysis in terms of the scope of issues addressed through them, the strategies adopted, the nature of community participation and the various social groups targeted through them.

6.2.2: EMPIRICAL EXAMINATION OF INNOVATIVE HEALTH PROJECTS THAT SUCCESSFULLY TARGETED HEALTH CHALLENGES OF DALITS IN KERALA

Though a big proportion of LSGIs in the State are helmed by Dalits or women facilitated by affirmative action policies, the extent of autonomy the leaders from Dalit castes and women enjoy deserves further examination. The findings from the current study too suggests the limited role and power Dalit and specifically Dalit women leaders of LSGIs had within decision-making related to health projects within the case study villages, leading to poor emphasis on health challenges of Dalits within these villages. This suggests the limited impact affirmative action policies have had in terms of their translation as the ability to identify and address health inequities of the under privileged social groups like Dalits in the study sites. We believe, it is therefore urgent to problematise the efficacy of policies of Dalit and women representation to resolve the health inequities of the same social groups and identify how these limitations have been overcome elsewhere in the state. We believe one of the ways to do this is to identify novel health care projects that had prioritised the specific health challenges of Dalits and to empirically explore the pathways and factors that facilitated the emergence of such models.

7. LIMITATIONS OF THE STUDY

- The primary source of information for the current study was strictly limited to the findings drawn from the case studies of social innovations. Though the study is driven from a social science approach to health and pivot itself on an interpretative lens, we acknowledge its limitations too. This include inability of the researcher to compare the findings vis a vis the data on health outcomes of the communities, specifically Dalits in the panchayats examined was found to be lacking. This was primarily because of the logistical limitation of a single individual to gather all the required data from PHC and LSGI sources. This was also found challenging given the pandemic situation that prevented the investigator to gain free access to health institutions as well as given the covid related work load of health staff during the study period.

- A second limitation was the limited number of case studies that the research could include given the financial as well as time related constrains of the researcher. This prevented the researcher to have case studies related to primary health care social innovations that could have presented itself as a contrast to the already examined case studies. A strong case study with findings that could challenge the findings from the current two case studies could have significantly added to better theorisation of the social innovations for primary health care.
- A third limitation was the coincidental overlap of similar politics within the two case studies. This also prevented me to have a case study of a panchayat with a non-left LSGI leadership as well as to examine how that could have affected the emergence of social innovations for primary health care in such panchayats. Though it was planned initially, my limitations in successfully undertaking a third case study owing to financial and time limited constrains prevented me in achieving this goal.
- Also, we feel that, the inability of the study to find case studies of social innovations for primary health care from a larger pool was also a limitation. Given the lack of any database of health care projects with their details limited the pool of innovative primary health care projects under 15.

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Annexure A: Curriculum Vitae

Name: Sreenidhi Sreekumar

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Institution: Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST)

Gender Male

Education:

Sl. No	Degree	Year	Subject	University	Percentage/ CGPA
1	MPH	2014-15	Public Health	Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER)	71%
2	MSc. Health Care Policy and Management	2010-11	Health Care Policy and Management	University of Birmingham	
3	BAMS	2004-10	Ayurvedic Medicine	Amrita Vishwa Vidyapeetam	62%

Designation: Doctoral Research Fellow, AMCHSS, SCTIMST

Ph.D Supervisor: Dr. K. Srinivasan

Title of the study:	Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Institutional Analysis Paradigm and Inclusiveness Assessment
Achievements:	LGT Impact Fellow-2022, Emerging voice for global health fellow-2021, NET
Papers Presented:	Social innovations for primary healthcare in the context of pandemic and the factors leading to its emergence in village panchayats in Kerala, IHEPA conference, January, 2022 Presented a paper titled "Innovations in Primary Health Care: A Realist Synthesis of Innovation Case Studies" at the 2018 Health Systems Global Symposium, Liverpool, UK, October 2018

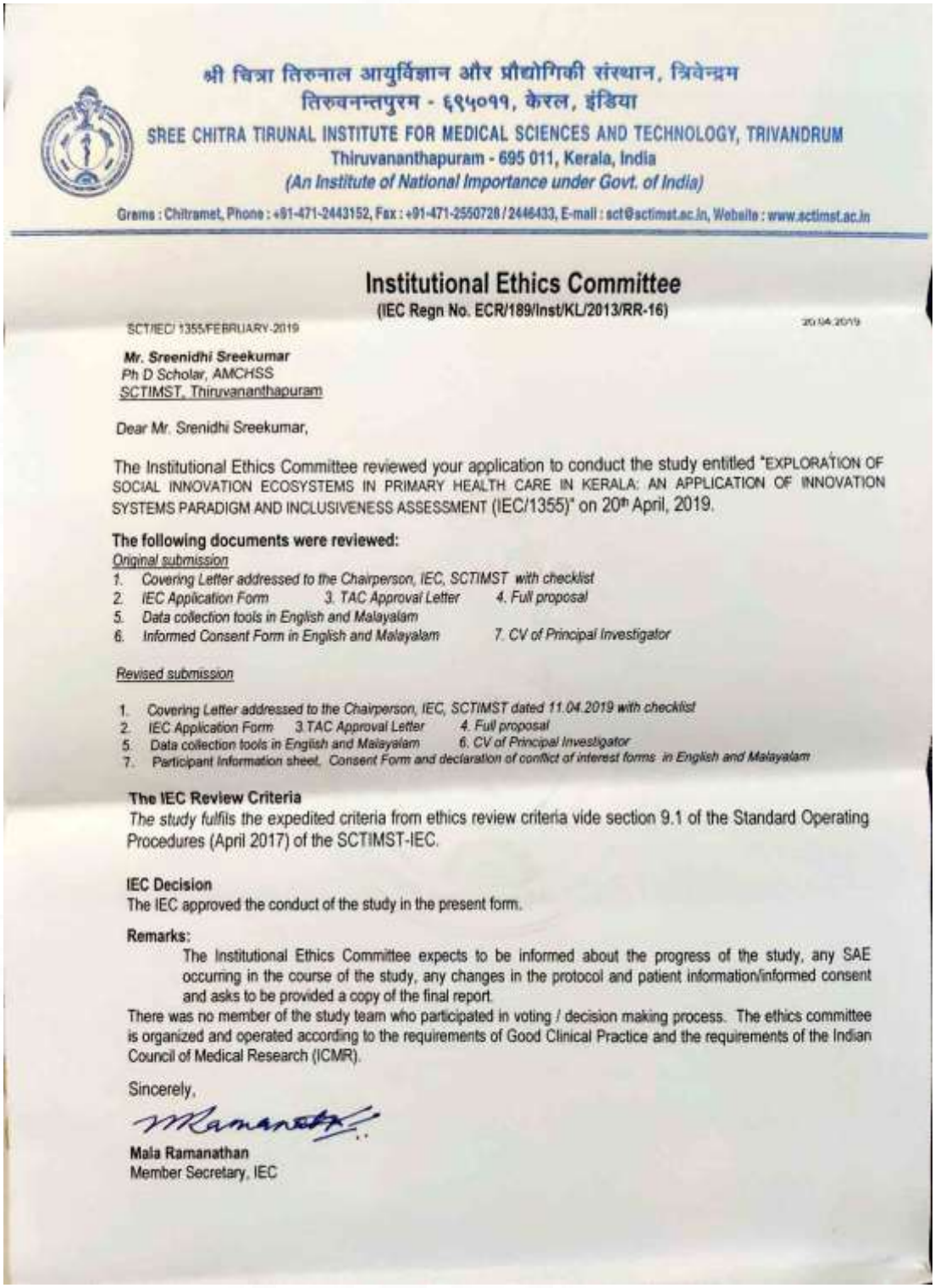
Publications:

- Sabu K Ulahannan , Sreenidhi Sreekumar, Johnson Jament, Malu Mohan, Prashanth Nuggehalli Srinivas. Tracing Covid-19 In A Mosaic of Climate Change and Social Inequalities: Case ***o***f ***t***he Poonthura Coastal Community In Southern India. Economic&Political Weekly (in press)

- Sreekumar S, Ramakrishnan J, Harisankar D, Mannethodi K. Felt needs and expectations of adolescents regarding sexual and reproductive health from schools and health systems: A descriptive study. Indian J Sex Transm Dis
- Sreekumar S, Harisankar D, Mannethodi K, Joseph J, Shinu KS. Health systems' response toward the temple fire accident in Kollam District, Kerala: A case study. Int J Health Syst Disaster Manage 2017;5
- Sreekumar S, Ramakrishnan J. Patterns and felt needs among college going adolescents regarding communication on sexual and reproductive health: a descriptive study. Int J Community Med Public Health 2017; 4: 190-4

Annexure B: Appendices

AI. Ethical Clearance by IEC for the study



श्री चित्रा तिरुनाल आयुर्विज्ञान और प्रौद्योगिकी संस्थान, त्रिवेन्द्रम
तिरुवनन्तपुरम - ६९५०११, केरल, इंडिया
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, TRIVANDRUM
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Institutional Ethics Committee
(IEC Regn No. ECR/189/Inst/KL/2013/RR-16)

SCT/IEC/ 1355/FEBRUARY-2019 20/04/2019

Mr. Sreenidhi Sreekumar
Ph D Scholar, AMCHSS
SCTIMST, Thiruvananthapuram

Dear Mr. Srenidhi Sreekumar,

The Institutional Ethics Committee reviewed your application to conduct the study entitled "EXPLORATION OF SOCIAL INNOVATION ECOSYSTEMS IN PRIMARY HEALTH CARE IN KERALA: AN APPLICATION OF INNOVATION SYSTEMS PARADIGM AND INCLUSIVENESS ASSESSMENT (IEC/1355)" on 20th April, 2019.

The following documents were reviewed:

Original submission

1. *Covering Letter addressed to the Chairperson, IEC, SCTIMST with checklist*
2. *IEC Application Form* 3. *TAC Approval Letter* 4. *Full proposal*
5. *Data collection tools in English and Malayalam*
6. *Informed Consent Form in English and Malayalam* 7. *CV of Principal Investigator*

Revised submission

1. *Covering Letter addressed to the Chairperson, IEC, SCTIMST dated 11.04.2019 with checklist*
2. *IEC Application Form* 3.*TAC Approval Letter* 4. *Full proposal*
5. *Data collection tools in English and Malayalam* 6. *CV of Principal Investigator*
7. *Participant Information sheet, Consent Form and declaration of conflict of interest forms in English and Malayalam*

The IEC Review Criteria

The study fulfils the expedited criteria from ethics review criteria vide section 9.1 of the Standard Operating Procedures (April 2017) of the SCTIMST-IEC.

IEC Decision

The IEC approved the conduct of the study in the present form.

