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Innovative Approaches to Convergence in Karnataka's Grama Panchayats: Insights from Five Case Studies

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Innovative Approaches to Convergence in Karnataka's Grama Panchayats: Insights from Five Case Studies

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Acronyms

AI	Accountability Initiative
ANSSIRD	Abdul Nazir Sab State Institute of Rural Development
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CEO	Chief Executive Officer
CHC	Community Health Centre
CHO	Community Health Officer
CO	Chief Officer
CPR	Centre for Policy Research
CRISP	Centre for Research in Schemes and Policies
CRP	Cluster Resource Person
CSO	Civil Society Organisation
CSS	Centrally Sponsored Scheme
DEO	Date Entry Operator
DHFW	Department of Health and Family Welfare
DHO	District Health Officer
DWCD	Department of Women and Child Development
FC	Finance Commission
FGD	Focus Group Discussion
FLFPR	Female Labour Force Participation
FY	Financial Year
GoI	Government of India
GoK	Government of Karnataka

GP	Grama Panchayat
GPDP	Grama Panchayat Development Plan
GPETFs	Grama Panchayat Education Task Forces
GPLF	Grama Panchayat Level Federation
GPS	Global Positioning System
GPTF	Grama Panchayat Task Force
ICDS	Integrated Child Development Services
IEC	Information, Education, and Communication
IPAAP	Integrated Participatory Annual Action Plan
KHPT	Karnataka Health Promotion Trust
KPI	Key Person Interview
KSRLPS	Sanjeevini - Karnataka State Rural Livelihood Mission
LS	Library Supervisor
MGIRERD	Mahatma Gandhi Institute for Renewable Energy and Rural Development
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MoU	Memorandum of Understanding
MRF	Material Recovery Facility
MSW	Municipal Solid Waste
MWCD	Ministry of Women and Child Development
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHM	National Health Mission
NRLM	National Rural Livelihood Mission
O&M	Operation and Management
OCR	Optical Character Recognition
OSR	Own Source Revenue
P2	Panchatantra 2.0
PDO	Panchayat Development Officer
PHC	Primary Health Centre
PRA	Participatory Rural Appraisal
PRI	Panchayati Raj Institution
RDPR	Rural Development and Panchayati Raj Department
SBM-G	Swachh Bharat Mission (Gramin)
SC	Scheduled Caste
SDG	Sustainable Development Goals
SDMC	School Development and Monitoring Committee
SHG	Self Help Group
SLW	Solid and Liquid Waste
ST	Scheduled Tribe

SWM	Solid Waste Management
TP	Taluk Panchayat
VHSNC	Village Health Sanitation and Nutrition Committee
WLF	Ward Level Federation
ZP	Zila Panchayat

TABLE OF CONTENTS

Background 1
Case Study 1: Grama Panchayat Library and Information Centres 3
Case Study 2: Koosina Mane 20
Case Study 3: Solid Waste Management 39
Case Study 4: Health Screening 52
Case Study 5: Perspective Planning 66
Conclusion 83
Annexures 84

LIST OF TABLES

Table 1: Sample Profile for Rural Libraries 4
Table 2: Findings from Library Visits 14
Table 3: Sample Profile for Koosina Mane 22
Table 4: State-level Component-wise Allocation for Koosina Mane 24
Table 5: Sample Profile for SHG-SWM 40
Table 6: Summary of Key Findings for SHG-SWM 48
Table 7: Sample Profile for Health Screening 54
Table 8: Sample Profile for Perspective Planning 68
Table 9: Organisational Structure of Key Actors in Perspective Planning 74

LIST OF FIGURES

Figure 1: Changes Made to Rural Libraries after Shifting to RDPR 8
Figure 2: Digitalisation of Rural Libraries 10
Figure 3: Caretaker Training Components 26
Figure 4: Food Timetable for Koosina Mane 27
Figure 5: Organisational Chart of Key Actors across Levels for Koosina Mane 29
Figure 6: Repurposed Creche in Vijayapura District with Learning Materials and Arts on the Wall 30
Figure 7: Creche in Yadgir District Lacked Most Amenities 31
Figure 8: Dry Waste Segregation Unit in Yadgir GP 42
Figure 9: Key Funding Sources for SHG-SWM 43
Figure 10: Key Stakeholders across Levels for SHG-SWM 44
Figure 11: Activities under Grama Arogya Program 53
Figure 12: Division of Responsibilities under the Grama Arogya Program 56

Figure 13: Health Checks Conducted during Screening 59
Figure 14: Components of a Health Kit 59
Figure 15: Sites for Conducting Health Screenings 63
Figure 16: Planning Dashboard on P2 Portal (First section of the process) 69
Figure 17: Perspective Planning Process at GP level 73
Figure 18: Data Collection Process for Perspective Planning in GPs visited. PRA Mapping and Grama Sabha Held at GP Level. 75

LIST OF BOXES

Box 1: At a Library We Saw 6
Box 2: Transfer of Honoraria 11
Box 3: Community Engagement in Libraries 17
Box 4: External Interview with Mobile Creches 25
Box 5: Observations from a State level Review Meeting for Koosina Mane 27
Box 6: Caretaker in KM 7 Goes Door-to-Door to Drop Off Children 31
Box 7: Several Other GP Level Actors Provide Support in Day-to-Day Implementation 45
Box 8: Breaking Barriers—SHG Woman Overcoming Fear of Driving 46
Box 9: Karnataka's *Dooradrushti Yojane* Initiative 67
Box 10: Types of Data Collection for Perspective Planning 71

Background

Bringing different actors together is crucial for development as it ensures a coordinated approach towards solving complex challenges. Within the government, different line departments have the ability to come together through cooperation and coordination, to work towards holistic solutions. Non-governmental Organisations (NGOs) and private businesses can also support the government in achieving these targets at scale. Every actor brings a unique perspective that play an important role in influencing solutions.

Termed as 'convergence', governments across India have attempted to increasingly bring various actors together to improve development at the grassroots. In the last decade, various policy interventions such as Centrally Sponsored Schemes (CSSs) and State Schemes have increasingly brought departments together to solve problems creatively through resource optimisation. For example, the Mahatma Gandhi National Rural Employee Guarantee Scheme (MGNREGS) converges with Swachh Bharat Mission or Pradhan Mantri Awas Yojana Gramin among other schemes to construct assets. Similarly, states can also converge their own schemes with MGNREGS. By converging with these schemes, MGNREGS not only addresses employment needs but also contributes to broader rural development goals, such as infrastructure improvement, health, sanitation, and housing. This integrated approach enhances the overall impact of development programs in rural areas.

Government of Karnataka, in particular, the Rural Development and Panchayati Raj Department (RDPR), has been a frontrunner with introducing various types of convergence models. For example, RDPR reformed rural libraries (termed as Grama Panchayat Library and Information Centres) in convergence with various line departments and NGOs. Similarly, a Grama Arogya health screening initiative was launched where Grama Panchayats (GPs) identify and lead screenings at public sites for non-communicable diseases using a health kit developed by Karnataka Health Promotion Trust.

Despite such major advancements of welfare initiatives led by the government, little is documented about the processes of institutionalising convergence. Crucial questions such as how to ensure regular communication, how to pool appropriate budgets and how to use digital platforms for planning remain unexplored. Answering these questions critically can inspire and support other actors to initiate convergence programs with common goals.

In this light, Accountability Initiative at the Centre for Policy Research partnered with RDPR to unpack five initiatives where the department converged with a range of actors. The five initiatives include Grama Panchayat Library and Information Centres, Koosina Mane creches, Solid Waste Management with Self Help Groups, Grama Arogya Health Screening and Perspective Planning on the Panchatantra 2.0 platform.

The five initiatives have been developed as individual case studies. Each case was designed to answer different aspects of how the initiatives were planned, executed and improved over a period of time. The cases provide perspectives on how other such initiatives can be replicated in different contexts. Methods used to unpack the cases include an extensive review of RDPR guidelines and orders and Key Person Interviews (KPIs) conducted at best performing GPs across the state. Through field visits and in-depth interviews, we understood how different actors engage with each other when working towards a select set of goals driven by a robust vision. The cases do not serve as representative evaluations of the initiatives but instead bring to light the various successes, challenges and opportunities that RDPR has encountered. The cases bring out perspectives of the people behind the initiatives, from the grassroot GP to the state-level department and training institute.

The remainder of the report is as follows. The first chapter presents findings from the Grama Panchayat Library and Information Centres. The second chapter explores the roll-out and early-stage implementation of Koosina Mane creches. Subsequently, we unpack how Solid Waste Management has improved in rural Karnataka through partnerships with Self Help Groups. The fourth chapter explores the case of Grama Arogya health screenings and we conclude with findings from the 5-year Perspective Planning initiative where GPs develop holistic forward-looking plans on a digital platform.

Case Study 1: Grama Panchayat Library and Information Centres

INTRODUCTION

In 2019, the Government of Karnataka initiated a comprehensive reform of its rural library system, transitioning the management of over 5,000 Grama Panchayat (GP) libraries from the Department of Public Libraries to the Rural Development and Panchayat Raj Department (RDPR). The libraries are now known as the 'Grama Panchayat Library and Information Centres'. As of August 2024, there are a total of 5,985 GP Library and Information Centres (RDPR, 2023).

This move was part of a broader strategy to decentralise governance and improve the accessibility and functionality of libraries in rural areas. The initiative aimed to rejuvenate these libraries by enhancing their infrastructure, expanding their services, and integrating digital resources, thereby fostering a culture of reading and learning among rural populations.

Public libraries are crucial in promoting education, civic engagement, and social cohesion, especially in rural areas where access to information and learning resources is often limited. Global evidence from both high and low-income settings has shown that by leveraging their expertise, resources, space, and services, public libraries can positively impact communities, strengthen digital inclusion, particularly of marginalised communities and promote economic benefits (Debono, 2002; Kerslake and Kinnell, 1998; Wojciechowskaa and Topolskab, 2021; Jaeger et al., 2011).

Karnataka recognised the potential of these libraries to serve as vibrant community hubs, offering not just books but also digital resources and spaces for community activities. The initiative sought

to harness this potential by modernising the libraries and making them more responsive to the needs of local communities.

OBJECTIVES AND METHODS

Following a case study approach, this brief seeks to understand the process of implementation of GP-level rural libraries in Karnataka with a view to documenting the processes of planning and coordination and highlighting the challenges and innovations in the program.

Specifically, the study aims to understand the following aspects:

- What is the process of institutionalisation since the shift from the Department of Public Libraries to RDPR?
- What are the barriers and facilitators to implementation?
- What are some of the features for replicability and sustainability?

The case study was developed in two steps. First, information available on the scheme was analysed from government documents, orders, and websites. Second, structured Key Person Interviews (KPIs) were conducted across 4 districts at three levels:

1. **State level**: this entailed conversations with various officials in charge of the scheme, who have supported the program.
2. **GP level**: Library Supervisors (LSs) and Panchayat Development Officers (PDOs) were interviewed to understand various aspects of day-to-day functioning.
3. **NGOs**: Members from Sikshana Foundation, Azim Premji Foundation and Kalike Tata Trust were interviewed to understand their perception of scheme implementation.

Table 1: Sample Profile for Rural Libraries

Respondent	Level	Number of interviews
Case Worker & DD	State	1
LS	GP	5
PDO	GP	3
ANSSIRD Faculty for Libraries	State	3
Sikshana Foundation	NGO	1
Azim Premji Foundation	NGO	1
Kalike Tata Trust	NGO	1

Limitations

We have covered seven rural libraries in three districts of Karnataka. Since the study follows a case study approach, it cannot make generalisations about the scheme across the state. It is for this reason that the focus is not on evaluating the performance of the rural libraries or assessing whether the libraries have led to an increase in reading among children. Instead, the focus is more on the process of creating rural libraries at the Grama Panchayat level, the actors involved, and their perspectives.

Further, interviews of LSs in Kolar and Vijayapura did not yield much information and have therefore not been included in this study.

The rest of this brief is structured as follows: Section 3 provides a brief descriptive account of the libraries. Section 4 delves into the institutionalisation process, including implementation, roles and responsibilities, and key innovations, such as the use of technology and focus on inclusion. Section 5 explores the barriers faced and innovative solutions. Following this, Section 6 explores some key outcomes and successes observed through the interviews. Lastly, Section 7 highlights essential characteristics that can be used to replicate and scale this or similar initiatives.

