Claudia Lang:

»Kerala«

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RADICAL HEALTH

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KERALA Model

The small South Indian state of Kerala is often celebrated for its health achievements in spite of low economic growth and per-capita income. A central feature of what is often called the "Kerala model" of health is the state's prioritizing and investment in comprehensive primary health care. Kerala is an interesting case for thinking radical health, since here, concerns and actions that are often pursued by grassroot initiatives are implemented at a state level and translated into policies. Moreover, medical traditions such as Ayurveda and Homeopathy are structurally included in the health care system in a similar manner as biomedicine. Kerala has public and private Ayurveda and Homeopathy colleges; public and private primary, secondary and tertiary care level hospitals and clinics; professional organizations for Ayurveda and Homeopathy doctors, as well as a Department for AYUSH, which stands for the various non-allopathic systems of medicine recognized by the Indian state. In this essay, I trace radical health in Kerala by looking into primary health care (PHC) as it has been imagined, practiced and indeed radicalized since the 1970s.

How do policy makers in Kerala envision healthy futures by radically prioritizing primary health care in a context of limited financial resources? Which local ideas of radical health emerge in the contexts of these debates?

Kerala is well-known in development theory as a case of "lopsided development": a gross domestic product typical of low-income countries and social indicators similar to those of industrialized high-income countries. From the late 1950s onwards, the state's rate of growth has been well below the rest of India, and yet the state has made major progress in terms of health, education, population control, or land reform. What is often glossed as "Kerala model" of health has been characterized by strong civil society engagement and community participation in decision-making and care, both have also proved important in the local responses to COVID-19 and in Kerala's better fare in comparison to the impact of the pandemic in the majority of Indian states.

KERALA Alma Ata



Photograph by the Pan American Health Organization, Office of Public Information (1978). VIDEO ▸ cache.ch/1703

In 1978, the WHO/Unicef Alma-Ata conference launched the primary health care strategy as a tool to move towards "health for all".[1] The strategy was influenced by experiences with social medicine and community medicine predominantly but not only in the global South. It also resonated with ideas of decolonization, sustainable development, a critique of top-down vertical international health approaches, an emphasis on self-reliance, a critique of biomedicine and an interest in lay perspectives on health. In the intersectional PHC agenda, health was defined not only as access to clinical services but also to clean water, food, sanitation, housing, and safe living conditions.

Dr. Ekbal Bappukunju is a senior public health activist and one of the architects of Kerala's most recent health policy. Actively engaged in Kerala's People's Science Movement (KSSP) and in the international People's Health Movement that advocates for PHC in the spirit of the Alma-Ata Declaration,[2] he advocates for PHC and social medicine, drawing on the legacy of Alma-Ata and Rudolf Virchow, one of the founders of social medicine. Both, he suggests, have been largely influential to Kerala's postcolonial health policy. Health policy makers in Kerala take intersectionality in health serious. For example, the *New Kerala Mission* integrates health with other components, such as educational reforms, organic agriculture, waste management, and affordable housing for the poor.

"Earlier, it used to be separate missions. All missions have now been integrated. The name is continuing [and] the work is also continuing under the respective mission. But it has been integrated into a common platform now. It was also a common platform earlier but it was just a coordinating body, coordinating four missions [health, education, agriculture, housing]. Now there is one single mission, *Nava Kerala Mission*, now with four components: health, housing, ecology, and education. All the campaigns are discussed between the missions, by the coordinating agency of *Nava Kerala*. We have meetings between the missions. Now the *Haritha Keralam* [Green Kerala Mission] has started a campaign of better water in the rivers. It's called 'Let the rivers flow free', in Malayalam. That campaign is part of the *Healthy Life Campaign* itself. Though it is done by the *Haritha Keralam Mission*, it has an impact on health. We [the Health Mission] also take part in the discussions and it's a coordinated effort between the missions. When you have polluted rivers, there is no use of talking about healthy living. The work of the *Haritha Keralam Mission* is directly linked to *Aardram Mission* [Health Mission], there is a lot of coordination, more than in the first phase. In the first phase, there was a lot of independent activities, even though there was some coordination. Now it's all more cohesive and integrated. From the experience of the first phase, we learnt there should be more integration. That is why the whole set up was changed."

Interview with Dr. V. Jitesh, Trivandrum, Kerala (31 May 2022).

"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

Testimony of a participant in the 2nd People's Health Assembly, https://phmovement.org/ar/node/3311 (2005).

KERALA Participation

Crucially, health policy makers in Kerala also work to strengthen community participation in decision-making, governance and intervention in health. Community participation was key to the PHC strategy. The Declaration of Alma-Ata of 1978 advocated an intersectoral and multidimensional approach to health that included the socioeconomic determinants of health, emphasized affordability and the use of appropriate technology, pushed for self-reliance and

self-determination and urged active community participation in health care and health education at every level.