Remarks:

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information/informed consent and asks to be provided a copy of the final report.

There was no member of the study team who participated in voting / decision making process. The ethics committee is organized and operated according to the requirements of Good Clinical Practice and the requirements of the Indian Council of Medical Research (ICMR).

Sincerely,

Mala Ramanathan
Member Secretary, IEC

AII. Informed Consent form for Policy Actors from Dept of Health/LSG for participation in In-Depth Interview

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Sl.No._____

Good morning/Afternoon/Evening

My name is Sreenidhi Sreekumar, I am a Ph.D. fellow at Achutha Menon Center for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science and Technology, currently I am undertaking a study on "Factors leading to Social Innovations in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment". It is being carried out as part of my course requirement.

I consider you as an important source of information since you are a/an _____ working in the Department of _____. It is important to know your views as you have a crucial role in the framing of policy on Primary Health Care services in Kerala. The study aims to understand how a policy actor view current primary health care projects and to capture your ideas about how an ideal primary health care project should be. This interview is about 30-40 minutes long and you can decide to withdraw permission to be part of this study at any point of time of this interview or decide not to answer a particular question. There are no specific benefits to you due to your participation in the study. However, we believe that the information collected through these interviews may help in improving the Primary Health Care in Kerala.

I will be willing to share more information about the study if you wish to know more. I may be contacted in this address

Sreenidhi Sreekumar

Achutha Menon Centre for Health Science Studies

Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram.

Contact Number: 9895848316

If you have any questions or concerns regarding this study later and would like to talk to someone other than me (the principal investigator), you may contact the Member secretary of the Institutional Ethics Committee of the Sree Chitra Tirunal Institute for Medical Sciences & Technology, Trivandrum: Dr Mala Ramanathan, Phone: 0471-2524234 or email to mala@sctimst.ac.in

Thank You

Consent Statement

I have read/ been read out the information in the information sheet. The nature of the study and my involvement has been explained and all my questions have been answered. By signing this consent form, I indicate that I understand what will be expected from me and that I am willing to participate in this study. I know that I can withdraw at any time. I have been informed who should be contacted if the need arises.

Yes, I am agreeing to the interview

Signature/Left thumb impression:_____

Details of witness (If the respondent is illiterate):

Signature of the witness:_____

Name and address of the witness:_____

_____
_____

If you are not willing to participate, then thank you for your time.

Name of the respondent:_____

Address:

Interviewer's Name:

Interviewer's signature:

Household Unique Identification Code: Date:

AIII. Informed Consent form for PHC/LSGI staff for participation in In-Depth Interview

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Sl.No._____

Good Morning/Afternoon/Evening

My name is Sreenidhi Sreekumar, I am a Ph.D. fellow at Achutha Menon Center for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science and Technology, currently I am undertaking a study on "Factors leading to Social Innovations in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment". It is being carried out as part of my course requirement.

I consider you as an important source of information as you are an individual who has a say in the implementation of innovative health projects in _____ Panchayat. The study aims to understand the various activities that have been undertaken as part of the innovation that is being currently implemented in you Village Panchayat. It also is trying to understand the various roles that you have played in the different processes of the current innovation. This interview is about 30-40 minutes long and you can decide to withdraw permission to be part of this study at any point of time of this interview or decide not to answer a particular question. There are no specific benefits to you due to your participation in the study. However, we believe that the information collected through these interviews may help in improving the Primary Health Care innovations that are currently ongoing in Kerala.

I will be willing to share more information about the study if you wish to know more. I may be contacted in this address

Sreenidhi Sreekumar

Achutha Menon Centre for Health Science Studies

Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram.

Contact Number: 9895848316

If you have any questions or concerns regarding this study later and would like to talk to someone other than me (the principal investigator), you may contact the Member

secretary of the Institutional Ethics Committee of the Sree Chitra Tirunal Institute for Medical Sciences & Technology, Trivandrum : Dr Mala Ramanathan, Phone: 0471-2524234 or email to mala@sctimst.ac.in

Thank You

Consent Statement

I have read/ been read out the information in the information sheet. The nature of the study and my involvement has been explained and all my questions have been answered. By signing this consent form, I indicate that I understand what will be expected from me and that I am willing to participate in this study. I know that I can withdraw at any time. I have been informed who should be contacted if the need arises.

Yes, I am agreeing to the interview

Signature/Left thumb impression:_____

Details of witness (If the respondent is illiterate):

Signature of the witness:_____

Name and address of the witness:_____

_____

_____

If you are not willing to participate, then thank you for your time.

Name of the respondent:_____

Address:

Interviewer's Name:

Interviewer's signature:

Household Unique Identification Code: Date:

AIV. Informed Consent form for community members for participation in In-Depth Interview

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Sl.No._____

Good Morning/Afternoon/Evening

My name is Sreenidhi Sreekumar, I am a Ph.D. fellow at Achutha Menon Center for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science and Technology, currently I am undertaking a study on "Factors leading to Social Innovations in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment". It is being carried out as part of my course requirement.

I consider you as an important source of information as you are an individual who is a resident of _____ Panchayat and is a beneficiary of the innovative health projects in your Panchayat. The study aims to understand the various roles that you might have played in the different processes of the current innovation and to understand your experience as a member of your community in utilising the services made available from the PHC as well as from the innovative health projects in your area. This interview is about 30-40 minutes long and you can decide to withdraw permission to be part of this study at any point of time of this interview or decide not to answer a particular question. There are no specific benefits to you due to your participation in the study. However, we believe that the information collected through these interviews may help in improving the Primary Health Care innovations that are currently ongoing in Kerala.

I will be willing to share more information about the study if you wish to know more. I may be contacted in this address

Sreenidhi Sreekumar

Achutha Menon Centre for Health Science Studies

Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram.

Contact Number: 9895848316

If you have any questions or concerns regarding this study later and would like to talk to someone other than me (the principal investigator), you may contact the Member secretary of the Institutional Ethics Committee of the Sree Chitra Tirunal Institute for

Medical Sciences & Technology, Trivandrum : Dr Mala Ramanathan, Phone: 0471-2524234 or email to mala@sctimst.ac.in

Thank You

Consent Statement

I have read/ been read out the information in the information sheet. The nature of the study and my involvement has been explained and all my questions have been answered. By signing this consent form, I indicate that I understand what will be expected from me and that I am willing to participate in this study. I know that I can withdraw at any time. I have been informed who should be contacted if the need arises.

Yes, I am agreeing to the interview

Signature/Left thumb impression:_____

Details of witness (If the respondent is illiterate):

Signature of the witness:_____

Name and address of the witness:_____

_____

_____

If you are not willing to participate, then thank you for your time.

Name of the respondent:_____

Address:

Interviewer's Name:

Interviewer's signature:

Household Unique Identification Code: Date:

AV. Informed Consent form in Malayalam for Policy Actors from Dept of Health/LSG for participation in In-Depth Interview

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

നയ രൂപീകരണത്തിൽ പങ്കു വഹിക്കാനാവുന്ന ആരോഗ്യ വകുപ്പ്/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉന്നത ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖത്തിനു പങ്കെടുകുവാനുള്ള കാര്യ വിവരണ പത്രം

സീരിയൽ നമ്പർ...

സുപ്രഭാതം/ഉച്ചകഴിഞ്ഞ്/വൈകുന്നേരം

എന്റെ പേര് ശ്രീനിധി ശ്രീകുമാർ, ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ, അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ് എന്ന സ്ഥാപനത്തിൽ പി.എച്.ഡി വിദ്യാർഥിയാണ് ഞാൻ. സാമൂഹികമായുള്ള നൂതന ആരോഗ്യ പദ്ധതികളുടെ വികസനങ്ങളിലേക്ക് നയിക്കുന്ന ഘടകങ്ങൾ : ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും എന്ന ഒരു പഠനം നടത്തുകയാണിപ്പോൾ. എന്റെ പഠന ഭാഗമായാണ് ഈ അഭിമുഖം ചെയ്യുന്നത്.

താങ്കൾ നിലവിൽ _____ വകുപ്പിൽ ഒരു _____ ആയി ജോലി ചെയ്യുന്ന വ്യക്തിയായതിനാൽ താങ്കളുടെ അഭിപ്രായങ്ങൾ എന്റെ പഠനത്തിനു വളരെ വിലയേറിയതാണ്. കാരണം താങ്കളുടെ അഭിപ്രായങ്ങൾക്കും, തീരുമാനങ്ങൾക്കും നിലവിൽ കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിൽ നടപ്പിലാക്കപ്പെടുന്ന ആരോഗ്യ പദ്ധതികളിൽ കാര്യമായ പങ്കു വഹിക്കാനാവും എന്നതിനാലാണ്. ഈ അഭിമുഖം 30 മുതൽ 40

മിനിറ്റ് വരെ നീളുന്നതും അഭിമുഖത്തിനിടയിൽ പഠനത്തിലെ പങ്കാളിത്തം പിൻവലിക്കാവുന്നതും, പ്രത്യേക ചോദ്യങ്ങൾക്ക് മറുപടി നൽകേണ്ടെന്ന് തീരുമാനിക്കാനുമാകും. ഈ പഠനത്തിൽ പങ്കെടുക്കുന്നത് കൊണ്ട് താങ്കൾക്കു പ്രത്യേകിച്ച് നേട്ടമൊന്നും ഉണ്ടാകില്ല, എന്നിരിന്നാലും ഈ അഭിമുഖത്തിലൂടെ ഞാൻ ശേഖരിക്കുന്ന താങ്കളുടെ അഭിപ്രായങ്ങളും കാഴ്ചപ്പാടുകളും നിലവിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിൽ വികസിക്കപ്പെടുന്ന പദ്ധതികളെ സഹായിക്കാനാകും എന്ന് ഞാൻ വിശ്വസിക്കുന്നു.