AT A LIBRARY WE SAW

Box 1: At a Library We Saw

The LS greets us with a warm smile and enquires about our interests. As we explore the library, the diverse collection of books arranged meticulously along the walls catches our attention. The shelves displayed books tailored for readers of all ages, carefully curated to cater to a wide audience. From educational materials for toddlers to study resources for young adults, the library offered an array of reading options. We observe a greater abundance of Kannada books than English ones. The placement of the books varied, with newspapers and literature on philosophy and politics available for adults. Books for children were hung on low-hanging wires that made them accessible for children. A separate section within the library provided books and toys for visitors with different disabilities, available upon request. At the entry, one can view details of the timings and services that are available at the library. Inside, the library walls were painted with alphabets, poems and inspirational quotes. One can often find a chart with career options distributed by NGOs. Upon request, the LS shows us worksheets and paintings that children have completed at the library. We also see the desktop computer, a mobile phone and a tablet that can be used to access digital resources. Typically, our visits would take place during the working hours of a Grama Panchayat - a time when children would still be in school. Hence, we often encountered adults reading at the library, and children visiting after school hours. As we leave, the LS reassures us that the library has, since its transition to RDPR, served as a fresh space for citizens of all ages, especially children, to engage with knowledge in its various forms. They share that there is excitement in the air when camps and programs are organised and that they expect enrolment and engagement to only increase going ahead.

UNPACKING THE INITIATIVE

This section will delve into the implementation process of the initiative and outline the roles and responsibilities of different stakeholders. Additionally, it will examine two key reforms implemented during the shift: the role of technology and the promotion of inclusivity within the initiative.

4.1 Implementation Process

The transition of rural libraries to the RDPR was carefully planned and involved several key steps:

Assessment and Planning

Before the transition, the RDPR conducted a comprehensive assessment of 500 libraries to evaluate their condition, including infrastructure such as library dimensions, electricity provisions, book quality and type, and accessibility. This assessment informed the development of a strategic plan to revamp the libraries.

Governance Shift

The management of libraries was transferred from the Department of Public Libraries to the RDPR, bringing the libraries under the direct control of Grama Panchayats. This shift allowed for greater local oversight and community involvement in library operations. For instance, after the shift, the GPs had more control over what books could be kept in a library.

Capacity Building

Library Supervisors (LSs), previously focused on basic tasks like issuing books, were trained to take on broader roles, including community engagement and digital literacy promotion. Their working hours were increased, and their honorarium was substantially raised to ensure better service delivery.

Increased Library Hours

The number of hours a library was open was increased from 4 to 6 hours with the aim of increasing access to the library as a public space to the community. As a result, children can now visit the library after school hours.

Funding

GPs received funds from three primary sources - Untied Finance Commission Grants, GP's own source revenue, and a 6% Library Cess[1].Salaries are funded through a combination of sources:

[1] 10% of the Library Cess must be used to procure dictionaries, the Indian Constitution, Karnataka Grama Swaraj and Panchayat Raj Act book, Atlas, weekly, monthly and yearly magazines, periodicals, posters related to child and women's rights, career guidance kit, and science kit.

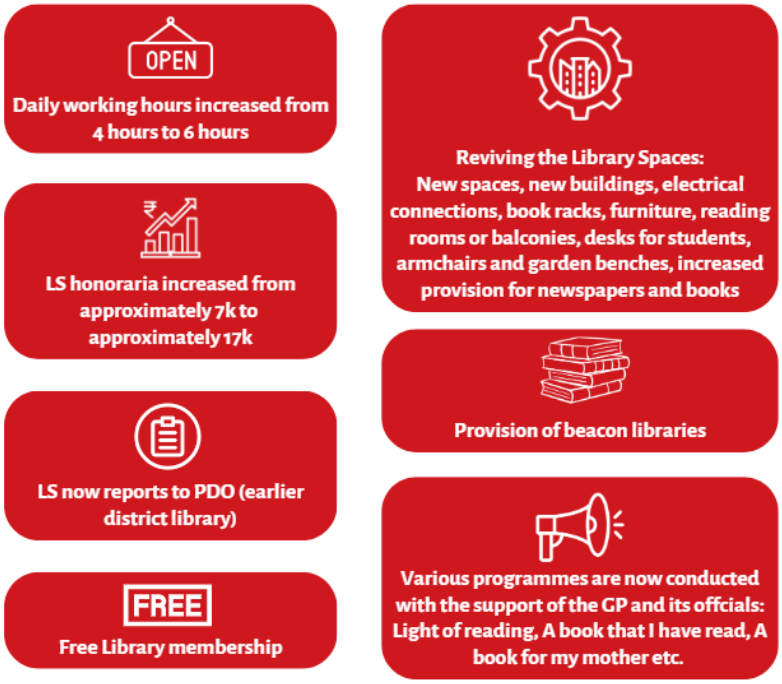
₹5,500 of the ₹17,000 total comes from the state, while the remainder is paid by the GP. To use the GP's own source revenue, they have to form a committee.

NGO Participation

A notable good practice that emerged during the implementation of the program was the effective coordination and collaboration among various NGOs. This synergy significantly enhanced the reach and impact of the program, particularly using digital platforms and devices (described in detail below).

NGOs such as the Sikshana Foundation, Azim Premji Foundation, CRISP, and Kalike Tata Trust have played key roles in working with the state to implement the scheme and experiment with innovative approaches to make rural libraries accessible and engaging to the community.

Figure 1: Changes Made to Rural Libraries after Shifting to RDPR



4.2 Role of Key Stakeholders

The success of the initiative hinged on the active participation of various stakeholders:

Government Officials

At the state level, officials in the RDPR provided strategic direction and oversight, while at the local level, PDOs and GP Presidents took on the day-to-day management of libraries. They work closely with the Executive Officers at the Taluka and Zilla level who supervise the implementation.

Abdul Nazir Sab State Institute of Rural Development (ANSSIRD) is involved in the development and implementation of training programs for LSs in partnership with experts and NGOs.

Library Supervisors (LSs)
LSs were crucial in managing library operations, engaging with the community, and implementing new programs. Their roles were expanded to include digital literacy training and organising community events.

Non-Governmental Organisations (NGOs)
NGOs played a significant role in supporting the initiative, particularly in digital integration and capacity building. Organisations like Sikshana Foundation and Kalike Tata Trust provided training, digital devices, and other resources to enhance library services. NGOs have also played a key role in organising events for a range of community members, including children, senior citizens, women and farmers.

Community Members
The initiative placed a strong emphasis on community involvement. Local citizens were encouraged to participate in library activities, donate books, and use the digital resources available.

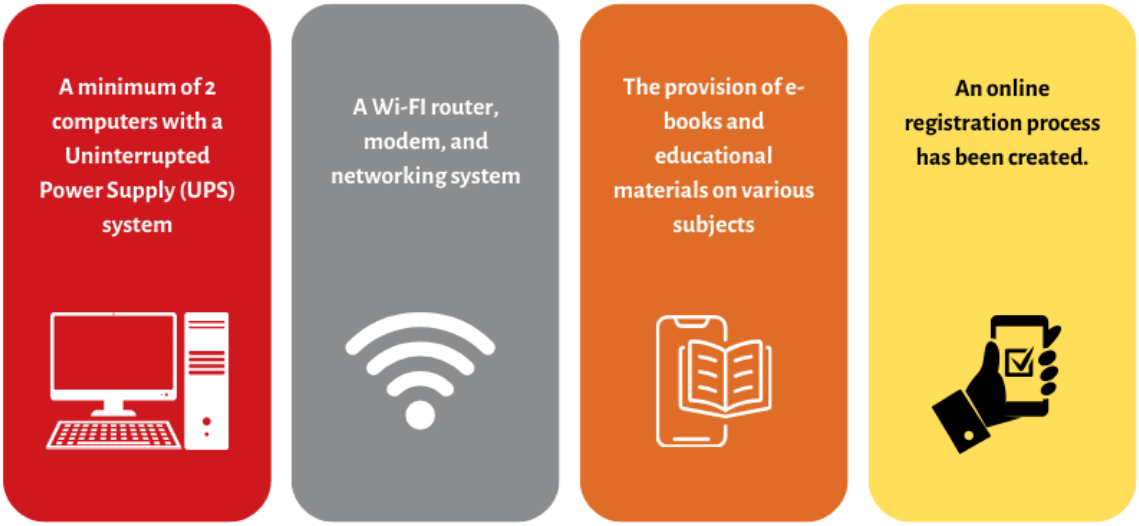
Convergence with other departments
There were roles of other departments as well. For instance, the head teachers within the Department of Education were responsible for utilisation of space and equipment in coordination with the schools, helping students enrol in libraries, and spreading awareness about libraries, school teachers and voluntary resource people conduct educational activities; the health department is responsible for monitoring basic hygiene.

Grama Panchayat Education Task Forces (GPETFs)
They had been formed in each GP to follow up on out-of-school children and re-enrol them in schools. Each task force is headed by the PDO and includes headmasters, ASHA and Anganwadi Workers, CRPs (Cluster Resource Person), SDMC members, and village leaders. The task force also aimed to ensure free enrolment of children (6–18 years) in GP libraries as well as create awareness among children about Child Rights, Child Labour and Child Marriage.

4.3 Use of Technology

Technology was another important area of Karnataka's rural library reform. The introduction of digital libraries transformed traditional book-lending libraries into modern information centres.

Figure 2: Digitalisation of Rural Libraries



Key technological initiatives included:

a) Library upgrades via digital integration

A key component of the initiative was the integration of digital resources. Over 4,800 libraries were upgraded to digital libraries equipped with computers, tablets, and internet access. This digital transformation was supported by NGOs like Sikshana Foundation, which provided the necessary infrastructure and training for LSs.

b) Digital Devices

Libraries were equipped with smartphones, tablets, and computers, which provided access to a wide range of digital resources, including educational materials and government documents.

c) E-Governance Tools

The Panchatantra 2.0 platform was used to streamline administrative processes such as attendance tracking, payment of LS honoraria, and monitoring library activities. The management and monitoring of data, including registrations, events, activities, and expenses, follow a systematic process. Data is initially recorded by the LS manually and then uploaded onto the Sikshana Foundation application by the GP Second Division Accountant. The data collection and monitoring process is overseen by the PDO, who ensures accuracy and consistency. The use of technology has thus ensured transparency and efficiency in library management.

Box 2: Transfer of Honoraria

Earlier the RDPR Department was transferring the honorarium to the GP account who then paid the LS via cheque. Now, LSs are paid online via the Human Resource Management Software module of Panchatantra 2.0 platform. The PDO creates a bill with a digital signature for the payment and the Panchayat President approves the bill with digital signature within 3 days. The Taluk Panchayat Chief Executive Officer gives their approval.

4.4 Inclusivity and Campaigns

Inclusivity including increased participation of women and persons with disabilities was a key focus of the program. Several program were thus run to ensure that libraries were accessible to all. Some of the specific interventions included:

Beacon Libraries for Persons with Disabilities

To create inclusive environments, Karnataka introduced the concept of Beacon Libraries, specifically designed to be accessible to persons with disabilities by addressing physical, information and attitudinal barriers. For instance, to address physical barriers, libraries were equipped with wheelchair ramps and disabled-friendly toilets. Similarly, to provide access to educational resources on an equal footing, braille books, audiobooks, and other assistive technologies were made available after multiple rounds of consultations with experts. To give an example, Daisy Forum and BookShare are two organisations that help provide books to children with print disabilities. Optical Character Recognition (OCR) technology was also used through Kibo (a Japanese product) to ensure children can learn. This allowed pictures to be converted to voice, which the reader could understand. Libraries aim to store books digitally with this feature so that children can use them easily. NGOs are also providing braille books. Initiatives were also undertaken to sensitise people implementing the program to ensure an attitudinal shift.

Interviews in March 2024 revealed that additional initiatives under consideration include universally designed chess boards and other board games, audible balls, a variety of puzzles and touch-and-see products tailored for individuals with intellectual barriers.

