Public Health Action

VOL 13 NO S1 PUBLISHED MARCH 2023

KERALA SUPPLEMENT

# Local government stewardship for TB elimination in Kerala, India

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http://dx.doi.org/10.5588/pha.22.0037

**SETTING:** The southern Indian state of Kerala has implemented 'Kerala Tuberculosis Elimination Mission' as 'People's Movement against TB' under the stewardship of local governments (LGs). The state has been certified by the Government of India for being on track to attain the UN Sustainable Development Goals related to TB elimination.

**OBJECTIVE:** To document the role of LG stewardship in the successful implementation of the TB elimination activities in Kerala.

**DESIGN:** 1) Key informant interviews with four state officials, 2) desk review of available documents, 3) in-depth interviews with seven LG leaders, three mid-level programme managers and three health department field staff.

**RESULTS:** LG involvement led to the establishment of solutions based on local problems, enhanced outreach of services to the socially vulnerable individuals, improved treatment support to patients with TB, increased community ownership of TB elimination activities, reduced TB-related stigma and social determinants being addressed. Institutional mechanisms such as LG TB elimination task forces, formal guidance in planning interventions and appreciation of their performance in the form of awards were facilitators for LG involvement.

**CONCLUSION:** LG stewardship can accelerate TB elimination. A good plan for engagement and institutional mechanisms are crucial for LG involvement.

India has the highest number of estimated TB cases in the world, comprising 26% of the global TB burden.[1] The Government of India is committed to achieving the UN Sustainable Development Goals (SDGs) related to ending TB.[2]

The southern Indian state of Kerala (population: 34 million) has health and social indicators (such as infant mortality rate and female literacy) at par with that of industrialised countries,[3] and a lower burden of TB (TB notification: Kerala, 60/100,000 vs. India, 131/100,000).[4] Kerala was felicitated by the Government of India for attaining the 2020 SDG milestones (37.5% reduction in TB incidence between 2015 and 2020).[5]

Local Governments (LGs) have been meaningfully empowered in Kerala through a massive transfer of resources and administrative powers.[6,7] There are 941 *grama panchayats* (village LG), 87 municipalities and six municipal corporations in Kerala, with 21,908 LG representatives. Many decision-taking responsibilities, including delivering local healthcare and community engagement in health, were devolved to democratically elected people's representatives of these LG bodies. These LGs play an important role in primary healthcare in Kerala through the ownership and maintenance of healthcare institutions. The LG plays an important role in implementing the 'Kerala TB elimination mission', which is envisaged as a peoples' movement against TB.[8] The mission aims at LG stewardship, which is support and supervision for applying the principles, strategies and interventions of TB elimination by appropriately adapting these to the local setting.

National Strategic Plan (NSP) for TB Elimination in India recommends the engagement of LGs for fostering community ownership for TB elimination.[2] While there is a specific document listing the role that LG could take in TB elimination, this has not been uniformly implemented in many states of India.

While the contribution of LGs to TB elimination in Kerala has been briefly mentioned in national status reports, the actual process, activities and why LG involvement was more successful in Kerala, have not been documented. The current study aims at documenting the LG stewardship process and how it contributed to the implementation of TB elimination activities in Kerala. This is expected to help policy makers and programme managers in other parts of India, and in other countries to explore the possibilities of LG involvement in TB elimination.

## METHODS

The study had three components: 1) key informant interviews (KIIs) with state officials, 2) a desk review of available documents, and 3) in-depth interviews (IDIs) with LG leaders, mid-level programme managers and health department field staff. KIIs were conducted during February 2021, desk review during March 2021 and IDIs during April–May 2021. The study components are given in Table 1.

KII were conducted to get an idea about the planned strategies, the actual process for engaging LGs and the role played by LGs in TB elimination activities in Kerala. The details of the key informants, their role in the government hierarchy and criteria for selection are given in Table 1.

All available documents regarding LG and TB elimination were referred to for information on 1) the process of engaging with the LG; 2) activities carried out by the LG; and 3) outcomes of LG involvement in TB

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ACKNOWLEDGEMENT
The authors thank HSTP (Health Systems Transformation Platform) for supporting this research; the Sir Ratan Tata Trust for its financial contribution, which made this research possible; and the various officials of the TB Control program of Kerala who supported the study by arranging the interviews and providing documents. The funders had no role in data collection and analysis or preparation of the manuscript.
The manuscript was prepared based on one of the sub-themes of the Local Government and Health project in Kerala, implemented by Health Action by People, Thiruvananthapuram, Kerala.