താങ്കൾക്കു കൂടുതലായി അറിയാൻ താല്പര്യം ഉണ്ടെങ്കിൽ പഠനത്തെ പറ്റി കൂടുതൽ വിവരങ്ങൾ നൽകാൻ ഞാൻ തയ്യാറാണ്. ഈ വിലാസത്തിൽ എന്നെ ബന്ധപ്പെടാം

ശ്രീനിധി ശ്രീകുമാർ

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം

ബന്ധപ്പെടാനുള്ള നമ്പർ : 9895848316

പഠനത്തെ പറ്റി പിന്നീട് ചോദ്യങ്ങളോ, ഉത്കൺഠകളോ താങ്കൾക്കു ഉണ്ടാവുകയും ഞാനല്ലാതെ മറ്റാരോടെങ്കിലും സംസാരിക്കണമെന്ന് താത്പര്യപ്പെടുകയും ചെയ്യുന്നെങ്കിൽ താങ്കൾക്കു ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ ഇന്സ്ട്ടിട്ടുഷനൽ എത്തിക്സ് കമ്മിറ്റി മെമ്പർ സെക്രട്ടറി ഡോ. മാലാ രാമനാഥനെ ബന്ധപ്പെടാം

ഫോൺ നമ്പർ. 0471-2524234

ഈമെയിൽ mala@sctimst.ac.in

നന്ദി

സമ്മത പ്രസ്താവന

കാര്യവിവരണ പത്രത്തിലെ വിവരങ്ങൾ ഞാൻ വായിച്ചു/എനിക്ക് വായിച്ചു തന്നു. പഠനത്തിന്റെ സ്വഭാവത്തെ പറ്റിയും എന്റെ പങ്കാളിത്തത്തെപ്പറ്റിയും വിശദീകരിച്ചു. എന്റെ

എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരം നൽകി. ഈ സമ്മത പത്രം ഒപ്പിടുന്നതിലൂടെ ഞാൻ സൂചിപ്പിക്കുന്നതെന്തെന്നാൽ, എന്നിൽ നിന്നും പ്രതീക്ഷിക്കുന്നതെന്തെന്നു ഞാൻ മനസ്സിലാക്കിയെന്നും പഠനത്തിൽ പങ്കെടുക്കാൻ എനിക്ക് സമ്മതമാണെന്നുമാണ്. എനിക്കേതു സമയത്തും സമ്മതം പിൻവലിക്കാമെന്നു എനിക്കറിയാം. ആവശ്യമുണ്ടാവുകയാണെങ്കിൽ ആരെ ബന്ധപ്പെടണമെന്ന് എന്നെ അറിയിച്ചിട്ടുണ്ട്.

അഭിമുഖത്തിനു ഞാൻ സമ്മതിക്കുന്നു.

ഒപ്പ്/ഇടതു തള്ള വിരൽ അടയാളം .....

സാക്ഷിയുടെ വിശദ വിവരങ്ങൾ (പ്രതികരിക്കുന്നയാൽ നിരക്ഷരയെങ്കിൽ)

സാക്ഷിയുടെ ഒപ്പ് .....

സാക്ഷിയുടെ പേരും മേൽവിലാസവും

.....
.....
.....
.....

താങ്കൾക്ക് പങ്കെടുക്കുവാൻ സമ്മതമല്ലെങ്കിൽ, സമയം ചിലവഴിച്ചതിനു നന്ദി

പ്രതികരിച്ചയാളുടെ പേര്

.....

മേൽവിലാസം

അഭിമുഖം നടത്തിയയാളുടെ പേര്

അഭിമുഖം നടത്തിയയാളുടെ ഒപ്പ്

തിരിച്ചറിയൽ കോഡ് തിയതി

AVI. Informed Consent form in Malayalam for PHC/LSGI staff for participation in In-Depth Interview

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

പ്രാഥമിക ആരോഗ്യ കേന്ദ്രം/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖത്തിനു പങ്കെടുകുവാനുള്ള കാര്യവിവരണ പത്രം

സീരിയൽ നമ്പർ...

സുപ്രഭാതം/ഉച്ചകഴിഞ്ഞ്/വൈകുന്നേരം

എന്റെ പേര് ശ്രീനിധി ശ്രീകുമാർ, ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ, അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ് എന്ന സ്ഥാപനത്തിൽ പി.എച്.ഡി വിദ്യാർഥിയാണ് ഞാൻ. സാമൂഹികമായുള്ള നൂതന ആരോഗ്യ പദ്ധതികളുടെ വികസനങ്ങളിലേക്ക് നയിക്കുന്ന ഘടകങ്ങൾ : ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും എന്ന ഒരു പഠനം നടത്തുകയാണിപ്പോൾ. എന്റെ പഠന ഭാഗമായാണ് ഈ അഭിമുഖം ചെയ്യുന്നത്.

താങ്കൾ നിലവിൽ _____ പഞ്ചായത്തിലെ _____ ഒരു _____ ആയി ജോലി ചെയ്യുന്ന വ്യക്തിയായതിനാൽ താങ്കളുടെ അഭിപ്രായങ്ങൾ എന്റെ പഠനത്തിനു വളരെ വിലയേറിയതാണ്. കാരണം താങ്കളുടെ അഭിപ്രായങ്ങൾക്കും, തീരുമാനങ്ങൾക്കും നിലവിൽ താങ്കളുടെ പഞ്ചായത്തിൽ നടപ്പിലാക്കപ്പെടുന്ന നൂതന ആരോഗ്യ പദ്ധതികളിൽ കാര്യമായ പങ്കു വഹിക്കാനാവും എന്നതിനാലാണ്. ഈ അഭിമുഖം 30 മുതൽ 40 മിനിറ്റ് വരെ നീളുന്നതും

അഭിമുഖത്തിനിടയിൽ പഠനത്തിലെ പങ്കാളിത്തം പിൻവലിക്കാവുന്നതും, പ്രത്യേക ചോദ്യങ്ങൾക്ക് മറുപടി നൽകേണ്ടെന്ന് തീരുമാനിക്കാനുമാകും. ഈ പഠനത്തിൽ പങ്കെടുക്കുന്നത് കൊണ്ട് താങ്കൾക്കു പ്രത്യേകിച്ച് നേട്ടമൊന്നും ഉണ്ടാകില്ല, എന്നിരിന്നാലും ഈ അഭിമുഖത്തിലൂടെ ഞാൻ ശേഖരിക്കുന്ന താങ്കളുടെ അഭിപ്രായങ്ങളും കാഴ്ചപ്പാടുകളും നിലവിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിൽ വികസിക്കപ്പെടുന്ന നൂതന പദ്ധതികളെ സഹായിക്കാനാകും എന്ന് ഞാൻ വിശ്വസിക്കുന്നു.

താങ്കൾക്കു കൂടുതലായി അറിയാൻ താല്പര്യം ഉണ്ടെങ്കിൽ പഠനത്തെ പറ്റി കൂടുതൽ വിവരങ്ങൾ നൽകാൻ ഞാൻ തയ്യാറാണ്. ഈ വിലാസത്തിൽ എന്നെ ബന്ധപ്പെടാം

ശ്രീനിധി ശ്രീകുമാർ

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം

ബന്ധപ്പെടാനുള്ള നമ്പർ : 9895848316

പഠനത്തെ പറ്റി പിന്നീട് ചോദ്യങ്ങളോ, ഉത്കൺഠകളോ താങ്കൾക്കു ഉണ്ടാവുകയും ഞാനല്ലാതെ മറ്റാരോടെങ്കിലും സംസാരിക്കണമെന്ന് താത്പര്യപ്പെടുകയും ചെയ്യുന്നെങ്കിൽ താങ്കൾക്കു ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ ഇന്സ്ട്ടിട്ടുഷനൽ എത്തിക്സ് കമ്മിറ്റി മെമ്പർ സെക്രട്ടറി ഡോ. മാലാ രാമനാഥനെ ബന്ധപ്പെടാം

ഫോൺ നമ്പർ. 0471-2524234

ഈമെയിൽ mala@sctimst.ac.in

നന്ദി

സമ്മത പ്രസ്താവന

കാര്യവിവരണ പത്രത്തിലെ വിവരങ്ങൾ ഞാൻ വായിച്ചു/എനിക്ക് വായിച്ചു തന്നു. പഠനത്തിന്റെ സ്വഭാവത്തെ പറ്റിയും എന്റെ പങ്കാളിത്തത്തെപ്പറ്റിയും വിശദീകരിച്ചു. എന്റെ എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരം നൽകി. ഈ സമ്മത പത്രം ഒപ്പിടുന്നതിലൂടെ ഞാൻ സൂചിപ്പിക്കുന്നതെന്തെന്നാൽ, എന്നിൽ നിന്നും പ്രതീക്ഷിക്കുന്നതെന്തെന്നു ഞാൻ മനസ്സിലാക്കിയെന്നും പഠനത്തിൽ പങ്കെടുക്കാൻ എനിക്ക് സമ്മതമാണെന്നുമാണ്. എനിക്കേതു സമയത്തും സമ്മതം പിൻവലിക്കാമെന്നു എനിക്കറിയാം. ആവശ്യമുണ്ടാവുകയാണെങ്കിൽ ആരെ ബന്ധപ്പെടണമെന്ന് എന്നെ അറിയിച്ചിട്ടുണ്ട്.

അഭിമുഖത്തിനു ഞാൻ സമ്മതിക്കുന്നു.

ഒപ്പ്/ഇടതു തള്ള വിരൽ അടയാളം .....

സാക്ഷിയുടെ വിശദ വിവരങ്ങൾ (പ്രതികരിക്കുന്നയാൽ നിരക്ഷരയെങ്കിൽ)

സാക്ഷിയുടെ ഒപ്പ് .....

സാക്ഷിയുടെ പേരും മേൽവിലാസവും

.....
.....
.....
.....

താങ്കൾക്ക് പങ്കെടുക്കുവാൻ സമ്മതമല്ലെങ്കിൽ, സമയം ചിലവഴിച്ചതിനു നന്ദി

പ്രതികരിച്ചയാളുടെ പേര്
.....

മേൽവിലാസം

അഭിമുഖം നടത്തിയയാളുടെ പേര്

അഭിമുഖം നടത്തിയയാളുടെ ഒപ്പ്

തിരിച്ചറിയൽ കോഡ് തിയതി

AVII. Informed Consent form in Malayalam for community members for participation in In-Depth Interview

“സാമൂഹികമായുള്ള നൂതന ആരോഗ്യ പദ്ധതികളുടെ വികസനങ്ങളിലേക്ക് നയിക്കുന്ന ഘടകങ്ങൾ : ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

പഞ്ചായത്ത് നിവാസികൾക്ക് വിശദമായ അഭിമുഖത്തിനു പങ്കെടുകുവാനുള്ള കാര്യവിവരണ പത്രം

സീരിയൽ നമ്പർ...

സുപ്രഭാതം/ഉച്ചകഴിഞ്ഞ്/വൈകുന്നേരം

എന്റെ പേര് ശ്രീനിധി ശ്രീകുമാർ, ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ, അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ് എന്ന സ്ഥാപനത്തിൽ പി.എച്.ഡി വിദ്യാർഥിയാണ് ഞാൻ. സാമൂഹികമായുള്ള നൂതന ആരോഗ്യ പദ്ധതികളുടെ വികസനങ്ങളിലേക്ക് നയിക്കുന്ന ഘടകങ്ങൾ : ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും എന്ന ഒരു പഠനം നടത്തുകയാണിപ്പോൾ. എന്റെ പഠന ഭാഗമായാണ് ഈ അഭിമുഖം ചെയ്യുന്നത്.