Across rural Karnataka, 678 GP libraries have been identified for the creation of Beacon libraries (Express News Service, 2024). This is being funded and maintained via FC Grants (5% of GPDP grants given to each level of Panchayat) and GP's own source revenue (Government of Karnataka, n.d.).

Dedicated Time and Space for Women
Recognising the unique needs and challenges faced by women, the libraries reserved specific hours in the afternoon for women-only access. During this time, libraries hosted programs focused on health, education, and skills development tailored to women's needs.

Children's Engagement and Literacy Programs
Programs such as '*Oduva Belaku'* and '*Odina Manege Hogana*' encouraged children to visit libraries outside school hours, read books, and engage in educational activities. Additionally, initiatives like 'A Book for Mother' aimed at involving families in children's reading habits, fostering a culture of reading at home.

Campaigns for Digital and Life Skills
Libraries have also hosted campaigns and workshops aimed at teaching digital literacy and life skills, with a particular focus on including marginalised groups such as rural youth and those from economically disadvantaged backgrounds.

In August 2024, RDPR launched a campaign to play chess titled '*Chess Aadona Abhiyana*' to encourage children to learn to play chess. These initiatives have promoted the use of libraries as dynamic spaces for learning beyond traditional reading.

CHALLENGES AND SOLUTIONS
In the implementation of any large-scale and ambitious government program, challenges are an inherent part of the process. These challenges often emerge as the program progresses, necessitating an iterative approach to refinement and improvement. Through our field visits and on-ground observations, we have identified a few issues that have surfaced during the rollout. The following section outlines these challenges and provides insights into the State's efforts to address them, ensuring the program's objectives are met effectively and sustainably. There are broadly seven key barriers that were found during our study.

Infrastructural Limitations
Many libraries, particularly in more remote areas, lacked basic infrastructure such as dedicated buildings, electricity, and internet connectivity. For instance, libraries from Udupi (L5, L6, L7) reported that they did not have computers for their own use yet. Some libraries were forced to operate from shared spaces within Panchayat offices, limiting their functionality and accessibility.

Digital Access Issues
Despite efforts to digitise libraries, some locations struggled with unreliable internet connectivity and a lack of digital devices. This digital divide hindered the full realisation of the initiative's goals,

particularly in ensuring that rural populations could access the same level of digital resources as their urban counterparts.

Human Resource Constraints
Initially, LSs were undertrained and undervalued, with limited job responsibilities and low compensation. This led to low motivation and, in some cases, a lack of commitment to the role. The lack of promotion opportunities further hindered the motivation of LS to take the initiative.

Centralised Control
Despite the push for decentralisation, the initiative still faced challenges related to top-down control. Many decisions and guidelines were issued at the state level, sometimes leading to a lack of local innovation and adaptation, and feedback loops were unclear.

For instance, reports on camps were prepared by the LS and sent to the state level which is forwarded to the Commissionerate within 15 days. However, it was unclear to all stakeholders interviewed how these reports were used beyond recording progress. In some cases, since the LS received detailed letters on WhatsApp containing instructions and suggestions for campaigns and activities from superiors at the GP and block levels, these 'suggestions' were often viewed as an order, leaving little scope to innovate based on the local context within a particular GP. Moreover, while GP-level committees were meant to be formed, in most cases where we visited, they had not yet been formed.

Financial Sustainability
Some GPs faced challenges in covering Wi-Fi costs, often depending on the LS's mobile hotspot for internet access (CRISP, 2023). One official highlighted that while 6% of the total 24% cess is allocated for the library, this is not considered a reliable source of funding. Questions of financial sustainability arose, especially as some NGOs were phasing out their activities in certain GPs, handing over the responsibility of maintenance of the library entirely to the GPs.

Implementing Convergence
In day-to-day functioning, actors from other departments have been less involved. For instance, apart from the LS and PDO working closely to plan activities and works at the library, other actors were not sufficiently involved in the process even though they had a role in implementation. There were no joint planning, budgeting, or training activities involving all actors at the GP level. In most cases, a GP-level committee responsible for making books, furniture, newspapers and digital infrastructure available in the libraries and conducting activities for the community were also found largely absent.

Penetration of the Program

Despite successes, the initiative faced challenges, particularly in reaching the most remote and underserved communities. While Beacon libraries have been created for people with disabilities, reaching these libraries has been a challenge for those living in GPs which are at a distance from the libraries.

Table 2 below shows the findings on the infrastructure, governance, and day-to-day functioning of the libraries that were visited.

Table 2: Findings from Library Visits

	L1	L2	L3	L4	L5
District	Udupi	Udupi	Udupi	Yadgir	Yadgir
Infrastructure					
Building	No	Yes	Yes	Yes	Yes
Computer	No	No	No	Yes	Yes
Electricity	No	Yes	Yes	Yes	Yes
Books	Yes	Yes	Yes	Yes	Yes
Governance					
Increased honoraria	Yes	Yes	Yes	Yes	Yes
Circular driven implementation	Yes	Yes	Yes	NA	NA
GP level committee	No	No	No	No	Yes
Shortage of funds	NA	No	No	No	Yes
Some training for LS	Yes	Yes	Yes	Yes	Yes
Progress sharing	Yes	Yes	NA	No	No
Adyaksha involved in meetings	Yes	Yes	Yes	No	Yes
Enrolling school children as enrolment target	Yes	Yes	Yes	NA	No
Day-to-day functioning					

System for organising books	Yes	No	Yes	Yes	Yes
Library open on visit	Yes	Yes	Yes	Yes	Yes
NGO support	Yes	No	NA	Yes	Yes

Karnataka is trying to address these challenges through a combination of strategic interventions: First, to address infrastructure gaps, while the government prioritised the **construction of dedicated library buildings and the provision of essential utilities** such as electricity and internet, in cases where full infrastructure development wasn't possible, creative solutions such as using mobile hotspots and sharing GP office resources were employed to maintain library services.

Efforts are also ongoing to expand the inclusive initiatives, such as increasing the number of Beacon Libraries and further integrating digital tools to reach those who cannot physically visit the libraries.
Moreover, through collaborations with NGOs such as Pratham and Azim Premji Foundation and community-driven initiatives like '*Pustaka Jolige*' (Book Bag), over 11.8 lakh books were donated to rural libraries, significantly expanding their collections, including reading material for Karnataka Administrative Service and Indian Administrative Service aspirants.

Second, to overcome digital access issues, the **initiative leveraged NGO partnerships**. Sikshana Foundation, for example, provided digital devices and ensured that they were equipped with parental controls and educational apps. Necessary software, such as the Sikshanapedia app, provides curated academic and digital skills content, including stories for children. In areas without wired internet, infrastructure supports 4G connectivity with routers using SIM cards. Additionally, LSs were trained to use these devices effectively, helping bridge the digital divide.

Third, to **enhance the capacity and motivation of LSs**, Karnataka significantly increased their honorarium from ₹7,000 to ₹15,000 initially and further increased to ₹17,000 per month. They also launched comprehensive training programs. These initiatives aim to equip LSs with the skills necessary for community engagement, event organization, and digital literacy training, positioning them as pivotal to the initiative's success.

Additionally, recognising the lack of formal training and limited career opportunities, the RDPR department, in collaboration with Kalike Tata Trust, introduced a certification program to facilitate LSs' progression to government librarian positions. This program, initially a 12-credit course hosted by Karnataka State Rural Development and Panchayat Raj University, is set to expand into a diploma course through additional certificate offerings.

> *"[Earlier], no one recognised me as a LS. After RDPR took control of the library [scheme], under the GP. [Now], everyone recognizes me and knows about the library's existence. Now, I feel like I have a designation in the Government*." - L1, Udupi

Fourth, to counteract the limitations of centralised control, there have been instances of **local-level innovation**. Examples include the creation of open-air libraries, the development of special sections for different user groups (e.g., children, seniors, job seekers), and the use of local spaces for library activities. These innovations demonstrated the potential for GPs to tailor the initiative to local needs.

Finally, effective coordination between NGOs was promoted to enhance the reach and impact of the program.

> *"We installed digital devices in the libraries, and soon, other NGOs began using our platforms to host their content. In the Odavu Belaku program, Shikshana Foundation served as the technology partner, while Pratham Books provided educational inputs. Donors also contributed by funding book purchases, which further attracted organisations like Adanya Foundation and Room to Read to supply books and other resources*." - Member, Shikshana Foundation

KEY OUTCOMES AND SUCCESSES

The rural library initiative in Karnataka has played an important role in strengthening community spaces and an interest in reading. While this case study did not seek to quantify outcomes and successes, a few points that were noticed from the interviews and visits are worth mentioning. These are described below:

Ease in Coordination at GP level

The organisational shift enabled ease in coordination between the librarian and functionaries working at the GP level.

> "*Although the libraries were often located within GP premises, the GP lacked control over their operations since the libraries were under the jurisdiction of the Department of Public Libraries. Following the shift, librarians began reporting directly to the GP, which streamlined operations. This change transferred accountability to GP officials, thereby enhancing the GPs' ownership and management of library operations*." - Member, Kalike Tata Trust

Increased Library Usage

The initiative led to a significant increase in the use of rural libraries. As of September 2024, according to the RDPR Department over 48 lakh children were enrolled in library programs, and the libraries became vibrant community hubs where people of all ages could access books, digital resources, and participate in events. The '*Oduva Belaku*' (Light of Reading) program, in particular, played a key role in promoting a reading culture among children.

Support During the COVID-19 Pandemic

During the pandemic, when schools were shut, libraries served as critical centres for continuing education. The availability of digital resources in these libraries ensured that students could continue their studies, mitigating the impact of school closures on rural education.

Empowerment through Digital Literacy

The introduction of digital libraries provides access to a wide range of digital resources, including educational materials, government services, and information on job opportunities. This digital literacy is crucial for bridging the gap between rural and urban areas.

Recognition and Community Involvement

The initiative also fostered a strong sense of community ownership and involvement. LSs reported increased recognition and respect from the community, and the libraries became spaces for social interaction and learning. The active participation of NGOs, schools, and community members in organising events and campaigns further strengthened the libraries' role as community centres.

Box 3: Community Engagement in Libraries

During our visits to the rural libraries, we observed a strong sense of positivity surrounding the new opportunities for community engagement. The introduction of a space that offers access to books, toys, audio-visual resources, and the chance for individuals to engage in conversation has been well-received. It's encouraging to see the community embracing this new platform for knowledge and interaction.

Focus on Inclusivity

Karnataka's rural library initiative has placed significant emphasis on ensuring that libraries are inclusive and accessible to all, particularly marginalised groups such as women, children, and persons with disabilities. The state recognised that for libraries to serve as true community hubs, they needed to address barriers that prevent certain groups from fully participating in and benefiting from library services.

REPLICABILITY AND SUSTAINABILITY

For anyone looking to replicate Karnataka's rural library model, several key characteristics stand out. First, gaining state support in the initial stages can provide the necessary backing to NGOs to innovate and adapt the model to local contexts. Decentralised control is also crucial, allowing flexibility and responsiveness to the needs of different communities. The capacity building of LSs, particularly in library science, is vital, enabling them to expand their roles beyond basic registrations to include community engagement and activity organization.

Additionally, focusing on infrastructure with a vibrant and welcoming design coupled with the integration of digital tools and resources, will enhance the library's relevance in the modern age. Finally, promoting inclusivity is paramount—not only by encouraging participation from all citizen groups but also by ensuring accessibility for people with disabilities, so that everyone can benefit from the library's resources.

For states to ensure the long-term success and resilience of the rural library model, several key strategies must be implemented to build sustainability into the program.

First, it is crucial to develop a sustainable **NGO exit strategy** to ensure that the state can independently lead the program once the NGO has exited. This involves a phased transfer of responsibilities from the NGO to state entities, along with sufficient capacity building to enable the state to carry the initiative forward. While NGOs are vital for innovation and support, over-reliance on them can hinder the program's sustainability.

Second, implementing **a clear HR policy**, including transparent hiring and firing procedures, is essential for building trust within the system. This is particularly important for roles like LSs, where clear guidelines and stability contribute to the overall effectiveness and morale of the staff.