KEY WORDS
Sustainable Development Goals; National Tuberculosis Elimination Programme; decentralisation; qualitative research

**Received** 15 May 2022
**Accepted** 4 October 2022

PHA 2023; 13(s1): 44–50
e-ISSN 2220-8372

**TABLE 1** Study components

| | |
|---|---|
| Key informant interviews | Key informants were persons with long experience in the field of TB policy implementation, who had broad knowledge of the TB scenario in the state, were aware of the TB programme activities over the years and who were involved in policy formulation and implementation related to TB and LG. They were selected as they were the persons with the longest experience (each having >25 years' experience) at senior level in the state and had a broad overview of the TB and LG scenario in the state and at national level<br>One state-level policy maker: a senior bureaucrat, involved in policy making and guiding and supervising implementation<br>One state-level programme manager: state-level official responsible for TB programme activity implementation in all the districts of the state, supervision and reporting to government<br>One state-level public health expert: leading public health expert, with expertise in LG involvement in various aspects of health, including TB<br>One technical consultant for TB elimination: official from a global partner agency, responsible for guiding the state in TB policy formulation, implementation and supervision |
| In-depth interviews | 7 LG leaders<br>3 district programme managers<br>3 field staff of health department |
| Document review | Official government orders related to LG TB control<br>Strategy document: Kerala TB Elimination Mission<br>Correspondences related to LG TB control<br>Guidelines for LGs for planning TB elimination<br>Report on implementation of TB elimination through LG<br>National programme reports (TB India 2001 to 2021; 21 reports), Central TB Division publications |

LG = local government.

elimination in Kerala. Documents included official government orders, correspondences, guidelines and compiled reports.[8–11] A high level of objectivity and sensitivity was maintained during the process; the authenticity of the documents were assessed, and the goals and biases explored before examining the content. The outputs were used to 1) triangulate information obtained from qualitative interviews, and 2) add data content to the final results.

A guide for IDI was developed. Major themes covered during the interview were 1) the process of involvement of LG in TB elimination activities, 2) the various activities undertaken by the LG for TB elimination, 3) the challenges faced during implementation, and 4) suggestions for improvement. IDIs were conducted with LG leaders, mid-level programme managers and National TB Elimination Programme (NTEP) field staff. These subjects were selected using purposive sampling based on suggestions obtained from the key informants who were asked to select district-level programme managers and key field staff in two categories 1) among those who were closely associated with engaging with the LG for TB elimination, and 2) those who were not that successful in engaging with the LG. District-level programme managers were then contacted and asked to propose leaders of LGs which had successfully implemented TB elimination activities at 'above average' and at 'below optimal' levels. Conscious efforts were taken to ensure geographical representativeness. Participants were approached by phone, the purpose of the interviews were communicated and the prerequisites during the interview (stable internet connection, calm environment and with video switched on) were communicated. All interviews were conducted in the local language, Malayalam, by PS (male, public health expert), who was well experienced in conducting qualitative studies and was fluent in the local language. All IDIs were conducted online using Zoom (Zoom Video Communications, San Jose, CA, USA) with video. One researcher recorded the proceedings, identifying key themes and monitored the verbal and non-verbal interactions. All participants who were contacted could participate. Each interview lasted for approximately 40 min (range: 23–65). IDI were conducted until thematic saturation was reached and there were no new themes in each category. Demographic characteristics of the participants are shown in Table 2.

IDIs were later transcribed verbatim and translated into English. The transcripts were then manually coded by two researchers (PS and SN), and emerging themes and sub-themes were identified and later verified by another investigator (KR). Citations with similar coding were grouped according to the predetermined themes. Recurrent themes were marked as important in red font colour. All the flagged statements were put together and synthesised. The team went through the transcripts and notes and reached a consensus. Any disagreements were discussed regularly by the team to reach a consensus regarding theme coding. Important quotations which gave rise to spontaneous discussion, those around which a lot of time was spent and those that had emotional cues were cited.

The study was cleared by the independent Institutional Ethics committee of Health Action by People, Thiruvananthapuram, India. Administrative permission was provided by the local government department of the Government of Kerala, India.