താങ്കൾ നിലവിൽ _____ പഞ്ചായത്തിലെ ഒരു അംഗമെന്ന നിലയിലും, ഈ പഞ്ചായത്തിലെ ആരോഗ്യ സേവനങ്ങൾ ഉപയോഗിക്കുന്ന ഒരു വ്യക്തി എന്ന നിലയിലും താങ്കളുടെ അഭിപ്രായങ്ങൾ എന്റെ പഠനത്തിനു വളരെ വിലയേറിയതാണ്. മാത്രമല്ല ഈ പഞ്ചായത്തിലെ ആരോഗ്യ സേവനങ്ങളുടെ ഒരു പ്രധാന ഗുണഭോക്താവ് എന്ന നിലയിൽ, ഈ സേവനങ്ങൾ ഉപയോഗിക്കുന്നതിൽ താങ്കളുടെ അനുഭവങ്ങളും അഭിപ്രായങ്ങൾക്കും, നിലവിൽ താങ്കളുടെ പഞ്ചായത്തിൽ നടപ്പിലാക്കപ്പെടുന്ന നൂതന ആരോഗ്യ പദ്ധതികളിൽ കാര്യമായ

പങ്കു വഹിക്കാനാവും എന്നതിനാലാണ്. ഈ അഭിമുഖം 30 മുതൽ 40 മിനിറ്റ് വരെ നീളുന്നതും അഭിമുഖത്തിനിടയിൽ പഠനത്തിലെ പങ്കാളിത്തം പിൻവലിക്കാവുന്നതും, പ്രത്യേക ചോദ്യങ്ങൾക്ക് മറുപടി നൽകേണ്ടെന്ന് തീരുമാനിക്കാനുമാകും. ഈ പഠനത്തിൽ പങ്കെടുക്കുന്നത് കൊണ്ട് താങ്കൾക്കു പ്രത്യേകിച്ച് നേട്ടമൊന്നും ഉണ്ടാകില്ല, എന്നിരിന്നാലും ഈ അഭിമുഖത്തിലൂടെ ഞാൻ ശേഖരിക്കുന്ന താങ്കളുടെ അഭിപ്രായങ്ങളും കാഴ്ചപ്പാടുകളും നിലവിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിൽ വികസിക്കപ്പെടുന്ന നൂതന പദ്ധതികളെ സഹായിക്കാനാകും എന്ന് ഞാൻ വിശ്വസിക്കുന്നു.

താങ്കൾക്കു കൂടുതലായി അറിയാൻ താല്പര്യം ഉണ്ടെങ്കിൽ പഠനത്തെ പറ്റി കൂടുതൽ വിവരങ്ങൾ നൽകാൻ ഞാൻ തയ്യാറാണ്. ഈ വിലാസത്തിൽ എന്നെ ബന്ധപ്പെടാം

ശ്രീനിധി ശ്രീകുമാർ

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം

ബന്ധപ്പെടാനുള്ള നമ്പർ : 9895848316

പഠനത്തെ പറ്റി പിന്നീട് ചോദ്യങ്ങളോ, ഉത്കൺഠകളോ താങ്കൾക്കു ഉണ്ടാവുകയും ഞാനല്ലാതെ മറ്റാരോടെങ്കിലും സംസാരിക്കണമെന്ന് താത്പര്യപ്പെടുകയും ചെയ്യുന്നെങ്കിൽ താങ്കൾക്കു ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജിയിലെ ഇന്സ്ട്ടിട്ടുഷനൽ എത്തിക്സ് കമ്മിറ്റി മെമ്പർ സെക്രട്ടറി ഡോ. മാലാ രാമനാഥനെ ബന്ധപ്പെടാം

ഫോൺ നമ്പർ. 0471-2524234

ഈമെയിൽ mala@sctimst.ac.in

നന്ദി

സമ്മത പ്രസ്താവന

കാര്യവിവരണ പത്രത്തിലെ വിവരങ്ങൾ ഞാൻ വായിച്ചു/എനിക്ക് വായിച്ചു തന്നു. പഠനത്തിന്റെ സ്വഭാവത്തെ പറ്റിയും എന്റെ പങ്കാളിത്തത്തെപ്പറ്റിയും വിശദീകരിച്ചു. എന്റെ എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരം നൽകി. ഈ സമ്മത പത്രം ഒപ്പിടുന്നതിലൂടെ ഞാൻ സൂചിപ്പിക്കുന്നതെന്തെന്നാൽ, എന്നിൽ നിന്നും പ്രതീക്ഷിക്കുന്നതെന്തെന്നു ഞാൻ മനസ്സിലാക്കിയെന്നും പഠനത്തിൽ പങ്കെടുക്കാൻ എനിക്ക് സമ്മതമാണെന്നുമാണ്. എനിക്കേതു സമയത്തും സമ്മതം പിൻവലിക്കാമെന്നു എനിക്കറിയാം. ആവശ്യമുണ്ടാവുകയാണെങ്കിൽ ആരെ ബന്ധപ്പെടണമെന്ന് എന്നെ അറിയിച്ചിട്ടുണ്ട്.

അഭിമുഖത്തിനു ഞാൻ സമ്മതിക്കുന്നു.

ഒപ്പ്/ഇടതു തള്ള വിരൽ അടയാളം .....

സാക്ഷിയുടെ വിശദ വിവരങ്ങൾ (പ്രതികരിക്കുന്നയാൽ നിരക്ഷരയെങ്കിൽ)

സാക്ഷിയുടെ ഒപ്പ് .....

സാക്ഷിയുടെ പേരും മേൽവിലാസവും

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താങ്കൾക്ക് പങ്കെടുക്കുവാൻ സമ്മതമല്ലെങ്കിൽ, സമയം ചിലവഴിച്ചതിനു നന്ദി

പ്രതികരിച്ചയാളുടെ പേര്
.....

മേൽവിലാസം

അഭിമുഖം നടത്തിയയാളുടെ പേര്

അഭിമുഖം നടത്തിയയാളുടെ ഒപ്പ്

തിരിച്ചറിയൽ കോഡ് തിയതി

AVIII. Critical Discourse Analysis Data Collection Tool: In-depth interview with policy makers

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Department…….. Employment position…….

1. Recently there has been a lot of interest around innovations as a strategy to improve/strengthen Primary Health Care, what is your opinion on it?
2. How do you define innovations? How does it differ from a normal program? Can you give examples?
3. Can you give examples of some good innovations? Why do you consider them so? Which aspect of it do you feel good?
4. Can you list out the key actors needed to be involved in the development of grass root level primary health care innovations in Kerala?
5. What would be the key roles of each stakeholder? Can you give some examples?
6. According to you what are the major features of primary care innovations at different levels? (at the level of PHC, LSGI, Community, District, NRHM and State)
7. What do you feel are the important considerations that PHC and LSGIs should have while designing an innovation in primary health care?
8. How do you feel, can the existing innovative projects in the area of primary health care be improved?
9. What do you consider are the different roles community can play in the area of primary health care innovations? (marginalised/vulnerable sections)
10. What are the specific policies on primary health care innovations in Kerala currently?
11. Is there anything else you might want to add?

AIX. In-depth interview tool for analysis of institutional analysis with actors within PHC and Local Self-Governments institutes

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Panchayat…….
Organisation……..

Employment……..

a. What are the key objectives of the current innovation and kindly explain the brief history of the project in terms of its inception and development?
b. What were the major reasons and motivation for starting such an innovation in the area?
c. Who were the major actors who championed for such an innovation?
d. Who were the major actors who supported the champion?
e. What do you consider are the major activities that were crucial in the development of the innovation?
f. How do you think the knowledge and information for initiating such a project came about? Was there any reference innovation elsewhere that might have motivated the current project?
g. If so how did you/champion come to know about such an idea?
    i. Any formal or informal discussions or interactions between various people within and outside the system that helped the idea to be shared?
    ii. Or through some other channel
h. How was the idea made convincing among the actors to be developed as a reality?
    i. What were the initial strategies adopted among the champions to realise the implementation of the innovation? Who were those people who participated in such activities?
i. Was such an innovation also developed as part of any requirement that was given by the authorities? Or are there any policies that require you to prioritise the current area of innovation that is being implemented?
j. How was the support from higher authorities in initiating the innovation in your area?
k. Were there any already existing processes that served the same community before the current innovation?
l. Did these existing practices and service delivery strategies create a burden on the newer processes of innovation? If so how did you overcome those limitations?
m. Was there any policy structures that enabled better facilitation of the innovation?
n. How did you manage to mobilise the needed resources and infrastructure for the innovation? Was there any challenges associated with it? How were they solved?
o. Was there any resistance from any section including staff, community, authorities, LSG members or any others in the implementation of the innovative strategies?

p. If so how did you manage to overcome the resistance? Who were the actors who supported the innovation process to sustain?

AX. In-depth interview tool for analysis of institutional entrepreneurship among innovation actors at PHC and LSGI

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Panchayat…….
Organisation……..

Employment……..

1 What do you feel are the major health related issue in your PHC area? How have your organisation addressing them?

2 What are your opinions on experimenting changes in the existing ways of service delivery in Primary Health Care through innovative methods?

3 What do you feel are the roles of communities, specifically beneficiaries of a program within the processes of innovation?

4 What were the reasons that made you feel that, only such an idea can improve the situation?

5 When you thought about such an idea, what were the major challenges that you faced?

6 What were the strategies that you adopted in convincing the authorities to implement the innovation? Who were the people that you initially discussed the idea with?

7 How did you manage to mobilise the resources needed for the innovation? What were the challenges and how were they managed?

8 Have you attempted similar innovations previously in this organisation or other?

9 What were the strategies that were taken to ensure that the innovation is sustained?

AXI. In-depth interview tool for analysis of inclusiveness among actors at PHC and LSGI

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Panchayat…….
Organisation……..

Employment……..

2. Who were the members of the community that were involved in the processes of innovation?

3. In what ways do you feel are the community part of the current innovation?
    a. Were they/you part of the initial consultations during the designing of new strategies? How?
    b. Were they/you in any way part of planning and development of strategies and in the actual delivery of the service? How?

4. What encouraged such an involvement of the community?
    a. Were there any demand from the beneficiary for better and innovative service delivery strategies to meet their needs?

5. Do you consider that there might be groups who may still not receive the services even among the beneficiary groups? If so who may be these groups and why?