Third, fostering **cross-learning opportunities** between different GPs can strengthen the model by allowing the exchange of best practices and solutions to common challenges. This collaborative approach can enhance the effectiveness and adaptability of the program across various contexts. A regular practice among the LS of visiting libraries in neighbouring GPs can encourage a collaborative learning environment which enables them to share challenges with one another and seek inspiration from innovative solutions adopted by other LS.

Fourth, encouraging decentralised functioning within the program allows for greater flexibility and responsiveness to local needs. This empowerment at the local level can lead to more innovative and contextually appropriate solutions, contributing to the overall sustainability of the initiative.

Finally, enhancing community engagement is key to the long-term sustainability of the libraries. By encouraging regular use and fostering a sense of ownership, the community becomes more likely to seek accountability and ensure that the library remains a vibrant and essential public space.

CONCLUSION

In conclusion, the Rural Library and Information Centres in Karnataka are steadily emerging as vital public spaces, offering communities access to information and essential resources.

While there are ongoing areas for improvement, the state is actively working to enhance these libraries, positioning them as a valuable model for other regions. They provide a significant opportunity for states across the country to learn from Karnataka's experience and explore innovative approaches to further strengthen the role of rural libraries in fostering knowledge and development within local communities.

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Case Study 2: Koosina Mane

INTRODUCTION

The Koosina Mane scheme, announced in Karnataka's Budget for the Financial Year (FY) 2023-24, is an important initiative aimed at improving women's employment opportunities and young children's nutritional and health needs. The scheme was launched by the Rural Development and Panchayati Raj (RDPR) Department, Government of Karnataka (GoK), with dual objectives: to alleviate the childcare burden that often restricts women's full participation in the workforce and to address the nutritional needs of children under three years of age. By targeting 4,000 Grama Panchayats (GPs) across Karnataka, the scheme seeks to establish childcare centres or creches in each of these GPs, thereby creating a supportive infrastructure for working women and contributing to the state's broader goals of economic empowerment and child welfare.

The initiative aligns with a growing body of work on India's low Female Labour Force Participation Rate (FLFPR). The rise in FLFPR[2] from 23.3% to 37% between 2017-18 and 2022-23 was driven by self-employment categories like unpaid work, which do not reflect significant improvements in women's working conditions (Deshpande, 2023; Press Information Bureau, 2023). Further, as per the Time Use Survey (TUS) 2019, women spend a disproportionate amount of work on unpaid domestic work and care responsibilities. Women and girls (above 6 years of age) spent 532 minutes, on average, on such work, compared to only 275 minutes by men and boys in the same age group (Ministry of Statistics and Program Implementation, 2019).

Moreover, demand-side issues, such as the nature of work available, often limit sustainable employment for women, and unpaid domestic labour exacerbates the situation. Education has also not effectively translated into higher FLFPR, as women's disproportionate unpaid

[2] Usual status, 15 years and above.

responsibilities hinder their ability to participate in the workforce despite improving educational levels (Deshpande and Singh, 2021; Afridi et. al., 2016).

Current national attempts at addressing these issues, such as the Mahatma Gandhi National Employment Guarantee Act[3] (MGNREGA) and the National Creche Scheme offer some relief by acknowledging women's caregiving roles, but their implementation has been riddled with financial and logistical issues (Lok Sabha, 2024).

In this context, Koosina Mane's emphasis on addressing women's care burdens through child support services has the potential to enhance women's workforce participation. The scheme aims to go beyond the current childcare infrastructure established by the Women and Child Development (WCD) Department, which primarily focuses on maternal and child health. Instead, it plans to utilize existing resources through MGNREGS to provide a sustainable solution to the childcare burden while also enhancing children's early development outcomes (Chowdhury and Ravindranath, 2023). This convergence is not just a novel approach but also particularly relevant in the context of Karnataka which has seen high demand for work and participation by women under MGNREGS[4].

1.1 Objectives

Following a case study approach, this analysis aimed to examine the process of institutionalising the Koosina Mane scheme, identify the emerging barriers and opportunities during its implementation, and derive key learnings from the initial stages of its rollout. **Given the early stage of the scheme's implementation, this study focuses on understanding the foundational processes that will shape its future success.**

Specifically, the study sought to understand the following aspects:

1. To examine how the Koosina Mane scheme has been institutionalised at various levels of governance, from the State to Grama Panchayat, and to understand the roles and responsibilities of different stakeholders.
2. To identify the challenges faced during the early stages of implementation and opportunities for overcoming these challenges through innovative solutions.
3. To document the key lessons learned from the initial phase of the scheme's implementation, which can inform future scaling and replication efforts.

[3] MGNREGA also enshrined the right to facilities such as shade, clean drinking water, among others, for children at worksites (Government of India, 2005). Section 1 (28) of the Act particularly states the provision of creche facilities for children less than six years of age. Further, (Chakraborty and Singh, 2018) found that the workforce participation rate was 10 times higher for women who held MGNREGS job-cards, compared to women who did not. This gender sensitive approach has also improved women's intra-household bargaining power.

[4] In 2022-23, rural FLFPR for Karnataka stook at 49%, compared to 44% India average.

1.2 Methods

This case study employs a qualitative research approach, combining document review with primary data collection through Key Person Interviews (KPIs) at the State and GP levels between February 2024 and April 2024 and external interviews. The study involved three steps:

1. **Document Review**: The first step involved collating government documents, including orders, circulars, and information available on official websites, to synthesise existing knowledge about childcare initiatives and barriers to FLFPR. This review provided a foundational understanding of the policy context and the design of the Koosina Mane scheme.
2. **KPIs:** The second step involved conducting KPIs between February and March 2024 at the State and GP levels. Interviews were conducted with key stakeholders involved in the scheme's implementation, including state-level officials, Panchayat Development Officers (PDOs), and Caretakers at Koosina Mane centres. The sample included three districts across Karnataka which were selected based on a mix of Human Development Indicator (HDI) scores and their proximity to urban centres. Out of 18 GPs, we conducted KPIs in seven Koosina Manes across seven GPs in Vijayapura, Udupi, and Yadgir. We visited four creches in Vijayapura (KM 1, KM 2, KM 3, and KM 4), two in Udupi (KM 5 and KM 6), and one in Yadgir (KM 7). interviews were conducted in seven GPs across Vijayapura, Udupi, and Yadgir, where the Koosina Mane centres were already operational.
3. **External Interview**: To understand the important role played by external partners as well as corroborate our field insights, we spoke to Mobile Crechess which has been involved in providing technical and training support for Koosina Mane implementation in August-September 2024.

Table 3: Sample Profile for Koosina Mane

Respondent Position	Level	District	Number of Interviews
Program Consultant	State	-	1
Case Worker	State	-	1
State Institute for Rural Development (ANSSIRD) Officer	State	-	1
Panchayat Development Officer (PDO)	GP	Vijayapura (KM 1, KM 2, KM 3, KM 4), Udupi (KM 5, KM 6), Yadgir (KM 7)	7

Caretaker	GP	Vijayapura, Udupi, Yadgir	7

The data collected through these interviews were analysed to identify the processes, challenges, and innovations involved in the scheme's implementation (refer to Annexure 1 for more details). The findings from this analysis form the basis for the subsequent sections of this case study.

1.3 Limitations

We have covered seven Koosina Mane centres in three districts of Karnataka. This brief does not evaluate the performance of the scheme or assess whether the implementation of the scheme has increased the uptake of women's MGNREGS works in these districts. Moreover, while the initial scope of the study sought to understand inter-departmental convergence for Koosina Mane activities, over the course of the study, we realised that the Koosina Mane is in its early stages of implementation. The KPIs were conducted as the creches were being set-up. **We, thus, changed the scope to focus on the initial stage implementation challenges and learnings for furthering the scheme's vision of women's empowerment under MGNREGS.**

The rest of the report is structured as follows: Section 2 looks at the policy cycle of the program and the key actors involved. Section 3 consolidates our field insights. Section 4 and 5 dive into key successes and proposes some solutions, respectively, to sustain the scheme's vision. Section 6 concludes the case study.

UNPACKING THE INITIATIVE

2.1 Implementation Processes

Koosina Mane was designed to be implemented in close coordination with the MGNREGS and the WCD Department. The implementation process involves multiple stages:

1. **Planning and Coordination**:
   At the planning stage, the scheme is coordinated by the RDPR Department in collaboration with the WCD Department. There are committees across different levels of governance (more detailed in sub-section 2.2) with responsibilities ranging from planning, coordination at the State level to implementation at the GP level.

2. **Funding Mechanism**:
   The funding for Koosina Mane is drawn from a combination of sources, including RDPR via the MGNREGS, Zila Panchayat (ZP) and GP funds. The total allocation is expected to be ₹4 lakh per creche annually[5]. The overall allocation for the scheme, thus, was ₹160 crore for 4,000 creches. This included a fresh allocation of ₹65.73 crore from RDPR, ₹40 crore from RDPR's previous FYs unspent balance, ₹3.20 crore from Taluk Panchayat (TP) Fund, and

[5] As per order GO dated 30 March 2023.

₹51.07 crore from GP Fund (Own Resources). Out of the total budget of ₹4 lakh per creche, the GP's and Taluk's share of contribution is expected to be over ₹3 lakh.

The funding covers initial setup costs, including infrastructure development, purchase of toys and learning materials, and provision of nutritious food and other amenities. Each GP received an initial grant of ₹1 lakh from the RDPR Department to kickstart the setup of the creches, totally ₹40 crore. A majority share of this money is meant for providing nutritious food and other everyday amenities (approximately 57%), followed by set up costs, infrastructure development, and purchase of toys (refer to Table 4 for the component-wise breakup).

Table 4: State-level Component-wise Allocation for Koosina Mane

Component	Allocation (in ₹)
Initial one-time expenditure for setting up the creche	35,000
Infrastructure development	30,000
Purchase of toys (per year)	5,000
Nutritious food, first aid, cleaning materials, learning materials, community participation, parent meeting, stewardship and supervision (per year)	57,680
Total	**1,00,680**

Source: Scheme guidelines

3. **Convergence with Existing Programs**:
   The scheme has been designed to align with existing government programs to maximise resource utilisation and avoid duplication of efforts. For instance, the WCD Department, with its experience in running AWCs, is meant to play an integral role in providing technical support and training for the creche's Caretakers. MGNREGS, on the other hand, is providing the operational framework, leveraging its established presence in rural areas to ensure the smooth rollout of the creches.

4. **Training and Capacity Building**:
   A critical component of the scheme is the training of Caretakers, also known as *Kayaka Mitra* or *Kayaka Bandhu*, who are being selected locally. They are meant to be between the ages of 25 to 45 years, holding MGNREGS job cards and passed matriculation. Identified women are sent for a 7-day training at the Taluk headquarters. The training enables them to take up the job as Caretakers of Koosina Mane under MGNREGS for 100 days. The position is rotational.

In July 2023, 67 Information, Education, and Communication (IEC) Coordinators (RDPR staff at the Taluk and Zila levels) and Child Development Project Officers (WCD Department) were trained by Mobile Creches, according to ANSSIRD. After this initial training, ANSSIRD was involved, and 267 Resource Persons were trained by Mobile Creches. These Response Persons are responsible for training the Caretakers at the Taluk level. Resource Persons were selected based on their educational qualifications in home science or social work.

Box 4: External Interview with Mobile Creches

We spoke to Mobile Creches, an external partner supporting Koosina Mane's implementation. Mobile Creches has been providing technical and training support at different levels since the beginning of the initiative. Apart from training the Resource Persons, they have also been involved in training Caretakers in seven districts. The spokesperson emphasised the "cascading model" of training where Resource Persons train Caretakers at the Taluk level. He said,

> *"We cannot train 32,000 Caretakers. Cascading model is important. In Tumkur, for example, we trained 8 master trainers [or resource persons]. Those people should do training as per module. In Most cases, they are training for only 2-3 days. We have provided a detailed, structured training module. Master trainers say that the Taluk does not provide them with training materials."*

The training program for Caretakers, who are at the helm of service delivery and implementation, covers various aspects of childcare, including nutrition, hygiene, and early childhood education. However, the duration and content of the training varied across GPs. Some Caretakers received only partial training due to time constraints, as further illustrated in the next section.

Figure 3 consolidates the different topics – food, safety, cleanliness, and other activities – in Caretaker training.