## RESULTS

Final insights from the analysis of four KIIs, 13 IDIs and the desk review are presented below.

### *Local governments and TB control activities (2000–2015)*

In 2003, the TB control programme made its first formal attempt to include local governments for a focused active case-finding campaign. However, the activity could not be sustained due to the lack of continuous advocacy by the TB programme. In 2007, a formal attempt was made to sensitise all LG leaders regarding TB Control, followed by their involvement in TB control activities by medical officers and health department field staff. LG engagement was intended mainly for providing treatment support to needy patients and linking them to social welfare activities. However, LG engagement depended heavily on the initiatives by and enthusiasm of individual officers from the health department. In 2011, following vigorous campaigning by the district TB programme manager, the Kasaragod District LG formally launched a nutritional support scheme for patients with drug-resistant TB using its development fund.[12] Nutritional supplementation kits were distributed monthly to all patients with drug-resistant TB throughout their treatment

**TABLE 2** Demographic characteristics of the study participants

| Study component | Characteristics | Categories | *n* (%) |
|---|---|---|---|
| Key informant interview | Age group, years | <30 | 0 (0) |
| | | 31–60 | 2 (50) |
| | | >60 | 2 (50) |
| | Sex | Male | 4 (100) |
| | | Female | 0 (0) |
| | Years of experience | <2 | 0 (0) |
| | | 2–5 | 0 (0) |
| | | >5 | 4 (100) |
| In-depth interview | Age group, years | <30 | 2 (15) |
| | | 31–60 | 9 (70) |
| | | >60 | 2 (15) |
| | Sex | Male | 6 (46) |
| | | Female | 7 (54) |
| | Years of experience in concerned field | <2 | 1 (8) |
| | | 2–5 | 5 (38) |
| | | >5 | 7 (54) |

period. Gaining experience from that project, which increased the treatment success rate, many LGs took up similar initiatives. In 2014, the Pathanamthitta District demonstrated that loss to follow-up rates among TB patients could be brought down to near-zero levels through treatment support groups (TSGs) in which LG members had played a significant role.[13,14]

### *TB elimination through local government stewardship (2015–2020)*

With a clear understanding about the potential impact of leveraging LG strengths in ensuring community ownerships, the Government of Kerala planned the TB elimination mission as a joint initiative by health and LG departments.[8,10] The objective of this mission was 1) to pool resources by LGs beyond the provisions by the TB programme for locally appropriate additional interventions, 2) to merge/link TB elimination with other developmental initiatives as added value to TB activities, 3) to ensure popularity and acceptance for the interventions, 4) to ensure civic adherence to the intervention, 5) to strengthen active surveillance and notification, and 6) to provide social support to diagnosed TB patients, when needed, to complete treatment successfully.[8,10]

### *Advocacy, tools and institutional mechanisms for local government stewardship for TB elimination*

A systematic plan for advocacy and engagement of LGs was included in the Kerala TB elimination mission strategy document released in 2017 (advocacy initiatives for engaging LGs are summarised in Table 3);[8,10,15,16] 83% of the LGs in Kerala formed a TB elimination task force.[9] Various tools and guidance documents prepared for LGs to play the roles as expected and institutional mechanisms are given in Table 4.[8,11,15,16]

> LG-wise TB statistics is a powerful tool for opening their (LG leaders) eyes. We used to release LG-wise aggregate figures of presumptive TB examination, TB notification, child TB notification and treatment outcomes every quarter. (IDI; male district TB programme manager aged 44 years)

### *Major activities undertaken by local governments for TB elimination*

Common TB elimination activities performed by most of the LGs are shown in Table 5. These included 1) decentralised surveillance, planning and action,[17] 2) mobilising of resources for case-finding and door-step service delivery for vulnerable individuals, 3) nutritional support to TB patients, 4) treatment support to TB patients, 5) vulnerability reduction for TB and addressing social determinants, and 6) airborne infection control.