6. How have you made sure that most of them are covered in the process?

AXII. In-depth interview tool for analysis of inclusiveness among beneficiaries from communities

Exploration of Social Innovation Ecosystems in Primary Health Care in Kerala: An Application of Innovation Systems Paradigm and Inclusiveness Assessment

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Science &Technology
Trivandrum – 695011, Kerala

Panchayat…… Sex of the respondent……

Age of the respondent……

1. What is your knowledge regarding the program?

2. Were you or any one that you may know of part of this program in any way? If yes, what was the nature of that participation? If no why?

3. Do you feel that there is space for your voice and suggestions in the current program for its improvement?

4. Have you ever been a beneficiary of the current program? Since how long and how was your experience with the program?

5. Do you consider that the new program has benefitted you more, than the previous services available from the PHC?

6. What were the challenges that you experienced in receiving the same service before such a program was initiated?

7. Do you still experience any challenges in seeking care from the new program? If yes, can you explain the nature of the challenges?

8. Do you feel that the current initiative can be further modified to improve its ability to meet your needs? If yes, how do you think that it could be done?

AXIII. Critical Discourse Analysis Tool in Malayalam**: In-depth interview with policy makers**

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

വിഷയ പഠനത്തിനുള്ള വിവര ശേഖരണ സാമഗ്രി: നയ രൂപീകരണത്തിൽ പങ്കു വഹിക്കാനാവുന്ന ആരോഗ്യ വകുപ്പ്/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉന്നത

ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖം നടത്തുന്നതിനുള്ള മാർഗ്ഗ രേഖകൾ

വകുപ്പ്..... ഉദ്യോഗ
തസ്തിക.....

1. നിലവിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയുടെ സേവനങ്ങൾ മെച്ചപ്പെടുത്താനായി നൂതനമായ ആരോഗ്യ പ്രൊജെക്ടുകളുടെ പ്രാധാന്യം ഏറി വരുന്നതായി കാണാൻ സാധിക്കുന്നു, അതിനോടുള്ള താങ്കളുടെ അഭിപ്രായം എന്താണ്?

2. ഒരു സാധാരണ ആരോഗ്യ പദ്ധതിയും നൂതന ആരോഗ്യ പദ്ധതിയും തമ്മിൽ താങ്കൾ കാണുന്ന പ്രധാന വ്യത്യാസം എന്താണ്? ഒരു ഉദാഹരണം തരാൻ സാധിക്കുമോ?

3. താങ്കളുടെ അഭിപ്രായത്തിൽ നല്ലത് എന്ന് തോന്നിയ കുറച്ചു നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഉദാഹരണം തരാൻ സാധിക്കുമോ? എന്തുകൊണ്ടാണ് താങ്കൾ അവ നല്ലത് എന്ന് കരുതുന്നു? അവയിൽ ഏതു കാര്യമാണ് അതിനെ കൂടുതൽ വ്യത്യസ്തമാക്കുന്നത്?

4. താങ്കളുടെ അഭിപ്രായത്തിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിലെ നൂതന പദ്ധതികൾ വിഭാവനം ചെയ്യുമ്പോൾ പങ്കു ചേരേണ്ട പ്രധാന പങ്കാളികൾ ആരെല്ലാമാണ്?

5. മേൽപ്പറഞ്ഞ ഇത്തരം പങ്കാളികൾ കൈകാര്യം ചെയ്യേണ്ട ഉത്തരവാദിത്വങ്ങൾ എന്തെല്ലാമാണ്? ഉദാഹരണം തരാമോ?

6. താങ്കളുടെ അഭിപ്രായത്തിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിലെ നൂതന പദ്ധതികളുടെ വികസനത്തിൽ ഓരോ തലത്തിലും ഉള്ള പ്രധാന ഘടകങ്ങൾ എന്തെല്ലാമാണ്? (പ്രാഥമിക ആരോഗ്യ കേന്ദ്രം, തദ്ദേശ സ്വയംഭരണ സ്ഥാപനം, ജില്ലാ തലത്തിലുള്ള വകുപ്പുകൾ, ജനങ്ങൾ, സംസ്ഥാന തല അധികാരികൾ മുതലായവർ)

7. താങ്കളുടെ അഭിപ്രായത്തിൽ ഇത്തരം നൂതന പദ്ധതികൾ വികസിപ്പിക്കുമ്പോൾ പ്രാഥമിക ആരോഗ്യ കേന്ദ്രവും, തദ്ദേശ സ്വയംഭരണ സ്ഥാപനവും ശ്രദ്ധിക്കേണ്ട പ്രധാന ചുമതലകൾ എന്തെല്ലാമാണ്?

8. താങ്കളുടെ അഭിപ്രായത്തിൽ നിലവിലെ നൂതന പദ്ധതികളെ എങ്ങിനെയെല്ലാം മെച്ചപ്പെടുത്താൻ സാധിക്കും?

9. താങ്കളുടെ അഭിപ്രായത്തിൽ പ്രാഥമിക ആരോഗ്യ പദ്ധതികളിൽ അതാതു സ്ഥലങ്ങളിലെ ജനങ്ങൾക്ക് എന്ത് തരം ഇടപെടലുകൾ ആണ് സാധ്യമായിട്ടുള്ളത്?

10. നിലവിൽ പ്രാഥമിക ആരോഗ്യ മേഖലയിലെ നൂതന പദ്ധതികൾക്കായി സംസ്ഥാനത്ത് എന്തു നയങ്ങൾ ആണ് ഉള്ളത്?

11. കൂടുതൽ എന്തെങ്കിലും താങ്കൾക്കു കൂട്ടിചെർക്കാനുണ്ടോ?

AXIV. In-depth interview tool with actors within PHC and Local Self-Governments institutes in Malayalam

"കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും"

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

വിഷയ പഠനത്തിനുള്ള വിവര ശേഖരണ സാമഗ്രി: പ്രാഥമിക ആരോഗ്യ കേന്ദ്രത്തിലെ/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖം നടത്തുന്നതിനുള്ള മാർഗ്ഗ രേഖകൾ

പഞ്ചായത്തിന്റെ
പേര്.....

സ്ഥാപനം..... ഉദ്യോഗ
തസ്തിക.....

1. നിലവിലെ ഈ ആരോഗ്യ പദ്ധതിയുടെ പ്രധാന ലക്ഷ്യങ്ങൾ എന്തെല്ലാമാണ്? ദയവായി ഈ പദ്ധതിയുടെ തുടക്കത്തെ പറ്റിയും അതിന്റെ നാൾവഴികളെ പറ്റി സൂചിക്കാമോ?
2. ഇത്തരമൊരു പദ്ധതി നടപ്പിലാക്കാനുള്ള പ്രധാന കാരണങ്ങൾ വിവരിക്കാമോ?
3. ഈ പദ്ധതിയുടെ നടത്തിപ്പിനായി മുൻകൈ എടുത്ത വ്യക്തികൾ ആരെല്ലാമാണ് ?
4. അങ്ങനെ മുൻകൈ എടുത്തവരെ പ്രധാനമായും അനുകൂലിക്കുകയും അവരെ കൂടുതൽ സഹായിച്ചവരും ആയ വ്യക്തികൾ ആരെല്ലാമാണ് ?
5. താങ്കളുടെ അഭിപ്രായത്തിൽ ഈ പദ്ധതി നടപ്പിലാക്കാൻ അനുകൂലമായ പ്രധാന നടപടികളും പ്രവർത്തനങ്ങളും എന്തെല്ലാമായിരിന്നു?
6. താങ്കളുടെ അഭിപ്രായത്തിൽ ഇത്തരമൊരു പദ്ധതിയുടെ ആശയം എവിടെ നിന്നാണ് ഉടലെടുത്തത്, അല്ലെങ്കിൽ അതിനാവശ്യമായ കാതലായ അറിവ് ലഭ്യമായത് എവിടെ നിന്നാണ് ? മറ്റെവിടെ നിന്നെങ്കിലും ആണോ ഇത്തരം ഒരു ആശയം ലഭ്യമായത് ?
7. അങ്ങനെയാണെങ്കിൽ അതു എങ്ങിനെയാണ് താങ്കൾ അല്ലെങ്കിൽ ഇതിനു മുൻകൈ എടുത്ത വ്യക്തി അറിയാനിടയായത് ?
    a. മറ്റേതെങ്കിലും വ്യക്തികളോ സ്ഥാപനങ്ങളോ തമ്മിലുള്ള ഇടപെടലുകളിലൂടെയാണോ ഈ ആശയം പങ്കിടാനിടയായത് ?
    b. അല്ലെങ്കിൽ മറ്റേതെങ്കിലും മാർഗത്തിലൂടെയാണോ ?
8. എങ്ങിനെയാണ് താങ്കൾ അല്ലെങ്കിൽ ഇതിനു മുൻകൈ എടുത്ത വ്യക്തി ഇത്തരം ഒരു ആശയം നടപ്പിലാക്കാൻ മറ്റുള്ളവരെ വിശ്വാസത്തിലെടുത്തത് ?
    a. ഇതിനു വേണ്ടി താങ്കൾ അല്ലെങ്കിൽ ആ വ്യക്തി കൈക്കൊണ്ട പ്രധാന ഇടപെടലുകൾ എന്തെല്ലാമാണ് ? അത്തരം കാര്യങ്ങളിൽ ഉൾപ്പെട്ട മറ്റു വ്യക്തികൾ ആരെല്ലാം ആണ് ?