Figure 3: Caretaker Training Components

Source: (1) Scheme guidelines and (2) Own interviews

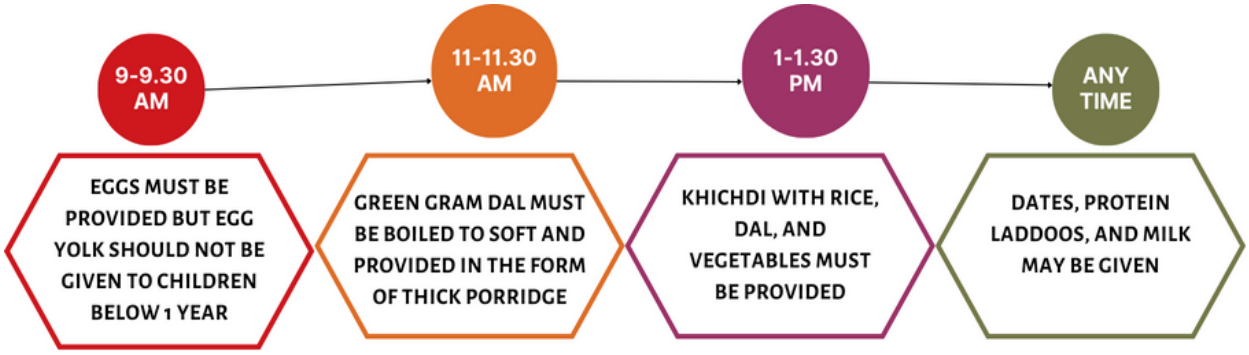
5. **Other Day-to-Day Implementation:**

   Based on scheme guidelines, the day-to-day implementation of Koosina Mane includes the following:

   - **Opening Hours and Capacity:** Koosina Mane are meant to be open for at least 6.5 hours and must be able to accommodate a maximum of 25 children.
   - **Infrastructure:** Creches should be spacious enough to facilitate children's play, learning, and relaxation. Most old, existing government buildings are meant to be repurposed to run as creches if a separate building is not feasible. GPs are tasked with the identification of a suitable location for the creche. At the same time, it is ideal for these facilities to exist near an AWC or school.
   - **Creche Amenities:** Apart from food and cooking provisions, creches are also meant to have functional toilets, feeding cubicles, water connections, etc. Creches must also have designated play areas with toys for children. Guidelines also encourage the provision of locally made *Channapatna* and *Kinnala* dolls. Scheme guidelines have detailed instructions on the amenities and tools that should be provided at the creches.

- **Food Provision:** Food is meant to be provided at different intervals during the day. The food is also expected to be prepared within the creche premises. Figure 4 highlights the schedule.

Figure 4: Food Timetable for Koosina Mane



Source: (1) Scheme guidelines and (2) Own interviews

6. Feedback through Review Meetings

Monthly review meetings are meant to be conducted across the different levels. The GP informs the Taluk about the actions undertaken which further communicates this information to the Zila. Thus, the higher levels are tasked with the responsibility of providing recommendations on challenges arising in implementation, while the lower levels overlook the day-to-day implementation of the scheme.

Box 5: Observations from a State level Review Meeting for Koosina Mane

Committees at different levels organise regular, monthly meetings to take stock of scheme implementation. Chaired by the Commissioner, we had the opportunity to observe a State level meeting held on 12 February 2024. The meeting consisted of the Deputy Director, Senior Consultant managing the program, a member from Mobile Creches, and two other Zila Panchayat officers. The Deputy Director sought to understand the status of scheme implementation from ZP officers while noting the observations made by the Senior Consultant and Case Workers. He raised questions on the status of food served at the creches, mentioning that he received complaints from an NGO that visited the ZP even though the ZP had reported that food was being served. He further asked the ZP officers if they had visited the creches in their Taluks. The Director flagged the reporting of incorrect information and feedback, which can hinder the effective uptake of the scheme. Lastly, he also enquired about the training of Caretakers.

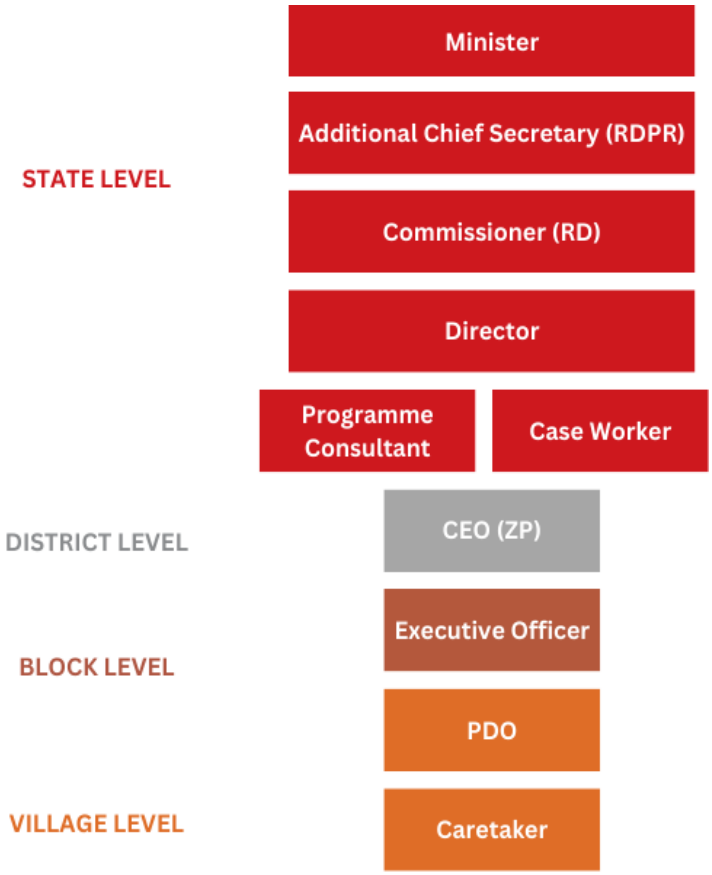
2.2 Roles of Different Stakeholders

The successful implementation of Koosina Mane hinges on the coordinated efforts of multiple stakeholders across different levels of governance through the formation of Committees (refer to Table 2, Anneure 1 for a detailed list of actors in Committees across levels):

1. **State Level**:
    - The RDPR and WCD Departments are the principal agencies responsible for the scheme's overall planning and monitoring. They ensure the scheme aligns with state policies on women's empowerment and child welfare.
    - There are two Committees at the State level: the Steering Committee and Executive Committee. The former is meant to provide strategic support for operations and data monitoring, issue guidelines, and facilitate inter-departmental coordination, while the latter supports implementation strategy, ensures human and financial resources at the State level, and holds progress review meetings with ZPs' CEOs.
2. **District and Taluk Levels**:
    - At the district level, ZP CEOs and District Reproductive and Child Health Officers play key roles in monitoring the scheme's implementation, identifying challenges, and providing feedback at the state level.
    - Taluk-level officers, including Executive Officers and Child Development Project Officers, are responsible for operationalising the scheme at the GP level. They ensure that funds are distributed appropriately and that creches are equipped with the necessary resources.
3. **Grama Panchayat Level**:
    - GPs are responsible for scheme implementation. The Panchayat Development Officers (PDOs) are responsible for day-to-day management, including overseeing the construction or renovation of creche buildings, selecting and supervising Caretakers, and ensuring that the centres operate smoothly.
    - GP-level committees, including Caretakers, ICDS Supervisors, and community members, are involved in planning and decision-making processes. These committees play a crucial role in fostering community ownership of the scheme.
4. **External Organizations**:
    - NGOs like Mobile Creches and CRISP are involved in providing training and assessing the scheme's implementation. These organisations bring expertise in early childhood care and education, helping to enhance the quality of services provided at the creches.

The key actors in the planning, coordination, and implementation of Koosina Mane are listed in Figure 5. This list indicates the main actors involved at different levels of governance of this scheme. Across levels, actors form a feedback loop for ensuring implementation and monitoring.

Figure 5: Organisational Chart of Key Actors across Levels for Koosina Mane



Source: (1) Organisation Structure, RDPR and (2) Own interviews.
Note: These are only the key actors involved in planning and coordination of the scheme. The other actors have been mentioned in Table 2, Annexure.

OBSERVATIONS FROM FIELD VISITS

During the site visits to seven Koosina Mane centres across three districts—Vijayapura, Udupi, and Yadgir—several observations were made regarding the operational realities and conditions of the childcare centres. **It is important, however, to remember that during our study period, the scheme was in its initial stages of feedback and revisions from higher levels**.

The State level Program Consultant for Koosina Mane informed us,

> *"I would say the scheme is still in an infant stage. We just started working on this fully three months ago. Out of the 4,000 GPs, we are doing this [planning and coordination] well in only 60% GPs so far. Challenges we are facing include identifying the buildings, constructing, ensuring safety, and making sure the Caretakers are selected and trained well."*

These observations, thus, should be taken in that spirit. However, they do provide insights into the early-stage implementation of the scheme and highlight the on-the-ground challenges faced by both the centres and the communities they serve. These are described below:

1. **Infrastructure and Setup:**
    - **Varying Conditions of Creche Buildings**: During the time of our visit, rooms in most creches were still undergoing development to make it child friendly. For instance, we witnessed that in some creches walls were repainted with learning materials stuck to the walls. The condition of the buildings housing the Koosina Mane centres also varied significantly. In some cases, like in KM 1 in Vijayapura, the creche was being operated in a repurposed godown, while KM 2 was housed in a building constructed in 1937. KM 3 utilised a spare room in a school, and KM 4 used a room in the GP office. These older structures often lacked basic child-friendly amenities.
    - **Proximity to Other Facilities**: There was some disparity in site selections across visited GPs. For instance, while KM 6 is located within the premises of an AWC, it benefitted from existing infrastructure such as access to water and toilets. However, KM 5 was located near a Solid Waste Management shed, posing a health hazard for children.

Figure 6: Repurposed Creche in Vijayapura District with Learning Materials and Arts on the Wall

Source: CPR Team

- **Lack of Amenities**: During our visit, some centres reported the absence of these basic amenities. For example, KM 7 in Yadgir lacked functional toilets and safe cooking areas, forcing Caretakers to take children outside for restroom needs. In KM 3 and KM 4, the absence of gas cylinders and other cooking equipment meant that food was not being prepared on-site, limiting the centre's ability to provide meals to children.

Figure 7: Creche in Yadgir District Lacked Most Amenities

Source: CPR Team

2. **Operations:**
   - **Longer Hours for Creches:** Most creches we visited began operations between January and February 2024. In most cases, creches open between 9 AM and 10 AM for over eight hours on all days except Sundays. In KM 7, however, the creche opens at 6 AM and closes at 11 AM because of hot weather.

Box 6: Caretaker in KM 7 Goes Door-to-Door to Drop Off Children

Priya (name changed) is one of the two Caretakers in KM 7. A mother of one child and pregnant with another, she has been working at the facility since its inception in January 2024. Priya has a BA degree and possesses a job-card. Since she could not avail of regular work under MGNREGS, she decided to take up this opportunity. She was told about the training and enrolled to participate. Compared to the other GPs in this report, her GP's Koosina Mane has

22 children registered, out of which 10-15 visit regularly. She informed us that parents who do not work also sometimes drop their children off at the creche. Because of the heat, however, she does not keep the creche open after 11 AM. She informed us that it is challenging for her to keep the place clean. On most days, she also has to drop the children back home which is a difficulty for her.

- **Inconsistent Attendance**: As previously mentioned, 25 children can be accommodated in a creche. Children's attendance, however, was inconsistent across the GPs. For instance, while KM 3 had 30 children registered, only 10 attended regularly. This inconsistency was often linked to the availability of MGNREGS work in the GP—if there were no active works, parents were less likely to send their children to the creche.

The PDO in KM 5, for instance, highlighted,

"Though the Koosina Mane is well-maintained, children are not being sent. This is because there are no MGNREGA works happening in the Panchayat."

In KM 5, the PDO said,

"The Anganwadi are admitting children from the age of 2 ½ years and people are not willing to send the children because even to the Anganwadi. Once the child is attained the age of 3 ½ or 4 years, they are sent to the private kindergarten. It is a new set-up. There is anxiety in the community about how it will work. They don't have confidence in Koosina Mane like the Anganwadi."