> I was informed by the LG task force that the TB testing rates (presumptive TB testing rates) are too low in my LG. Being a remote place, starting TB tests in our laboratory was recommended. I called Mr X (District Programme Manager) and requested support. We provided one laboratory attendant from our fund. Next month we started the service. (IDI; male LG leader aged 37 years)

> I personally visited the house of two TB patients. One was a chronic alcoholic with lots of family issues. I made arrangements for his de-addiction in coordination with an NGO and his family. He completed his treatment successfully. Another one was a man who was left by his family. He was having difficulty in going to hospital daily for injection. We arranged an autorickshaw (taxi) for his transportation daily from home. I also arranged a sack of rice for him. (IDI; male LG leader aged 47 years)

> We had a patient who required continuous hospital care. Nobody, including his wife, was willing to be with him. We arranged a homecare nurse for 90 days and paid the nurse from our fund. The person completed his treatment and is happy now. We also spoke to his family, convinced his wife and brought her back to him. (IDI; female LG leader aged 37 years)

In 2020, 35 LGs funded their TB elimination projects from their own development funds. The majority of TB development programmes focused on nutritional support for patients. Another 48 had a funded project to explore TB determinants such as tobacco control and malnutrition.[9]

### *Determinants of local government ownership for TB elimination*

Programme managers agreed that LGs were playing a big role in TB elimination activities, although their level of involvement was not uniform. LGs which were doing exceptionally well in TB elimination were those which were performing well in other health programmes as well. The presence of an efficient officer at the primary health centre who could advocate for TB elimination and good leadership at LG emerged as important determinants of

**TABLE 3** Advocacy initiatives taken up for LGs involvement for TB

| Advocacy initiatives | Description/details | Responsible agency who undertook the initiative |
|---|---|---|
| Letter from state government to all LG heads | Communication sent officially by state government to all LGs seeking support for TB elimination activities[10] | State government, State TB programme division |
| Sensitisation of LG heads | 98.1% of all LG heads were formally sensitised about TB Elimination Mission[9,10] | District TB programme division |
| Advocacy by an independent agency | Through a reputed non-governmental organisation in one district | Non-governmental organisation |
| Single overriding communication objective | "My TB Free LG [name of LG]" | State TB programme division |
| Decentralised surveillance data | Various parameters of case-finding and outcomes captured LG wise, analysed quarterly, published and presented as maps[17] | District TB programme division |
| Awards for LG | State government has honoured 561 LGs which had zero TB among those aged <5 years in 2019, 688 LGs which had zero lost to follow-up during treatment of TB in 2019 and 709 LGs which had zero drug-resistant TB in 2019[15–17] | State government |

LG = local government.

the level of involvement of the LG in TB elimination activities. LG leaders' personal experiences with TB or TB-affected individuals also played a role in ensuring their commitment.

> I don't think any LG will say 'no' to any good activity proposed by the primary healthcare team for the benefit of the society. If some LGs are not doing TB-related activities, it is because they were not made aware about it. (IDI; male LG leader aged 43 years, state president of association of all rural LG heads)

> I was taken by Mrs X (Health Department field staff) to the house of a TB patient. I had understood the suffering due to the disease, suffering due to stigma and the difficulty they were facing in obtaining good food. I presented this to our committee. From that year onwards, we provided nutritional support to all TB patients in our LG area. (IDI; female LG leader aged 36 years)

> A good officer at the primary healthcare could be a field staff or a medical officer who is interested in TB elimination and good LG leadership is a wonderful combination for extraordinary ownership of TB elimination activities by LGs. (IDI; female district TB programme manager aged 43 years)

A lack of advocacy on the part of the primary healthcare team on behalf of the LGs was identified as a cause for the insufficient involvement of some LGs. Districts that employed an independent agency for advocacy purposes had comparatively higher number of LGs with a funded TB elimination developmental project.

### *Outcomes and impact of activities undertaken by local governments for TB elimination*

The presumptive TB testing rate for the state increased from 1,105/100,000 population in 2015 to 1,461/100,000 population in 2019.[15,16] Actual TB notification went up in 2018 and 2019, closing the gaps in the surveillance system.[15,16] Programme managers felt that LGs had provided a leadership role for periodic active case-finding by mobilising volunteers and ensuring acceptance of the interventions in the community. Strengthening TB diagnostic infrastructures by establishing 127 new TB diagnostic laboratories based on local needs and enhancing screening in populations which previously had poor accessibility were notable efforts to ensure equity of services. Over 22 million vulnerable individuals at risk of developing TB were mapped by a task force under the LG.[15,16] Total loss to follow-up rate among diagnosed TB patients fell in the state to 2% in 2020 from 4.5% in 2015.[15,16] By providing support to those in need, TSGs ensured social inclusion. LGs also helped in ensuring continuity of services during the pandemic and lockdowns by extending social support to TB patients. LGs provided support in training children