9. ഇത്തരമൊരു ഇടപെടൽ വേണം എന്ന് മേലധികാരികളുടെ ഭാഗത്ത് നിന്നും നിർദേശം എന്തെങ്കിലും ഉണ്ടായിരിന്നത് കൊണ്ട് കൂടിയാണോ ഈ പദ്ധതി നടപ്പിലാവാൻ ഇടവന്നത് ? അഥവാ ഇത്തരം പദ്ധതികൾ ആവശ്യമാണ് എന്ന രീതിയിൽ എന്തെങ്കിലും നയം ആരോഗ്യ വകുപ്പിൽ ഉള്ളത് കൊണ്ടാണോ ഈ പദ്ധതി നിലവിൽ വന്നത് ?
10. ഈ പദ്ധതി നടപ്പിലാക്കാൻ മേലധികാരികളുടെ ഭാഗത്ത് നിന്നും ലഭിച്ച അനുകൂല നടപടികൾ എന്തെല്ലാം ആണ് ?
11. ഈ പദ്ധതി നടപ്പിലാക്കുന്ന സാഹചര്യത്തിൽ അതേ മേഖലയിലെ ആവശ്യങ്ങൾക്കായി മറ്റേതെങ്കിലും പദ്ധതി ഉണ്ടായിരിന്നോ ?
12. ഉണ്ടായിരിന്നെങ്കിൽ അത് മൂലം നിലവിലെ ഈ പദ്ധതിക്ക് ഏതെങ്കിലും രീതിയുലുള്ള തടസങ്ങൾ അനുഭവിച്ചിരിന്നോ ? അങ്ങനെയെങ്കിൽ എങ്ങിനെയാണ് അതിനെ തരണം ചെയ്തത് ?
13. ഈ പദ്ധതിക്കു അനുകൂലമായ രീതിയിൽ ആരോഗ്യ വകുപ്പിൽ ഏതെങ്കിലും നയങ്ങളോ നിയമങ്ങളോ നിലനിന്നിരിന്നോ?
14. പദ്ധതിക്കാവശ്യമായ ചിലവുകളും വിഭവങ്ങളും ഏതു മാർഗങ്ങളിലൂടെയാണ് സമാഹരിച്ചത് ? അതിൽ തടസങ്ങൾ നേരിട്ടിരിന്നോ ? എങ്കിൽ എങ്ങിനെയാണ് അത് തരണം ചെയ്തത് ?
15. ഏതെങ്കിലും ഭാഗങ്ങളിൽ നിന്നു ഈ പദ്ധതിക്ക് തടസങ്ങൾ നേരിട്ടിരിന്നോ ? മറ്റു ജീവനക്കാരിൽ നിന്നോ, അധികാരികളിൽ നിന്നോ, തദ്ദേശ സ്വയംഭരണ സ്ഥാപനത്തിൽ നിന്നോ, ജനങ്ങളിൽ നിന്നോ ?
16. അങ്ങനെയെങ്കിൽ അത്തരം തടസങ്ങളെ എങ്ങിനെയാണ് നേരിട്ടത് ?

AXV. In-depth interview tool for analysis of institutional entrepreneurship among innovation actors at PHC and LSGI in Malayalam

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ:

ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും"

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

വിഷയ പഠനത്തിനുള്ള വിവര ശേഖരണ സാമഗ്രി: പ്രാഥമിക ആരോഗ്യ കേന്ദ്രത്തിലെ/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖം നടത്തുന്നതിനുള്ള മാർഗ്ഗ രേഖകൾ

പഞ്ചായത്തിന്റെ
പേര്.....

സ്ഥാപനം..... ഉദ്യോഗ
തസ്തിക.....

1. താങ്കളുടെ അഭിപ്രായത്തിൽ ഈ മേഖലയിലെ പ്രധാന ആരോഗ്യ പ്രശ്നങ്ങൾ എന്തെല്ലാമാണ്, ആർക്കാണ് കൂടുതൽ ശ്രദ്ധ കൊടുക്കേണ്ടത്? നിലവിൽ അത്തരം പ്രശ്നങ്ങളെ എങ്ങെനെയെല്ലാമാണ് നേരിട്ടു കൊണ്ടിരിക്കുന്നത് ?

2. നിലവിൽ ആരോഗ്യ സേവനങ്ങൾ കൊടുക്കുന്ന രീതികളിൽ നിന്നും വ്യത്യസ്തമായി നൂതനമായ മാർഗങ്ങൾ കൈകൊല്ലുന്നതിനെ പറ്റി താങ്കളുടെ കാഴ്ചപ്പാട് എന്താണ് ?

3. താങ്കളുടെ അഭിപ്രായത്തിൽ പ്രാഥമിക ആരോഗ്യ സേവനങ്ങൾ സ്വീകരിക്കുന്ന സമൂഹത്തിലെ അംഗങ്ങൾക്ക് ഇത്തരം നൂതന പദ്ധതികളിൽ എങ്ങിനെയെല്ലാമാണ് ഇടപെടാൻ കഴിയുക ?

4. ഇത്തരമൊരു ആശയമാണ് വേണ്ടത് എന്ന് താങ്കൾക്കു തോന്നാനുള്ള കാരണങ്ങൾ എന്തെല്ലാമാണ്?

5. ഇത്തരമൊരു പദ്ധതിയുടെ നടത്തിപ്പിനു വേണ്ടി ശ്രമിച്ചപ്പോൾ താങ്കൾ നേരിട്ട പ്രധാന വെല്ലുവിളികൾ എന്തെല്ലാമായിരിന്നു?

6. ഇത്തരമൊരു ആശയം നടപ്പിലാക്കാൻ മേലധികാരികളെ താങ്കൾ എങ്ങിനെയാണ് വിശ്വാസത്തിലെടുപ്പിച്ചത്? എന്തെല്ലാം പ്രവർത്തങ്ങൾ ആണ് താങ്കൾ നടത്തിയത്? ആരോടെല്ലാമാണ് താങ്കൾ ആദ്യം ബന്ധപ്പെട്ടത്?

7. ഈ പദ്ധതിക്കാവശ്യമായ ചിലവുകളും മറ്റാവശ്യ വസ്തുക്കളും ലഭ്യമാക്കിയത് എങ്ങിനെയൊക്കെയാണ്? അതിൽ നേരിട്ട പ്രധാന വെല്ലുവിളികൾ എന്തെല്ലാമാണ്? എങ്ങിനെയാണ് അതു തരണം ചെയ്തത്?

8. ഇത്തരം രീതിയിലുള്ള മറ്റു പ്രവർത്തനങ്ങൾ താങ്കൾ മുൻപ് ശ്രമിച്ചിട്ടുണ്ടോ?

9. ഈ പദ്ധതിയുടെ നീണ്ട കാലത്തെ നിലനിൽപ്പിനായി താങ്കൾ എന്ത് രീതിയിലുള്ള നടപടികൾ ആണ് സ്വീകരിച്ചിട്ടുള്ളത്?

AXVI. In-depth interview tool for analysis of inclusiveness among actors at PHC and LSGI in Malayalam

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

വിഷയ പഠനത്തിനുള്ള വിവര ശേഖരണ സാമഗ്രി: പ്രാഥമിക ആരോഗ്യ കേന്ദ്രത്തിലെ/തദ്ദേശ സ്വയഭരണ സ്ഥാപനങ്ങളിലെ ഉദ്യോഗസ്ഥർക്ക് വിശദമായ അഭിമുഖം നടത്തുന്നതിനുള്ള മാർഗ്ഗ രേഖകൾ

പഞ്ചായത്തിന്റെ
പേര്.....

സ്ഥാപനം..... ഉദ്യോഗ
തസ്തിക.....

1. ഈ പദ്ധതിയുടെ പ്രവർത്തനങ്ങളുടെ ഭാഗമായി ഉൾപ്പെട്ടിട്ടുള്ള സമൂഹത്തിൽ നിന്നുമുള്ള വ്യക്തികൾ ആരെല്ലാമാണ്?

2. ഏതെല്ലാം രീതികളിലാണ് അവർ ഈ പദ്ധതിയുടെ ഭാഗമായിട്ടുള്ളത്?

    a. അവർ ഈ പദ്ധതിയുടെ ആശയ വികസനത്തിൽ പങ്കാളികൾ ആയിരിന്നോ? എങ്കിൽ എങ്ങനെ?
    b. ഇതിന്റെ നടത്തിപ്പിന്റെ ഭാഗമായുള്ള ചർച്ചകളിൽ അവർ പങ്കാളികൾ ആയിരിന്നോ? ഇതിന്റെ ദൈനംദിന നടത്തിപ്പിൽ ഇവർ പങ്കാളികൾ ആണോ? ഉണ്ടെങ്കിൽ വിശദമാക്കാമോ?

3. ഇത്തരമൊരു പങ്കാളിത്തം അവരുടെ ഭാഗത്ത് നിന്നും വരുവാനുള്ള പ്രധാന കാരണങ്ങൾ എന്തെല്ലാമാണ്?
    a. അതിനു വേണ്ടി അവർ എപ്പോഴെങ്കിലും ആവശ്യമുന്നയിക്കുകയോ, മുന്നിട്ടിറങ്ങുകയോ ചെയ്തിരിന്നോ?

4. താങ്കളുടെ അഭിപ്രായത്തിൽ ഈ പദ്ധതി ഉണ്ടെങ്കിൽ കൂടിയും സേവനങ്ങൾ ലഭിക്കാത്ത അംഗങ്ങൾ സമൂഹത്തിലുണ്ടോ? എങ്കിൽ അവർ ആരെല്ലാമാണ്? അതിനുള്ള കാരണങ്ങൾ എന്തെല്ലാമാണ്?

5. ഈ പദ്ധതി എല്ലാവരിലും ലഭ്യമാക്കാൻ എന്ത് തരം നടപടികൾ ആണ് സ്വീകരിച്ചിട്ടുള്ളത്?

AXVII. In-depth interview tool for analysis of inclusiveness among beneficiaries from communities in Malayalam

“കേരളത്തിലെ പ്രാഥമിക ആരോഗ്യ മേഖലയിലുള്ള സാമൂഹ്യ നൂതന ആരോഗ്യ പദ്ധതികളുടെ ഒരു സൂക്ഷ്മ പരിശോധ: ഇന്നവേഷൻ സിസ്റ്റംസ് മാതൃക ഉപയോഗിച്ചുള്ള ഒരു പരിശോധനയും, പാർശ്വവൽക്കരിക്കപ്പെട്ടവരുടെ സാന്നിദ്ധ്യവും”

അച്യുത മേനോൻ സെന്റർ ഫോർ ഹെൽത്ത് സയൻസ് സ്റ്റഡീസ്

ശ്രീ ചിത്ര തിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആൻഡ് ടെക്നോലോജി, തിരുവനന്തപുരം, 695011, കേരളം

വിഷയ പഠനത്തിനുള്ള വിവര ശേഖരണ സാമഗ്രി: പഞ്ചായത്തിലെ അങ്ങങ്ങൾക്കുള്ള വിശദമായ അഭിമുഖത്തിനുള്ള മാർഗ്ഗ രേഖ

പഞ്ചായത്തിന്റെ
പേര്.....

പ്രതികരിക്കുന്നയാളുടെ ലിംഗം.....
വയസ്സ്.....

1. ഈ പദ്ധതിയെ കുറിച്ചുള്ള താങ്കളുടെ അറിവെന്താണ്?

2. താങ്കളോ താങ്കൾ അറിയുന്ന ആരെങ്കിലുമോ ഈ പദ്ധതിയിൽ ഏതെങ്കിലും രീതിയിൽ പങ്കാളികൾ ആയിട്ടുണ്ടോ? എങ്കിൽ ഏതു രീതിയിലാണ്? ഇല്ലെങ്കിൽ എന്തുകൊണ്ടാണ്?

3. ഈ പദ്ധതി മെച്ചപ്പെടുത്തുവാൻ താങ്കൾക്ക് ആവശ്യം എന്ന് കരുതുന്ന നിർദേശങ്ങൾ മുന്നോട്ടു വയ്ക്കുവാനുള്ള സ്വാതന്ത്ര്യം ഉണ്ട് എന്ന് കരുതുന്നുണ്ടോ?