Community participation stressed the idea that communities should be actively involved in the identification of their own health needs, as well as in the planning and implementation of the responses to those needs.

As a critique of top-down, vertical and technical approaches to health, the PHC strategy stressed bottom-up, horizontal and intersectional approaches rooted in site-specific, local processes. The radical PHC approach of Alma-Ata as an international strategy was replaced by the far less ambitious and more pragmatic and vertical selective PHC approach that focused on a few low-cost interventions that were easy to monitor and evaluate already one year later. However, its utopian force continues to be an inspiration for social movements working towards social medicine and health justice, especially in the Global South. And it continues to drive health policy-making in Kerala. In global health, community participation is often reduced to a buzzword and active community involvement in identifying local needs and planning and managing health activities is still rare. Kerala's PHC is a notable exception and thus an interesting case for the study of radical health.

"The concept of democratic decentralisation proposed here also requires a movement beyond representative democracy. Appropriate institutions and opportunities but also necessary capabilities have to be created at the lower levels in order for ordinary citizens to participate in the decision making, implementation, monitoring and sharing of the benefits and responsibilities of governmental activities."

T. M. Thomas Isaac: "Campaign for Democratic Decentralisation in Kerala", in: *Social Scientist* 9/10/29 (2001), p. 8.

In the initial years of primary health care in Kerala since the 1960s – well before the Alma-Ata conference - community participation had not been thought of in terms of the ability to make decisions regarding the organization of the primary health centres or the type of service provided. Community participation was understood as participation in costs and maintenance: an active involvement of the panchayats in the purchase of an adequate piece of land and the construction of the building, including proper housing for the medical officer in charge.
In the 1990s, the People's Campaign for Decentralized Planning led to a radicalization of participatory democracy in Kerala by devolving planning and financial power to the Gram Panchayats, the local self-governments.[3] Following the 1996 decentralization reform not only have primary health centres, as well as their ayurvedic and homeopathic equivalents, the dispensaries, been brought under local control. Panchayats have since then also played a key role in the prioritization of people's needs, the responses to these needs and in formulating development priorities. A Panchayat member explained to me:

"This is an initiative of the government to identify the needs of the society at the grass-root level and formulate projects locally to address the needs of the local community."

Interview with Panchayat member in Panavoor, Kerala (10 November 2016).

KERALA Community Health Workers



Photograph by Claudia Lang (2016).

Accredited Social Health Activists in Panavoor, Kerala.

The 2000s brought two important changes strengthening, or radicalizing, PHC. The first one was the introduction of a new cadre of volunteer field workers to further expand community participation: the Accredited Social Health Activists (ASHAs). This was a national scheme but it worked especially well in Kerala's context of local self-governments. ASHAs are trained female community health workers, acting as a link between the healthcare system and the community. They are the healthcare system's grassroot level. Visiting households on a daily basis, they take stock of health problems, facilitate access to health services, create awareness about healthy living, nutrition, basic sanitation and hygienic practices, immunisation and contraception, or in the context of the COVID-19 pandemic, accompanying patients to hospitals and providing first aid and palliative care. They also conduct screenings and mobilize people to come for medical consultations or attend health camps. ASHAs support the employed and salaried field staff of the primary health centres who also visit houses regularly.

"We are supposed to visit 250 houses or 1'000 population per month, each of us. [...] We get a honorarium of 1'500 Rupees [$18.20] per month. We get remuneration for specific tasks. For example, for TB [tuberculosis] and leprosy, we get remuneration. But these are very rare. For other diseases such as malaria or dengue, we don't get. We also get money if we bring a pregnant lady to the hospital. She should be registered within the first three months. And she should attend a government doctor and a government hospital. We are government staff, so we are promoting government care. For one pregnant lady being registered we get 300 Rupees [$3.60]. And for one child being brought to immunization we get twenty Rupees [$0.30]. We have to bring at least five children for immunization. [...] ASHA workers are usually from the community, those who have married into this place. They [employed community workers] are different, they are staff, they even come from other districts. They have frequent transfers. We belong to the community."

Interview with ASHA worker, Kalliyoor, Kerala (21 February 2019).

While the employed staff community workers are subjected to regular transfers, ASHAs are part of the community. They get a basic monthly honorarium and additional incentives for certain activities. Apart from financial remuneration, working as an ASHA provides symbolic and social capital; several ASHAs have become elected members of the local self government or are otherwise influential in their community. From a critical feminist perspective, ASHAs are the latest iteration of non-salaried workers at the bottommost layer of the healthcare system. Rather than as labor, their work counts as service or voluntary work, and different from employed health workers, ASHAs are not unionized. On the other hand, ASHAs hold important social capital and for many their work has been an entry into local politics.