- **Committees at Taluk and GP Levels Have Not Been Formed:** As highlighted in Section 2, Committees at the lower levels play an important role in scheme implementation and monitoring. These cross-sectoral committees, however, had not been formed at the GP level across the KMs visited. PDOs in KM 5 and KM 6 informed us that no Committees were formed at their level. In KM 7, the PDO has a weekly meeting with the Project Director at the District level but did not suggest the existence of any GP level Committee either. Even though the WCD members are included in the GP level Committee, the PDO in another GP mentioned that he had met these members only once at the Taluk level but must report to a District level officer every week. Thus, it currently seems that perhaps the scheme is not fully working in convergence with the WCD Department at the GP level.
- **GP Revenue Mobilisation is in Initial Stages:** Of the seven Koosina Mane centres we visited, four provided information on fund utilisation. Our interviews with the

PDOs indicate that money had been spent on toys, gas, cooking equipment, plates, and spoons but they were still unaware of the total funds utilised. The PDO in KM 7, for instance, informed us that he was not aware of how much money was spent but that they had been asked to set budgets for one year. He said that the budget was yet to be planned as it depends on the tax collected in the GP. In KM 4, on the other hand, the Data Entry Operator (DEO) informed us that the GP has not set aside any money for the functioning of the creche this year. For the upcoming FY, however, they have made an action plan of ₹3 lakh.

- **Limited Awareness**: Awareness about the scheme was limited in some communities and also among some frontline workers. For example, the Caretaker at KM 2 mentioned that the Anganwadi Worker in the area was unaware of the existence of the Koosina Mane centre. Similarly, post-training, in KM 5, the Caretakers identified as many as 130 children in the GP under 3 years who can be registered, of which only 11 finally registered. This lack of awareness within the community, Caretakers acknowledged, contributes to low enrolment and attendance rates.

3. **Food Provision**:
    - **Varied Food Availability**: As previously mentioned, most of these creches had just begun operations during our study period. As a result, the provision of food at the creches varied greatly during our visit. For instance, KM 7 had a well-functioning meal program, with food being provided as per the schedule. In fact, the PDO mentioned that the Anganwadi Workers often visit the creche with their children because it has better food. The Caretaker also noted that all food-related demands were met at the creche from its establishment. However, KM 3 and KM 4 faced significant challenges, with no food being prepared due to the lack of necessary equipment. In KM 6, food was provided from the nearby AWC, but this arrangement was not ideal as it relied on the resources of the AWC rather than the creche itself. The Caretakers had requested for the provision of biscuits and *chikki* in situations where children are crying, but this is yet to be provisioned.

4. **Training and Capacity Building**:
    - **Inadequate Training**: As indicated before, Caretaker training is designed to be for seven days. The duration and quality of training provided to Caretakers, however, varied across the GPs. While KM 6's Caretakers received a full seven days of training, others, like those in KM 2, received only two days. This inconsistency affected the Caretakers' abilities to perform their duties effectively, particularly in managing the children and maintaining the creche. Training for Caretakers also does not happen on a continuous basis.

The Caretaker in KM 6 described how she was enrolled to take training under the scheme,

> *"He [PDO] is the one who asked us to take the training, while we were doing MGNREGS work. We did not know anything about this, Kayaka Bandhu and the Secretary asked us to take the training for the time being, saying the work would be there for 100 days and may continue in the future. That is the reason we took the training."*

Further, the ANSSIRD official pointed out that GPs have been struggling with identifying Caretakers given the stringent requirements apart from women being MGNREGS job-card holders. In some cases, therefore, it has led to selecting family members of Elected Representatives or GP staff for the Caretaker position.

Our findings are broadly consistent with those of other organisations. For instance, in 2023, CRISP conducted a study on the pilot phase of creches which were then referred to as *Shishupalana* creches. The objective was to understand the "features and processes" of setting up these creches in Karnataka's 4,000 GPs. The pilot's recommendations are consistent with prioritising children's safety, hygiene, Caretaker's training, convergence with other departments, etc., through Government Orders and Circulars. Operational challenges, however, remain. (Centre for Research in Schemes and Policies, 2023).

INITIAL SUCCESSES AND OUTCOMES

The early stages of the Koosina Mane scheme's implementation have yielded several promising outcomes, despite the challenges. They highlight the potential of the scheme to significantly impact both women's economic participation and child welfare in rural Karnataka.

Increased Awareness and Community Participation

In the districts where the scheme was better publicised and supported, there was a noticeable increase in community engagement. In particular, GPs that conducted effective outreach through door-to-door visits and local meetings saw higher registration and attendance rates at the creches. Increased community participation is a positive indicator of the scheme's success.

Empowerment of Local Women

The scheme has allowed women to explore a new form of work as Caretakers under MGNREGS. Not only does this enhance women's standing it also facilitates economic empowerment. Thus, by creating jobs specifically for women, the Koosina Mane scheme is helping to elevate the economic status of women in rural areas and contributing to the broader goals of gender equality and inclusive economic development.

Convergence of Services for Holistic Development

The convergence of the Koosina Mane scheme with existing government programs, such as MGNREGS and the services provided by Anganwadi Centres, has facilitated a more holistic approach to child welfare. This convergence ensures that children receive not only care but also nutrition and early childhood education. The integration of services across different programs

enhances the program's effectiveness and provides a comprehensive support system for both children and working mothers.

This has further allowed fund releases of at least ₹1 lakh across 4,000 creches. All Koosina Manes in our study received funding from RDPR for opening the creches and installing basic amenities like gas, cooking utensils, toys, etc. While there are challenges in mobilising funds at the GP level, the scheme has set benchmarks for allocations through its guidelines.

Positive Feedback Loops in Implementation

The establishment of feedback mechanisms, where local committees report to higher levels of governance, has led to iterative improvements in the scheme's implementation. For instance, some GPs have already begun addressing infrastructure issues based on feedback from the community and Caretakers. This feedback-driven approach allows for real-time adjustments and improvements, making the implementation process more dynamic and responsive to on-the-ground realities.

The spokesperson from Mobile Creches further emphasised the role of Nodal Officers at the District level and recognised existing success stories. He said,

> *"[To improve implementation feedback and monitoring] First, Nodal Officers should conduct proper quality visits every 2-3 months and come up with reports on on-ground implementation. Second, successful stories need to be captured for motivating others"*

Further, the state is also looking to integrate Koosina Mane data with Panchatantra 2.0 MIS which will strengthen data monitoring and feedback.

Bottom-up, Responsive Approach is Central to Scheme Guidelines

Finally, the scheme guidelines are detailed and provide clarity on the supervisory, strategic, monitoring and implementation roles of different Committees formed across levels. With day-to-day implementation rested with GPs, the GP-level Committees, including parents, Caretakers, and other departments are crucial in facilitating a bottom-up feedback loop for effective scheme implementation. There is also clarity on the role of external actors to monitor progress and perform certain tasks, such as training, to decrease the burden of implementation on GoK.

REPLICABILITY AND SUSTAINABILITY

Given the initial stages of scheme implementation, we propose a few ways for RDPR to sustain the scheme's vision:

Expanding Eligibility Beyond MGNREGS

The state is already in the process of allowing all working mothers in the GP to utilise benefits under Koosina Mane. This has the potential to broaden the scheme's reach and ensure that the facilities are utilized more consistently. Expanding eligibility would help stabilise attendance at

the creches, making the scheme more effective in supporting women's participation in the workforce.

Improving Infrastructure

The state could prioritise the allocation of additional funds for infrastructure improvements, focusing on creating child-friendly environments in all creches. This could include renovating existing buildings, ensuring the availability of basic amenities, and providing safe and engaging spaces for children, some of which have been already suggested in the guidelines. Improved infrastructure would enhance the appeal of the creches, encouraging higher attendance and making them more effective in achieving their dual goals of childcare and early childhood development.

Standardising Training Programs

The training programs for Caretakers should be standardised across all GPs, ensuring that each Caretaker receives the same comprehensive training, regardless of their location. To begin with, the existing support materials provided by Mobile Creches should be properly disseminated to the Resource Persons at the district level. Regular refresher courses should also be introduced to keep Caretakers updated on best practices.

This is already being explored. An ANSSIRD official described their plans to undertake a refresher course for the Caretakers trained. He said,

> *"We will have to do a refresher course. We have not yet completed the first round entirely. Out of eight Caretakers in each GP, we had targeted four. So, the remaining four still have to be trained. Till June 2024, we have to train the remaining Caretakers. But, for the rotation of the remaining four caretakers, we will conduct their training after June."*

Standardised training would improve the quality of care provided at the creches, ensuring that all children receive the same level of attention and support, regardless of which GP they are in.

Community Engagement and Awareness Campaign

Dedicated funds could be allocated for IEC campaigns to raise awareness about the Koosina Mane scheme. These campaigns could involve door-to-door visits, community meetings, and collaboration with local influencers to build trust and encourage participation. Increased awareness and community engagement would lead to higher registration and attendance rates, ensuring that more families benefit from the scheme.

At the same time, the formation of GP level Committees is a priority which the state recognises. It allows for several important members, such as those with the existing technical capacity (WCD Department) as well as the primary eligible citizens (parents and children), to review the scheme's progress and determine a bottom-up feedback and planning paradigm, as envisaged under the scheme. Committee meetings can be planned monthly, as per guidelines, inside the creche itself.

CONCLUSION

The Koosina Mane scheme represents a significant step forward in addressing the dual challenges of low FLFPR and inadequate childcare services in rural Karnataka. While the scheme is still in its early stages, the initial outcomes suggest that it has the potential to make a substantial impact. The convergence of services, the empowerment of local women, and the creation of positive feedback loops are all indicators of the scheme's potential success.

Conclusively, the scheme presents an opportunity for other states to learn and find innovative ways to strengthen India's FLFPR and improve children's nutrition.

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Case Study 3: Solid Waste Management

INTRODUCTION

This case study examines Karnataka's innovative approach to Solid Waste Management (SWM) by leveraging Self-Help Groups (SHGs) for operational and maintenance activities across Grama Panchayats (GPs). Since 2021, as a part of a broader initiative led by the Rural Development and Panchayati Raj Department (RDPR) under the Swachh Bharat Mission (Grameen) (SBM-G)[6], SHGs are playing a crucial role in managing local waste collection, segregation, and composting facilities. This intervention not only addresses the logistical challenges of SWM but also empowers rural women by providing them with alternative livelihoods, improving their financial independence, and enhancing their skills.

Through contracts with Grama Panchayat Level Federations (GPLFs), SHGs are engaged in the day-to-day management of '*Swachcha Sankeerna*' units—facilities constructed to support waste management infrastructure in rural areas. These SHGs are supported by the Sanjeevini-Karnataka State Rural Livelihoods Promotion Society (KSRLPS), which facilitates skills training and helps ensure the sustainability of this decentralised waste management model.

The importance of this intervention is underscored by the growing urgency to improve SWM in India. Karnataka generates over 11,000 tonnes of Municipal Solid Waste (MSW) daily, with Bengaluru alone projected to exceed 13,000 tonnes per day by 2031 (Government of Karnataka, 2020). Improper waste management practices can lead to severe public health and environmental consequences, including contamination of water sources, the spread of diseases, and greenhouse gas emissions (Ministry of Urban Development, 2016).

However, Karnataka's story extends beyond the sheer volume of waste. The state boasts a long-standing tradition of decentralisation through the strengthening of Panchayati Raj Institutions and GPs are empowered to have a say in development activities, including SWM strategies.

[6] SBM-G is a Centrally Sponsored Scheme designed by the Government of India (GoI) scheme but implemented by States. It has a 60:40 fund sharing ratio, where GoI provides 60 per cent of funds.

Further, the development of five-year perspective plans enables GPs to break down long-term goals into achievable annual targets, encouraging a more strategic approach to issues like SWM.

In this context, the involvement of SHGs presents a unique opportunity to decentralise waste management, promote community ownership, and address rural unemployment by creating meaningful work for women.