4. താങ്കൾ എപ്പഴെങ്കിലും മേൽപ്പറഞ്ഞ പദ്ധതിയുടെ ഗുണഭോക്താവായിരിന്നോ? ആയിരിന്നെങ്കിൽ എത്ര നാളുകളായി താങ്കൾ അതിലൂടെ സേവനം ഉപയോഗിക്കുന്നു? താങ്കളുടെ അനുഭവം എങ്ങിനെയുള്ളതായിരിന്നു?

5. താങ്കളുടെ അഭിപ്രായത്തിൽ മുൻപുള്ള രീതിയിൽ നിന്നു മെച്ചപ്പെട്ട രീതിയിൽ ആണോ ഈ പദ്ധതിയിലൂടെ സേവനങ്ങൾ ലഭ്യമാകുന്നത്?

6. ഈ പദ്ധതിക്ക് മുൻപ് ഇതേ സേവനങ്ങൾ ലഭ്യമാകുന്നതിൽ ഏതു രീതിയിലുള്ള ബുദ്ധിമുട്ടുകൾ ആണ് നേരിട്ടിട്ടുള്ളത് ?

7. നിലവിൽ ഈ പദ്ധതിയിലൂടെ സേവനങ്ങൾ ലഭ്യമാകുന്നതിൽ താങ്കൾ ഏതെങ്കിലും രീതിയിലുള്ള ബുദ്ധിമുട്ടുകൾ അനുഭവിക്കുന്നുണ്ടോ ? ഉണ്ടെങ്കിൽ വിശദമാക്കാമോ ?

8. ഈ പദ്ധതി മെച്ചപ്പെടുത്തുവാൻ ഏതു രീതിയിലുള്ള വ്യത്യാസങ്ങൾ വേണം എന്നാണു താങ്കൾ കരുതുന്നത് ? എങ്ങിനെയാണ് അത് നടപ്പിലാക്കേണ്ടത് ?

AXVIII. Details of 'I care we care' campaign in Village A

The 'I care we care' was a campaign mode activity undertaken by Karakulam LSGI during May, 2020. The project was aimed as a community owned campaign that attempted to support the health staff in undertaking routine pre-monsoon cleaning and house-to-house surveillance. This was planned since lockdown measures were in place due to the ongoing Covid-19 pandemic which made it difficult for health staff to achieve their usual responsibilities in the panchayat.

Community volunteers for house-to-house surveillance and cleaning drive

To support the campaign, LSGI had recruited volunteers from among the community. These volunteers were expected to undertake the responsibilities of house-to-house cleaning, awareness building, ensuring hygiene of public spaces and institutions within the panchayat. As part of the campaign at least 2 volunteers were recruited for every 50 households in the panchayat and at least 50 members were recruited from all 23 wards in the panchayat. In total the whole campaign had the support of around 1000-1500 volunteers including community members, Kudumbasree members, Health promotion team, ASHA, Health staff, ward members as well as staff from LSGI.

The key activities undertaken by the community volunteers were scoring of the households in the panchayat using a pre-prepared interview schedule, cleaning of various institutions in the panchayat including schools and other spaces as well as cleaning of all major public places including roads. The volunteers also provided orientation on covid-19 disease and ‘Ardra bhavanam’ concept. ‘Ardra Bhavanam’ is a model house concept developed as part of the Government Health Department’s Aardram mission.

Interview schedule and use of ODK platforms to score the households

The community volunteers were entrusted with the responsibility of administering an interview schedule that was developed as part of the campaign. The interview schedule was developed by GPK leadership and included questions that aimed at the status of environmental hygiene in and around the household. The interview schedule used for the house-to-house surveillance by community

I CARE WE CARE

Ward number

House number

Name of the head of the household

House name

Total number of individuals in the household

Number of individuals below 10 years

Number of individuals above 60 years

Is the house and surroundings cleanly maintained? 1 Mark 2 Marks 3 Marks

Is there any chance of water logging leading to mosquito breeding? 1. Yes 2. Not at all 3. Need to improve

Has the surrounding foliage been maintained hygienically? 1. Yes 2. No

Is the toilet bend pipe well netted? 1. Yes 2. No

Solid waste including plastic? 1. Karmasena 2. Categorised and sold by the HH

3. Thrown around the HH 4. Others

Use of santiser/soap for hand washing? 1. Only after returning from outside

2. Four to five times 3. While bathing

Knowledge about the spread and preventive measures about leptospirosis, dengue, scrub typhus, diarrhoeal diseases, corona?

1. No 2. Have some information 3. Knows well

The above-mentioned interview schedule was developed as a mobile application by the GPK team using Kobo toolkit, an Open Data Kit (ODK) platform. This was then used by the volunteers in their mobile phones to record the responses which was then uploaded to the GPK server in Karakulam.

Training of community volunteers using online platforms

A key activity that was undertaken as part of the campaign was to train the volunteers on the various activities expected out of them. These included training on administering the interview schedule using mobile application, scoring of the

households based on the questionnaire as well as awareness building activities to be undertaken by the volunteers.

Since the State was under a lockdown state, the LSGI leadership in partnership with GPK had adopted online means to conduct the training session for the volunteers. As part of the activity, pre-recorded training sessions were also collected from public health experts from government medical colleges as well as by FHC medical officers. In addition to pre-recorded sessions by public health experts, live training on using the mobile application too were provided online by GPK experts. The main platform that was used to provide training was through the 'facebook live' feature through the facebook pages of GPK and Karakulam FHC. Links to the live training sessions were shared to all volunteers prior to the scheduled training. The live sessions also provided the volunteers the opportunity to raise questions and doubts which were then cleared by the experts from GPK, FHC as well as LSGI.

Project implementation

The whole 'I care we care' program was planned from a campaign mode and was conducted in phases.

Phase I – Announcement of the campaign

The initial stage of the campaign was to announce the cleaning drive by the LSGI leadership. A week before the household level surveillance, the project was announced by the LSGI. This was achieved by announcement of the event throughout the panchayat as well as through the distribution of printed materials in all wards of the panchayat.

Phase II – one week cleaning drive

The households in the panchayat area were asked to clean their surroundings as part of the campaign. The recruited volunteers were deployed in various parts of the panchayat including public institutions, commercial areas, roads as well as other areas of the panchayat for cleaning activities. As part of the supervision of the activities ward level 'I care we care' social media groups using watsapp application was commenced.

These groups were led by ward members and had representatives from residence associations, NREG members, kudumbasree members, HPT members, Haritha karma sena volunteers, health staff as well as staff from LSG. Details of all the activities were communicated and updated to all members using the mobile social media application. The responsibilities of collecting and compiling ward level details were assigned to a staff from LSG in each ward.

Phase III – House-to-house surveillance by volunteers

After a week of cleaning drives, the trained volunteers with the support of ASHA and other healthcare staff were deployed in each ward to conduct house-to-house surveillance. The volunteers were to evaluate the hygiene status of the household and surrounding areas as well as provide awareness on hygiene, source reduction as well as Covid related information. As part of the surveillance a scoring was done by the volunteers based on the hygiene status of the household and surroundings and based on the scores, each household was also assigned a star rating.

Score interval	Star rating
1-6	2
7-9	3
10-12	4
13-15	5

Phase IV – Repeat surveillance of households

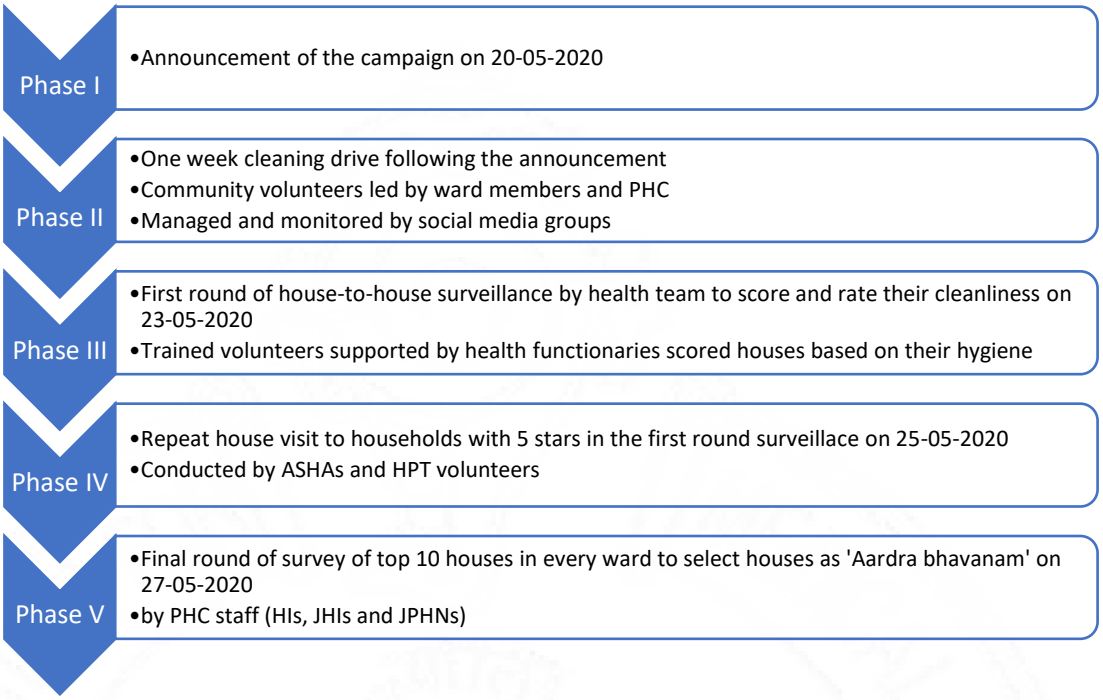
Based on the scoring of the household through the initial survey by trained volunteers, health staff selected all the households that had received 5 stars. Then as part of the health departments 'Aardra Bhavanam' concept a second level survey was conducted by ASHAs and HPT volunteers to all the households with 5 stars for ensuring the hygiene status. Based on the second level survey 10 households were selected from all 23 wards by the health staff. The second level survey used a broader questionnaire to ensure the quality of hygiene and health of the household. These included questions on management of solid and liquid waste, measures adopted to ensure prevention of communicable diseases, mental health, greenery around the house and NCD related questions including diet and lifestyle of the household members.

Phase V – Final survey by health staff

The 10 households selected from each ward were then finally surveyed individually by public health staff including JHI, JPHN and HI. Based on the survey one house was qualified as 'Aardra bhavanam' from the panchayat.