KERALA Traditional Medicine

The second change that strengthened, or radicalized, Kerala's PHC was the wider integration of Ayurveda, and to a certain extent homeopathy, into PHC. Ayurveda is one of the medical systems promoted by the Indian Ministry of AYUSH, an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy, and, since 2012, Sowa Rigpa. Kerala now boasts the largest number of private Ayurveda clinics in India; it also provides Ayurveda treatment in hospitals at every level of the healthcare system. ayurvedic dispensaries are the equivalent to the biomedical Primary Health Centres.



Photograph by Claudia Lang (2019).

Pharmacist at Ayurveda dispensary in Kalliyoor, Kerala.

Two main factors led to an increased investment into ayurvedic and homeopathic dispensaries on the village-level: First, with decentralized governance, decision-making and budgeting, communities were in a position to push through traditional or alternative medical care even on the PHC level. Second, national policies and programs for 'mainstreaming' AYUSH led to a further proliferation of ayurvedic facilities in rural areas. Kerala now hosts at least one Ayurveda and one Homeopathy dispensary in every Panchayat. Rather than an attempt to manage scarcity, as is the case in other parts of India, the integration of Ayurveda within PHC has been a way to offer choice for patients in Kerala. While patients largely frequent ayurvedic dispensaries for noncommunicable and chronic diseases, Ayurvedic dispensaries have also played a significant role in the prevention and treatment of COVID-19 and other infectious disease outbreaks. The integration of traditional medicine within primary health

care is in line with WHO's PHC strategy. Yet, Kerala's specific way of integrating traditional medicine as parallel or juxtaposed PHC is unique in India and elsewhere and reveals a rare configuration of modernization of traditional medicine. A vast body of literature deals with other instantiations of Ayurveda's modernization such as the professionalization and standardization of education, standardization and reformulation of ayurvedic pharmaceuticals, translation of ayurvedic concepts of body and diseases in biomedical categories, the reinvention of ayurvedic disciplines such as psychiatry, or the reinvention of Ayurveda as spa. In other Indian states, ayurvedic doctors often stand in for absent biomedical physicians, by providing basic biomedical treatment in the newly designated health and wellness centres, the former primary health sub-centres. Rather than a failure of integration, the juxtaposition of ayurvedic centres on the primary health level provides the physicians in the ayurvedic dispensaries in Kerala with relative autonomy from the biomedical PHC providers. Paralleling the tasks of biomedical PHC physicians, ayurvedic doctors in ayurvedic dispensaries are engaged not only in clinical work but also in disease prevention and health promotion work that they call "public health work", "social work" or "service to the community", in collaboration with the ASHA workers.

"We are trying to teach ASHA workers what Ayurveda is, and by making use of them we are trying to propagate Ayurveda. For example, most people in Kerala think that Ayurveda is simply oil therapies for pain and for geriatric patients. We are trying to correct them. We have different projects of Ayurveda, here in the panchayat. We concentrate on children women and NCDs. We make people know about the strength of Ayurveda, and also the building of immunity through Ayurveda. We are correcting the lifestyle, daily and seasonal regimen, or the food habits of the people."

Interview with Dr. Siddhi, Government Ayurveda Dispensary, Kalliyoor, Kerala (8 March 2019).

During the pandemic, Dr. Siddhi propagated health diet and lifestyle, dispensed Ayurvedic medicines to strengthen the immune system, and made sure ASHA workers distributed special powders for fumigation to control viral loads to all households.

KERALA Second PHC Revolution

As a response to the epidemiological transition and the massive rise in noncommunicable diseases and mental health issues, the increasing use of private and tertiary health care and exploding health expenditures, Kerala has launched the *Aardram Mission* in 2016 as of the overarching *New Kerala Mission*. Building explicitly on the WHO Alma-Ata Declaration's principle of community participation and decision-making, it aims at transforming the public health sector by strengthening primary health centres.

"We are making Kerala future-ready."

Interview with Rajeev Rajeev Sadanandan, Kerala's former chief secretary of health, Frontline (29 September 2017).

"Before our Aardram mission, primary health care had mainly implemented national programs. While we have national programs for communicable diseases, noncommunicable diseases like diabetes, hypertension or mental health are not addressed by any national programs and so we didn't deal much with them in primary health care. But our health system couldn't keep up with the pace of the epidemiological transition. The health needs of the people were largely with chronic conditions, but the health system was going on with infectious diseases and family planning, which was not the priority of the population."