**TABLE 4** Institutional mechanism and guidance for LGs to implement TB elimination

| Tool/guidance documents | Description |
|---|---|
| Strategy document | The strategy document for Kerala TB Elimination Mission was issued as a state government order.[10] The document had detailed description of 48 activities that had to be undertaken in the state for TB elimination under the leadership of the LG |
| LG TB elimination task force | • LG TB elimination task force is a group of responsible citizens and public servants organised under the leadership of the LG specifically to achieve the goal of TB elimination in the population stewarded by that LG<br>• The LG TB elimination task force is supposed to plan activities, implement, mobilise resources, self monitoring its activities, adopt mid-course corrections and report to the district TB elimination task force<br>• It is chaired by the elected head of LG. Other members included all elected representatives of the LG, officials of all government departments including health, revenue, social justice, community volunteers, civil society representatives and TB survivors<br>• It was proposed to meet quarterly |
| Handbook on role of LGs in TB elimination | The Department of Health issued a guidance document on the roles and responsibilities of LGs in TB elimination.[11] The guidance book also had a set of model projects that could be implemented by LGs for TB elimination |

LG = local government.

**TABLE 5** Major activities undertaken by LGs for TB elimination

| Activity | Description of activity | Quantitative outputs linked to the activity |
|---|---|---|
| Decentralised surveillance, planning and action | Comparing the LG-wise presumptive TB testing and notification rates by the LG TB elimination task forces led to the initiation of many local actions within the LG, including identification of areas where screening rates are low, and improvements[17] | 127 new designated microscopy centres were started in the state based on local needs in the last 2 years[9] |
| Mobilising resources for TB elimination activities | LGs mobilised volunteers for all TB-related activities, including active case finding, awareness generation and door-step service delivery | 78,000 volunteers were mobilised across the state in 2018 for door-to-door campaign[9] |
| Nutritional support to TB patients | Many LGs provided nutritional support to TB patients during their treatment. Volunteers of TB elimination task force deliver the kits to the houses of patients monthly | Projects worth $60,000 have been implemented by LGs own developmental fund during 2020[9] |
| Treatment support to TB patients | 57% of LGs had formed a treatment support group for TB patients. Treatment support group supports needy patients by providing financial, nutritional, emotional support and door-step service delivery | NA |
| Linkage to social welfare schemes | LGs supported TB patients to link them to various schemes like TB pension ($21 every month during treatment period) schemes by the Revenue Department, housing schemes, poverty alleviation programmes and obtaining bank account for direct benefit transfers | NA |
| Vulnerability reduction for TB and addressing its social determinants | LGs ensure social inclusion and effectively deliver poverty alleviation programmes at the village level. LGs conduct anti-tobacco campaigns and ensures stricter implementation of legislations, including banning of public smoking | NA |
| Airborne infection control | LGs organised a ‘handkerchief revolution’ aiming at behaviour change communication for good respiratory hygiene among school children<br>LGs invested for infrastructure modifications of health facilities for ensuring cross ventilations, installing exhaust fans at laboratories and procuring biosafety cabinets for laboratories | 60 LGs had done infrastructure modifications of health facilities related to strengthening infection control during the year 2020[9] |
| Additional activities | Additional activities undertaken by some LGs included ensuring access to care for migrant population and destitute, care of destitute TB patients, comprehensive screening camps among marginalised population and funding comprehensive lung health programme | NA |

LG = local government; NA = not available.

in cough etiquette of carrying a handkerchief and covering their mouth/nose while coughing (this has been described as the “handkerchief revolution”). This had high visibility in the community and was reported to have generated greater awareness among children. LGs also ensured accountability in poverty alleviation programmes, which were meticulously implemented through various schemes.

> Given there were no LGs in the state, we never would have thought of such a massive programme for the elimination of TB. We even might not have dreamt of elimination of TB. LGs have literally made it a ‘people’s movement’ against TB. (KII; male senior technical consultant aged 56 years who worked for the TB programme for 20 years)

> As far as TB elimination is concerned, it was not the LG structure as such, but rather individual LG leaders who actually played a leadership role in solving local problems and providing support to needy people. Similar people with the willingness to address public health issues would have to be identified and engage forany public health initiative at LG level to be a success. (KII; male aged 65 years).