Timeline of the activities under 'I care we care'

The whole 'I care we care' program was planned from a campaign mode and was conducted in phases.



AXIX. Details of Sayamprabha project in Village B and timeline of activities

Sayamprabha project details

The word 'Sayamprabha' in Malayalam could be translated as 'rays of light during dusk' is a project initiated for the welfare of elderly members between the age group of 60-75 in Eraviperoor village panchayat. One among the many projects implemented by Eraviperoor LSG that is considered as a model across the State for the welfare of elderly. The project was first implemented in the financial year 2018-19 through the plan fund earmarked for elderly, children and differently abled by the Integrated Child Development Scheme (ICDS) department. The project had an initial budgetary allocation of around 13.3 lakhs with ICDS supervisor at the LSG as its implementing officer.

Elderly clubs at the anganwadi centres

Though the whole project is managed by the LSG, the implementation of the project follows a hierarchical structure with elderly clubs or societies at the Anganwadis and a larger level Sayamprabha committee at the LSG level managed by elderly members from the village. As part of the projects routine functioning, the project formed 27

elderly clubs based at every Anganwadis. These local Sayamprabha clubs are managed by an executive committee comprised of a president, secretary, and treasurer who are elected from among themselves. Each local Sayamprabha club has a membership of around 25-50 members and are convened together on first Friday of every month at their local Anganwadi. These meetings are usually scheduled after the routine timings of Anganwadis between 3.30 – 5.00 PM facilitated by the Anganwadi worker and helper. The elderly communities are now a regular presence at the Anganwadis providing them an opportunity to spend time together with their peer group. They also now participate in events including Independence Day or children's day celebrations. To facilitate the elderly clubs, the LSG provided 20 chairs, table, radio, and water purifiers to anganwadi centres operating in LSG owned buildings. All meetings of the club members are recorded in the registers which are collated at the LSG level.

Survey for the need assessment of elderly individuals in the panchayat

A key element within the project was an innovative method of conducting a survey to gauge the needs of the elderly individuals in the panchayat region before planning the actual project. This was intended to aid the decision-making with respect to the various components to be involved within the project that could have real benefit the elderly individuals. Hence the initial phase of the project was conceived with a panchayat level door-to-door survey of all individuals between the age of 60-75 years to collect the information related to; the number of individuals, their health-related needs, and the services they would like to have from such a project.

Yet another key element was the decision to conduct the survey of elderly and their needs by the elderly members themselves. Through this method the door-to-door survey of elderly people were decentralised and delegated to the anganwadi level clubs. The interview schedule for the survey was developed by the LSG staff and was distributed to all anganwadi level elderly clubs. The details of the survey and the means to collect the survey details were briefed to the club members with the help of anganwadi workers. The responsibility to collect the needed information and the ways in which surveys shall be conducted were delegated to the leadership of local Sayamprabha clubs. Under their leadership the survey was conducted by elderly

individuals who volunteered for the door-to-door survey. The whole process was successfully completed within a month and the collected information were passed on to the anganwadi worker by the club members.

Through the survey the project could collect vital information related to the actual number of individuals within the age group of 60-75 years and well as their health needs. Some of the key demands as felt by the elderly members were related to needs like medicines and financial support to purchase medicines. Provision of spectacles and hearing aids and nutritional support were the key needs revealed through the survey among the elderly individuals within the panchayat region.

Medical camps for the elderly

Soon after the survey was completed, the information collected by the Sayamprabha clubs were collated under the leadership of ICDS supervisor, the implementing officer of the project. Given the needs generated through the survey, meetings were convened at the Sayamprabha clubs at the anganwadi to discuss further actions warranted through the project. Based on the suggestions received from the Sayamprabha clubs, the LSG planned medical camps at the panchayat to identify the health needs and medical requirements of its elderly community. Three separate sites were designated for the easier functioning of the medical camps in three key areas of Eraviperoor panchayat which were, Vallamkulam, Eraviperoor and Othera.

Formal requests were made by the ICDS supervisor to the medical officers at the Family Health Centre, Ayurveda health centre as well as Homeopathy facilities for the conduction of medical camps. In addition to these three camps, arrangements were also made for eye and dental screening camps in collaboration with local private health facilities. Dental camps were voluntarily supported by dental council and eye care camps were supported by a private hospital from Alappuzha. Information related to the medical camps including date and venue were dissipated through the anganwadi centres and Sayamprabha club leadership. Instructions were provided to the Sayamprabha clubs to pre-register the details of the individuals who plan to attend the medical camps which could better facilitate the smooth functioning of the camps.

Based on the health check-ups and screenings through the camps, free of cost medicines were provided for the elderly individuals who attended the camps. The medicines needed were provided by the health centre staff during the medical camps, which was then reimbursed by the LSG using the fund available within the project. As part of the medical camps screening of the nutritional requirements of the elderly members was also performed by the FHC medical officer. Based on this screening a maximum of 5 members selected from every Sayamprabha club in the panchayat. Individuals who required hearing aids were also selected through the screening camps in collaboration with Keltron company. Further this list of beneficiaries was sanctioned and vetted through a social audit gramasabha attended by elderly members in the panchayat.

The individuals selected for nutritional support were provided with a fixed supply of nutritional supplements every month called 'Sayamprabha Nutrimix powder'. The preparation of the nutritional supplement in terms of the needed ingredients was aided with the inputs received from the FHC medical officer. Further the manufacturing of the nutritional supplements was done through local kudumbasree unit and was procured by the LSG using funds available within the project. Based on the requirements for hearing aid, LSG authorities in collaboration with keltron company provided hearing aids to 22 individuals in the panchayat. In addition to the provision of hearing aids, the LSG through the dental screening camps identified the number of individuals who required dentures. Based on this assessment LSG collaborated with the 'Mandahaasam' program operated by Social Justice Department through which around 7 individuals were provided with dentures. LSG in collaboration with Joy Alukkas provided spectacles to around 30 individuals who required them.

Electric auto rickshaw facility

Yet another challenge faced by the elderly individuals was the issue of geographical access to the FHC. The location of the FHC in Eraviperoor is rather towards the Southern corner of the Panchayat at a location called Othera. In addition to this access to the location through public transport was also limited making it difficult for people in other areas of the panchayat to access the FHC.

"Our PHC is located at a region with very limited bus transport, so many elderly individuals found it very difficult to travel to and from the PHC"

"MO had also informed us that whoever came to the FHC had to wait 2-3 hours to access a bus transport back to their homes, and they might not also have the financial capacity to hire an auto rikshaw too. So, there is such an issue" (ICDS Supervisor)

Based on this assessment LSG leadership purchased an electric auto rikshaw using the project fund specifically for Sayamprabha members. The electric auto rikshaw was provided at the FHC with a lady driver from kudumbasree. Whoever required travel support to the FHC can inform the FHC medical officer upon which the auto rikshaw is send to their location and then back to their homes after FHC visit. The salary of the auto rikshaw driver was supported from the Hospital Management Committee (HMC) funds at the FHC.

Routine health check-up facility at the anganwadi centres

Given the difficult for individuals from all areas of the panchayat to easily reach the FHC, through the project a facility to provide routine health screening at the anganwadi centres in all wards. As part of this activity LSG purchased a BP apparatus and glucometer at all wards during the 2019-20 project period. To facilitate the screening of Sayamprabha members, a brief training was provided to all ASHAs with the support of FHC medical officer.

As part of the activity ASHA workers would provide BP and blood sugar screening at all anganwadi centres between 7.00-9.00 AM every morning. The Sayamprabha members in that specific anganwadi area could visit the anganwadi and avail the screening service free of cost.

Day trip to Alappuzha in collaboration with Joy Alukkas

Based on the suggestions received from the elderly individuals, the LSG also arranged for a day trip for the members of Sayamprabha to Alappuzha. The whole activity was planned in collaboration with Joy Alukkas through their CSR fund. As per the information received from the ICDS Supervisor, the involvement of Joy Alukkas Foundation was made possible through a newspaper notification of a special elderly

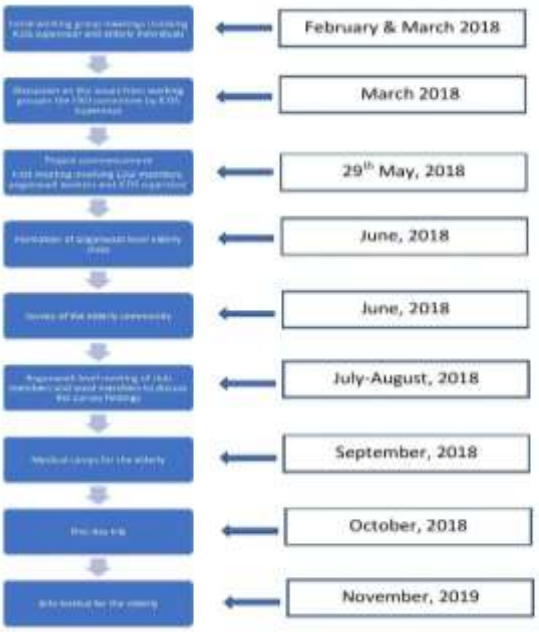
gramasabha in Eraviperoor panchayat. The complete expense for the trip for the elderly was met through the CSR funding of Joy Alukkas.

The day trip was planned for a maximum of 100 individuals and the selection of the individuals for the event was delegated to the Sayamprabha club leadership at the anganwadi centres. The LSG informed the Sayamprabha club leaders to provide the list of minimum 2 members from their clubs who they thought deserved to be on the trip. Once the final list of participants was collected, ICDS supervisor formally informed Joy Alukkas Foundation regarding the number of participants and the time and dates possible for the event. As per this information identification cards were printed for the 105 individuals selected for the trip which also included a few LSG ward members as well as ICDS supervisor. Two buses were arranged by the Joy Alukkas foundation and participants were picked up from the prefixed locations. The entire trip was planned for a day and included a trip to Alappuzha beach. The meals and other refreshments for the participants were arranged at Joy Alukkas store at Alappuzha.

Arts festival and competition for Sayamprabha members

Yet another feature of the Sayamprabha project was its inclusion of an arts festival and competition for the elderly members in the panchayat. This was decided at the panchayat level meeting of all elderly members from various Sayamprabha clubs. Based on this plan, arts competitions were conducted in the year 2019 where in the first phase anganwadi level competitions were held. The winners from anganwadi level then competed at the panchayat level and prizes were given. The expenses for food and other refreshments for the arts competitions was sourced by the LSG through private sponsors and the mementos for the winners were purchased from LSG own fund.

TIMELINE OF ACTIVITIES – "SAYAMPRABHA" PROJECT, VILLAGE B



AXX. Plagiarism report

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