Interview with Dr. Jameela, Aardram mission (21 March 2019).

Dr. Ekbal, member of the Kerala State Planning Board, imagined the scheme as a "second primary health revolution", intended to reshape Kerala's primary health care by recollecting key aspects of the Alma-Ata Declaration and adapting them to the needs of the early 21st century.

"I think that Aardram mission has a global relevance also, I would like to call it the second primary health care revolution."

Interview with Dr. Ekbal Bappukunju, Trivandrum, Kerala (30 January 2018).

In interviews, architects of the *Aardram Mission* and medical officers in the family health centres walk me through the major shifts: What they call "revamping" of primary health care in Kerala through its *Aardram Mission* comprises, first, a major reconfiguration of the primary health centres, now renamed as family health centres, including "patient-friendly services" (longer working hours, more physicians, less waiting time), laboratories and digitization (electronic health records, telemedicine). It includes, second, a novel focus on the prevention and treatment of what is locally known as lifestyle diseases, namely diabetes and hypertension. A third component of Aadram is a dedicated depression program that integrates depression screening, pharmacological treatment and counseling into primary health care. It expands the skills of community health workers, and it remakes what it means to suffer, who suffers, and how to intervene. Fourth, the program continues to move towards a more radical bottom up planning process including not only medical officers but also community health workers at the grassroot level of the health care system, reflecting what Dr. Jitesh, executive director of Kerala's State Health Systems Resource Centre in 2021, called a "paradigm shift" in health planning. Finally, PHC in Kerala moves increasingly away from being modeled around disease towards what Dr. Jitesh called "wellness".

PHC in Kerala expands beyond curative services towards a more comprehensive approach to health as promotion, prevention and rehabilitation.

It is the former sub-centres, now renamed as family wellness centres, that cater to citizens' wellbeing in the form of medical check-ups, yoga activities or promoting healthy ways of living, eating and relating. Moreover, in line with an intersectional approach to health as embedded within larger social and ecological contexts, the *New Kerala Mission* of the Left Democratic government aims to intervene in public health not only through medical services but also through fostering social justice, education, and environmental health.

"So far everything has been about disease prevention, it's not about wellness. Now with Aardram, we're taking it a step further to the public to talk about wellness, being well and being healthy, instead of being free from disease."

Interview with Dr. Jitesh, State Health System Resource Centre Trivandrum, Kerala (31 May 2021).

KERALA Radical Health

In pursuing political, economic and ecological responses along with medical and technological interventions, PHC in Kerala takes the intersectionality of health serious. The trajectory of PHC in Kerala is rooted in a sustained radical policy of investments in social development whose precondition has been the peculiar configuration of leftist politics that has characterized the state since its creation. Moreover, this prioritization in health has been based on democratically established and negotiated needs, rather than on the question of cost-effectiveness calculations or on performance indicators. This basic feature of health planning has resulted in a rare experience of democratization since the 1990s reforms that granted significant agency to the local Panchayats by decentralizing the definition of priority needs as well as the response to those needs.

The political radicality of PHC in Kerala is not only associated with the ability to grant access to health care as a classical understanding of social medicine would have it. Rather it is associated with rare choices and experiments regarding the targets and nature of health interventions.

Kerala's PHC as a particular form of radical health has kept vivid priorities, which were once part of the famous WHO primary health care strategy but have been marginalized since the 1990s. These are the building of horizontal infrastructures, the hiring and training of non-medical personnel, and the integration of traditional medicine. Moreover, in contrast to global health and its vertical programs that mainly target infectious diseases, Kerala's PHC has taken into account and targeted the mounting burden of noncommunicable diseases and mental health. Third, it has expanded narrow approaches to health by including the social and ecological determinants of health. Finally, it has provided forms of civil society engagement and community health that have also proved important in the local responses to COVID-19 and in Kerala's better fare in comparison with the impact of the pandemic in the majority of Indian states. The case of Kerala shows how the notion and experience of radical health is not only deeply rooted in the state's unique development experience on the one hand and larger movements of social medicine on the other. It is also continuously in flux and adapted to new challenges and needs such as the rising rates of chronic health conditions, environmental degradation and climate change.

Notes

1 Ted Brown, Marcus Cueto, Elisabeth Fee: "The World Health Organization and the Transition from 'International' to 'Global' Public Health", in: *American Journal of Public Health* 96 (2006), pp. 72–92.
2 "Kerala Sasthra Sahithya Parishad", https://kssp.in/about-us/; "People's Health Movement", https://phmovement.org/.
3 "Panchayat Raj" (nn.), in: *Participedia*, https://participedia.net/method/5402 (2019).