## DISCUSSION

The study intended to document the LG stewardship process and how this contributed to the implementation of the TB elimination activities in Kerala. We observed that informal LG engagement, which was already in place during the last 20 years, has been expanded to a state-wide, inclusive involvement since 2017, with institutional mechanisms such as LG TB elimination task forces, formal guidance in planning interventions and official appreciation of their performance. LG involvement had led to the establishment of certain solutions based on local problems and circumstances, increased reach of services to the socially vulnerable individuals, enhanced support for patients with TB in completing their treatment, greater social mobilisation and community ownership of TB elimination activities, reduced TB-related stigma and to the social determinants of TB being addressed. LG stewardships were not uniform, and advocacy and persistence by local health programme managers were the primary determinants of their level of involvement. LG taskforces could be further strengthened as local means for im-

plementing multi-sectoral accountability frame work for TB (MAF-TB).[18]

In Kerala, LG involvement has helped in developing local solutions, facilitating a faster response to those in need and thus increasing coverage. Many researches have reported similar results with service decentralisation.[19,20] There is a scarcity of objective evaluations of decentralised health initiatives from India.[21] Decentralisation of anti-malarial activities at the province level has allowed for a greater degree of adaptation to the requirements of local communities in other nations, such as Sri Lanka.[22] However, experiences from Brazil during late 1990s suggest that rapid decentralisation of the entire services from the federal level to states and municipalities that were not adequately prepared for this led to the weakening of local TB control programmes.[23] This highlights the need for a clear separation of government functions and responsibilities at the various levels, as well as systematic advocacy and guidance of local governments to ensure the sustainability of initiatives undertaken by them.

We have examined the role of LGs in TB elimination through a comprehensive review of all documents, and qualitative interviews by corroborating the findings from both. Our results should be interpreted in the light of several limitations. We have not attempted to quantify the outcomes or impacts specifically attributed to LG involvement. In Kerala, the primary health care system is robust and local governments have been granted considerable administrative authority over time. Further research is needed to understand how this will work in other regions where the healthcare system and LGs are weak.

## CONCLUSION

LG stewardship has helped Kerala in accelerating TB elimination. These interventions can be scaled up to other states in India, where LGs are active, with a potential impact on the TB burden. There is also potential to design and implement similar interventions in other low/middle-income-countries where LGs or similar structures are already active in order to accelerate the global agenda for TB elimination.

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**CONTEXTE :** L'État du Kérala, situé dans le sud de l'Inde, a mis en place la « Kerala Tuberculosis Elimination Mission » dans le cadre du « People's Movement Against TB », sous l'égide des gouvernements locaux (LG). Le gouvernement indien a certifié que le Kérala était sur la bonne voie pour atteindre les objectifs de développement durable des Nations unies en matière d'élimination de la TB.

**OBJECTIF :** Documenter le rôle de l'intendance des LG dans la bonne mise en œuvre des activités d'élimination de la TB au Kérala.

**MÉTHODES :** 1) Entretiens avec des informateurs clés (quatre responsables gouvernementaux), 2) analyse des documents disponibles, 3) entretiens approfondis avec sept responsables de LG, trois responsables de programme de niveau intermédiaire et trois membres du personnel de terrain du département de la santé.

**RÉSULTATS :** L'implication des LG a permis d'établir des solutions au vu des problèmes locaux, d'améliorer l'accès aux services pour les personnes socialement vulnérables, d'améliorer le soutien au traitement des patients atteints de TB, de renforcer l'appropriation par la communauté des activités d'élimination de la TB, de réduire la stigmatisation liée à la TB et d'agir sur les déterminants sociaux. Les mécanismes institutionnels, tels que les groupes de travail pour l'élimination de la TB mis en place par les LG, les conseils officiels reçus pour planifier les interventions et l'appréciation des performances sous forme de récompenses ont facilité l'implication des LG.

**CONCLUSION :** L'intendance des LG peut permettre d'accélérer l'élimination de la TB. Une bonne planification de l'engagement et des mécanismes institutionnels sont essentiels à l'implication des LG.

Public Health Action (PHA) welcomes the submission of articles on all aspects of operational research, including quality improvements, cost-benefit analysis, ethics, equity, access to services and capacity building, with a focus on relevant areas of public health (e.g. infection control, nutrition, TB, HIV, vaccines, smoking, COVID-19, microbial resistance, outbreaks etc).

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