1.1 Objectives and Methods

Following a case study approach, we sought to understand Karnataka's innovative approach to SWM through SHGs. Specifically, the study has:

- Explored the gaps and opportunities in the implementation of this model;
- Examined the key outcomes, strategies; and
- Identified recommendations and learnings for replicability and sustainability.

The case study was developed in three steps. First, information available on the scheme was analysed from government documents, orders, websites, and academic literature. Through this, we have identified key strengths and opportunities for identifying improvements which can contribute to the development of a replicable model for sustainable SWM across other states in India. Second, structured Key Person Interviews (KPIs) were conducted across four districts at two levels between February 2024 to June 2024. Third, we reached out to external stakeholders who have been deploying similar initiatives in Karnataka.

1. **State Level**: This entailed conversations with various officials in-charge of the scheme who have supported the program with a view to understand the broader vision of the integration and convergence of finances.
2. **GP Level**: Interviews were conducted with Panchayat Development Officers (PDOs), Grama Panchayat Secretaries, Clerks, Date Entry Operators (DEOs), etc., to understand implementation process, and the roles of GPs and SHGs.
3. **External Interview**: We spoke to a representative from Hasiru Dala which is a social impact organisation working on waste management since 2010.

See Table 5 for more details on KPIs at the State and GP levels.

Table 5: Sample Profile for SHG-SWM

Respondent Position	Level	District	Number of Interviews
Case Assistant	State	-	1
PDO	GP	Udupi (GP 1)	1
President, Supervisor	GP	Udupi (GP 2)	1

Clerk	GP	Udupi (GP 3)	1
DEO	GP	Udupi (GP 4)	1
Helpers	GP	Yadgir (GP 5), Kolar (GP 6)	5
Drivers	GP	Yadgir (GP 5), Kolar (GP 6)	2

The rest of the case study is structured as follows: Section 2 gives an overview of the implementation process and roles of institutional stakeholders. Section 3 dives into our field insights. Section 4 outlines the key outcomes and successes of the program, and Section 5 provides recommendations for strengthening program implementation. Section 6 concludes the case study.

UNPACKING THE INITIATIVE

2.1 Implementation Process

By 24 January 2021, GPLFs/SHGs were meant to operate at least one Solid and Liquid Waste (SLW) unit in each district. Further, by 8 March 2021, it was envisaged that one SLW unit be set-up at the Taluk level, while one SLW management unit was meant to be operational in all Hoblis (or clusters) by 2 October 2021.

The SWM program in Karnataka uses a multi-pronged approach, primarily focusing on building infrastructure, employing SHGs, and empowering women.

1. **Conducting Pilots:** Before the program was implemented across GPs, pilots were conducted in 10-15 GPs of Belgaum district of Karnataka. For this purpose, National Rural Livelihood Mission (NRLM) funds were used.

2. **Signing Memorandum of Understanding (MoU):** SHGs identified under KSRLPS take up the Operation and Maintenance (O&M) of waste through contracts (or MoUs) with GPLFs. According to the RDPR's existing data as on 26 August 2024, only one GPLF out of 5,954 GPs is yet to sign an MoU. During our study period, out of the six GPs we studied, one GP was yet to sign the MoU.

3. **Building Essential Infrastructure for SWM:** The program constructs '*Swachcha Sankeerna*' units (or sheds) across GPs, which are facilities for collecting, storing, segregating, and composting waste.

Figure 8: Dry Waste Segregation Unit in Yadgir GP

Source: Own interview in GP 5

4. **Training for SHG Women:** The first set of trainings is for GPLFs, conducted by the Abdul Nazeer Sab State Institute for Rural Development and Panchayat Raj, Mysore (ANSANSSIRD&PR) and Mahatma Gandhi Institute for Renewable Energy and Rural Development (MGIRERD) at the district level. This was a five-day training which involves understanding the SWM processes such as segregation, management of wet and dry waste, domestic hazardous waste, etc., and includes field visits for experiential learning. ANSSIRD and MGIRERD have also been tasked with identifying NGOs to facilitate trainings for remaining GPLFs.

   One such NGO engaged in training is Hasiru Dala. They informed us of their process of engaging with RDPR for training as well as designing content of these modules,

> *"We have a comprehensive training module. We have empanelled people from SBM-G. We give training on leadership, how to make MoU, using Information Education and Communication (IEC), how to make waste as a resource and business, establishing this as micro-enterprises like making wire bags, making bio-enzymes, Personal Protective Equipment (PPE), health and nutrition, etc. Our training is designed for three days. We have implemented this training in 11 GPs in different villages. We have given training in MGRIED and other organizations working with SHG members too."*

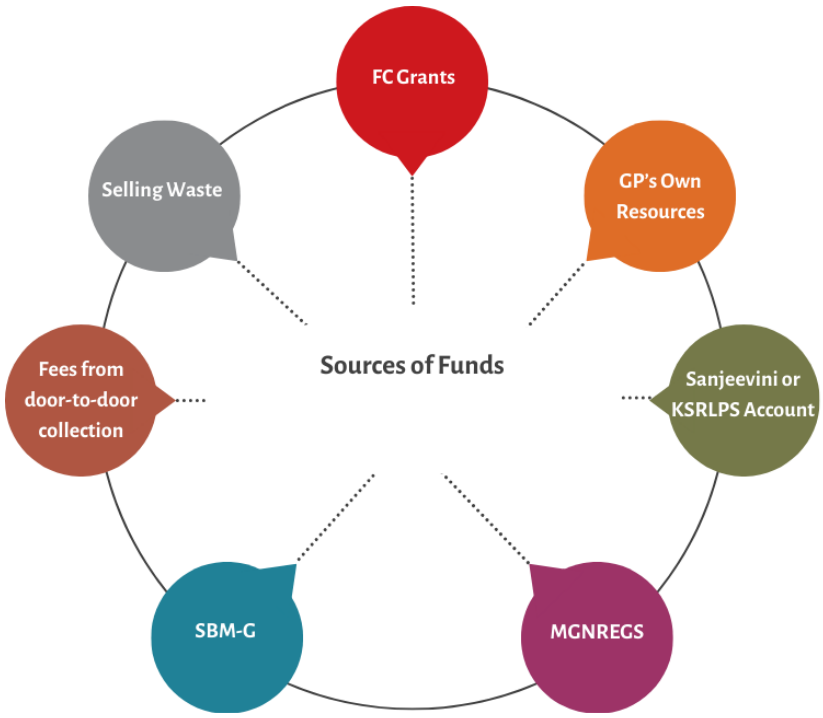
   The second set of trainings are for the SHG women engaged in everyday implementation. Trainings are conducted either at the Zila or Taluk and involves building skills for driving the *Swachchta Vahini's* which are the vehicles used for waste collection. GPs also facilitate the process for obtaining driving license for these women (Government of Karnataka,

2023). The number of training days are different based on the purpose too. Driver training is for one month, while that for learning segregation practices is between five to 15 days. According to RDPR's existing data as on 26 August 2024, trainings have been conducted in over 5,903 GPLFs. Of these GPLFs, 66% of trained GPLF participants are currently working.

5. **Convergence and Funding:** As previously mentioned, the program functions under SBM-G. The program further leverages convergence practices by pooling different sources of funding at the GP and State levels like the 15th Finance Commission (FC)[7], SBM-G, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), etc. Under the 15th FC, ₹1 lakh is allocated for SHG maintenance and salaries, and additional funds from rural water supply are given for infrastructure projects like shed construction. The PDO is expected to monitor these finances at the GP level.

   Figure 9 provides a break-up of different funding sources which GPs are expected to mobilise.

Figure 9: Key Funding Sources for SHG-SWM



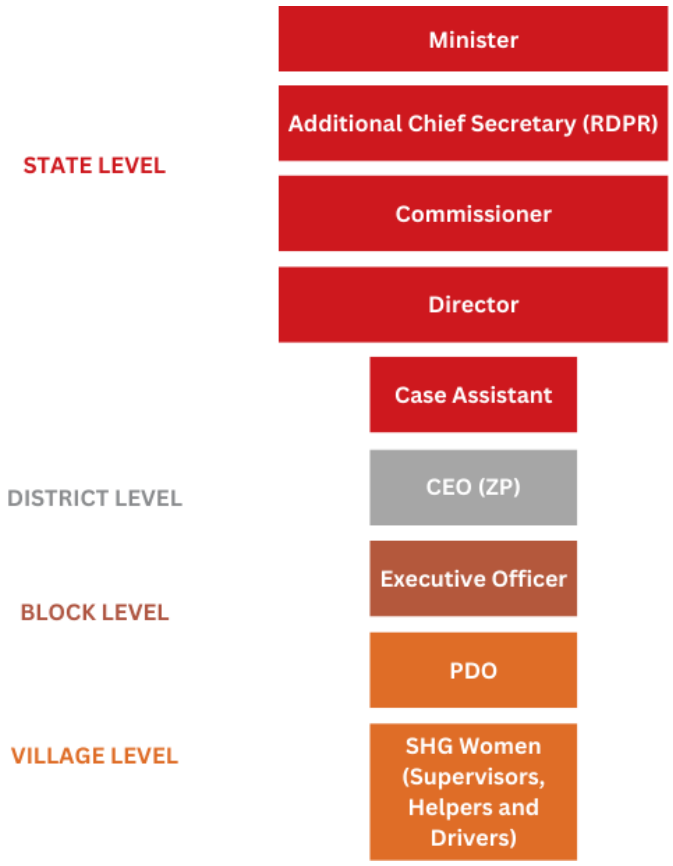
Note: Funding sources differed across GPs we interviewed. Please refer to Table 6.

[7] Out of total FC grants, 50% are tied to priorities such as drinking water supply, rainwater harvesting, and sanitation and the remaining are untied which Panchayati Raj Institutions can use for location-specific needs. Further, out of total 15th FC tied grants, Karnataka is set to receive ₹7,524 crore (5 per cent) of overall 15th FC tied funding (Press Information Bureau, 2022).

2.2 Roles of Different Stakeholders

The implementation for the SWM-SHG program involves a range of key actors across levels responsible for overseeing and implementing initiatives. GPs, along with GPLFs and SHG women, play a pivotal role in implementation, tasked with managing waste collection, segregation, collecting fees from residents, among other activities. Figure 10 provides an indicative list of key stakeholders across levels for this initiative.

Figure 10: Key Stakeholders across Levels for SHG-SWM



Note: This is not an exhaustive list of the institutional stakeholders.

Key actors under SBM-G provide the overarching vision for the program. Implementation and monitoring of progress is in the purview of the district and levels below it, as we further describe.

At the GP level, KSRLPS is entrusted with implementation through its existing community institution. At the first level of these institutions are SHGs, followed by Ward Level Federations (WLFs) and GPLFs. SHG women form the frontline for program implementation and are responsible for source segregation of waste, sorting and selling dry waste, and collecting user fees in villages, among others. SHG women can also realise opportunities for supervisory roles by becoming part of federations such as GPLFs.

Further, the GP is responsible for ensuring worker salaries, providing fuels for vehicles meant for solid waste transportation, managing expenses for vehicle maintenance, and regularly monitoring waste collection through photo documentation and updates from workers.

Monitoring of the initiative is localised, involving GPLFs and PDOs (Government of Karnataka, 2023). PDOs act as the coordinating officers as they manage the GP finances. Data collected at the GP level is also shared for feedback and monitoring to the Zila Panchayat and Taluk Panchayat, who conduct periodic meetings with actors in the GP.

Box 7: Several Other GP Level Actors Provide Support in Day-to-Day Implementation

Apart from PDOs and SHG members, we also saw that several other GP functionaries such as Clerks, Bill Collectors, Water Man, Helpers, etc., support the day-to-day implementation of the scheme.

In GP 5, for instance, the helpers told us,

> *"We reach out to the PDO for everything. We also reach out to the Bill Collector daily as the PDO might not be available for taking calls. There were issues with the vehicle a few days back, so we called the Bill Collector who came to help. He took the vehicle and got it fixed and also dropped us home."*

This suggests that initiatives built with the foundations of convergence can allow pooling existing resources like HR to support day-to-day implementation.

The next section deep-dives into our field observations.

OBSERVATIONS FROM FIELD VISITS

In this section, we focus on key insights from our interviews, which include selection and training and process for SHG members, financial position of GPs, and data management practices. Table 6 consolidates our findings in detail.

3.1 Selection and Training

We observed differences in the selection of women for training purposes across GPs. In GP 1, for instance, a woman was selected for segregation and management at the Material Recovery Facility (MRF) which is set up for waste recycling purposes, but most GPs are struggling to train women as drivers.

GP 2 faced implementation challenges when two trained women failed to execute the program, leading to the outsourcing of waste collection:

"Two women were trained for a month, but they failed in the implementation of the program. Now we have outsourced for collection of the waste. We are not collecting the wet waste [from households] as they [citizens] use it for their gardens."

Difficulties were also present in terms of social stigma and family hesitancy for women to engage as drivers. **In our study, out of the six GPs, only one was sending women for both training as drivers and for learning segregation practices.**

Box 8: Breaking Barriers—SHG Woman Overcoming Fear of Driving

In GP 5, the driver (SHG woman) told us that the training allowed her to shed fear of driving and was happy with its overall outcome. She said,

> *"They asked us to drop all fear of driving before they started training us. We cannot learn well if we are scared so we had to feel comfortable with driving first. I did not know what a steering wheel, clutch or break was before I went there but came back knowing how to drive. It was difficult being away from my children who are my entire universe for a month, but I did it anyway and I'm happy."*

Such examples are relevant to promote and diversify skills training for women's empowerment within the existing program.

These findings are consistent to some degree with official data. According to RDPR's existing data as on 26 August 2024, 5,161 women were trained as drivers but only 66% of them are currently working as drivers.

3.2 Financial Management

Our interviews confirmed that resources are being pooled from SBM-G and MGNREGS. According to the Case Assistant at the State level, every GP is allocated ₹20 lakh for segregating SLW waste. For shed construction, another ₹8 lakh to ₹15 lakh is allocated. They further informed us that 15th FC grants are also meant to be used to providing gloves and PPE for workers. However, none of the six GPs interviewed were utilising FC grants for day-to-day implementation such as provision of gloves and PPE, salaries, etc.

There were also differences in how SHGs received financial support from the GPs too. Only three out of six GPs **received support for paying salaries to the SHG women.** In GP 3, for instance, GP finances were used for construction and provision of sheds. However, even in the case of salaries, delays were found. For instance, in GP 6, the helpers and a driver reported not receiving salaries in the last six months (from the date of interview)[8].

[8] This interview was conducted on 25 June 2024.

Another major challenge was the collection of monthly fees from households for waste collection. Only half of the GPs in our study collected monthly fees for waste collection, and only one was generating some revenue from waste selling. The primary reason for this as per the GPs was the terrain which makes it difficult to collect waste and, thus, fees is not collected from all households. In one of Udupi's GPs, for instance, some houses are scattered, away from the GP, and have own farmlands.

For those that did collect it, in GP 1, ₹80 is collected per month from every household. This GP is currently also not using any other scheme related funds. GP 4 collects ₹30 per household but charges ₹50 for commercial sites. GP 2, on the other hand, relies on funds from the 15th FC. Other GPs did not report tapping into any other sources of funds.

3.3 Data Collection Practices

Across GPs, data on the number of households, quantity of waste collection, income, and expenditure through dry waste collection, are collected to inform the Taluk or Zila. In GP 4, information is also shared with the Chief Planning Officers of SBM-G. Inputted at the GP level, this data is typically collected in spreadsheets, as GP 1 and GP 2 informed our team.

No GP, however, indicated the process of monitoring information, or how data is used to strengthen implementation practices at the GPs. We, however, observed that the vehicle used for waste collection in the Yadgir GP is Global Positioning System (GPS) linked. In all GPs, pictures of waste collection are clicked every day and geo-tagged and shared on a common platform involving GP functionaries.

We further learnt from Hasiru Dala about how the SWM initiative is currently exceeding expectations of data management, given its nascent stages. The representative said,

> *"RDPR doing a wonderful job currently. They already had data related to SWM. But [the program] is still in the nascent stage. It should integrate this data in dashboards like the Bruhat Bengaluru Mahanagara Palike (BBMP) and maintain some kind of transparency. Wherever we [Hasiru Dala] work, we collect end-to-end data starting from waste collection, measuring the quantity of waste, recycling of waste, whether selling to aggregator, collecting user fee, etc. The state has also developed the model similarly. This data even helps the Taluk people with monitoring. Physical monitoring of implementation should also exist in the form of surprise visits in GPs."*

Table 6: Summary of Key Findings for SHG-SWM

GPs	Number of Active SHGs in the GP	MoU Status	Shed Construction Status	MRF Status	Selection and Training of SHG Women		Source of Funds (Sanjeevini/15th FC/Scheme/Waste Collection Fees)
					Selection By (PDO/SHG/Voluntary)	Training Purpose (Supervision/Segregation/Driving)	
GP 1	45	Signed	Constructed 5-6 years ago using MGNREGS funds.	Constructed and managed by ZP. 9 GPs pooled resources for construction.	PDO or SHG	Segregation	Fees
GP 2	54	Signed	Not constructed but resources have been pooled from GPs and the rural drinking water supply and sanitation grants to ZP.	Exists nearby	Voluntary	Supervision and driving (only if women are interested)	15th FC
GP 3	38	Signed	There are two sheds in the village.	Exists nearby	PDO	Supervision and shed management	Fees and GP's own resources
GP 4	80	Signed	Constructed using 14th FC grants.	Not constructed	SHG	Segregation and waste collection	Fees, selling of waste, GP's own resources
GP 5	N/A	Not signed	N/A	N/A	Voluntary	Driving	N/A
GP 6	N/A	Signed	Constructed 2-3 years ago.	N/A	SHG	Segregation and driving	N/A

KEY OUTCOMES AND SUCCESSES

Inherent Convergent Design

RDPR in Karnataka has been able to facilitate SBM-G's existing focus on solid and liquid waste management, and Information, Education, and Communication (IEC) and Capacity Building by tapping into the existing SHG network in GPs. The program has pooled in key actors (SHGs/GPLFs) with wide community presence, found complementarities with other schemes such as MGNREGS for constructing waste units/sheds, utilised FC grants and GPs own source revenues, among others, for fast-tracking implementation.

Breaking Stigma and Providing Alternative Livelihood Opportunities for Women

RDPR has been able to build on SHG's focus on promoting financial inclusion and alternative livelihood sources for women in rural areas. We also learnt about women breaking barriers to learn skills such as driving which currently attract social sanctions in the community. Moreover, the program also supports upskilling women for taking up leadership positions and promoting the role of NGOs to facilitate entrepreneurship among SHG women.

By including such components within the program, the state has provided a sustainable avenue for rural women to realise comprehensive empowerment.

Identifying Opportunities for Convergence

As previously mentioned, SBM-G has provided a binding framework to realise convergence opportunities in solid and liquid waste management in rural Karnataka. This presents a best practice scenario of converging schemes at the Union and State levels.

Localising Waste Management Solutions

By tapping into GPs resources, solutions to waste management have been localised, promoting a bottom-up approach for realising key SDGs related to poverty, environment, sanitation, among others. Kerala has been a front-runner state in doing so by utilising its *Kudumbashree* network (Government of Kerala, n.d.).

In the case of Karnataka, however, while the vision was entrusted by RDPR through SBM-G, identifying key grassroots players and their capacities has proven beneficial. Not only are SHG women involved in processes related to monitoring and supervising implementation but can also depend on resources made available to them under SBM-G without stressing their own finances.

REPLICABILITY AND SUSTAINABILITY

The SWM program in Karnataka has yielded several notable outcomes, both in terms of service delivery and strengthening women's empowerment. Thus, by integrating SHGs into the waste management process, Karnataka has not only improved its SWM infrastructure but also provided meaningful livelihood opportunities to women in rural areas. These outcomes reflect the state's commitment to addressing local challenges through a combination of innovative governance, convergence of schemes, and community-driven solutions. Below, we explore a few recommendations and suggestions which can further strengthen the program, ensure sustainability, and provide opportunities for replication in other contexts.

Improving Identification and Selection Process of Drivers

Our interviews found that women are primarily being trained for waste segregation. Women are also scared to drive on the narrow lanes in villages. RDPR data further suggests far fewer than identified women were being trained as drivers. One way to overcome this challenge is by marking *Swacchta Vahinis* as 'women-driven' vehicles. This signage practice will promote and normalise the practice of women driving and also ensure their safety. Citing success stories, such as the one we observed in GP 5, can also motivate SHG women to take up driver training.

Community Mobilisation to Support GPs Finances

Based on our interviews, funds are being used for different purposes. Since one of the key components of SBM-G is to build community ownership for clean villages, the earmarked funds for IEC can be used to hold regular dissemination activities. Given SHGs existing network in villages, they can also be trained as Community Changemakers. This not only aligns with SBM-G's vision of convergence of actors but also drives the need within communities who may then be willing to contribute to user fees. This can, correspondingly, support GP's own revenue for financing program implementation, as the GPs in our study suggest high dependence on this source.

Strengthening Data Monitoring Systems at the GP Level

Existing modern waste collection technologies across geographies have been using radio frequency technology identifying households and enabling GPS and GIS tracking of waste collection, estimating waste's weight, etc. (Patil and Gidde, 2023). While some GPs in our study were already doing this to some extent, standardising this process will prove beneficial for capturing real-time insights on door-to-door waste collection and overall management.

Incorporating digital innovations at early stages has the potential to commence a strong feedback loop in the governance architecture and strengthen implementation at the GP level. This is already being done to some extent in Karnataka. There are, thus, opportunities to continue expanding data collection and improve information storing practices at the GP level. This will further promote efficient monitoring and feedback from higher levels.

CONCLUSION

The SWM interlinkage with SHGs in rural Karnataka presents a best practice scenario for other states to find complementarities among existing resources and furthering multiple developmental objectives. In the case of Karnataka, the current framework for waste management through SBM-G has allowed for strengthening women's empowerment while also promoting sustainable waste management practices in rural communities. This makes Karnataka a front-runner state in utilising innovative convergence practices through localisation of resources.

We are hopeful that in the coming years of the program there will be opportunities to further these objectives by strengthening community participation, diversifying SHG women's skillsets, and promoting efficient data monitoring systems.

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Case Study 4: Health Screening

INTRODUCTION

The Grama Arogya Program, formerly known as the Grama Panchayat Arogya Amruta Abhiyan, was launched by the Department of Rural Development and Panchayati Raj (RDPR), Government of Karnataka in 2021 to reach rural communities by providing basic health examinations and services to vulnerable families. The aim was to increase ownership of Panchayati Raj Institutions (PRIs) in delivering health services in their villages and strengthening community participation. The entire model operates on the convergence between local government, community groups, and various government departments, ensuring that healthcare services are not only accessible but also integrated into the daily lives of rural populations.

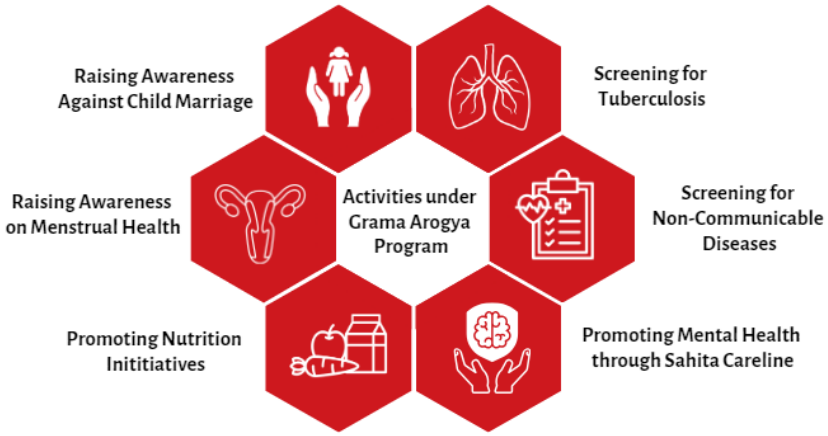
The importance of localised health screening in Karnataka came as a response to the COVID-19 pandemic when the government formed task forces at the Grama Panchayat (GP) level to curb the spread of the virus. As a part of this effort, simultaneous screening for Non-Communicable Diseases (NCDs) was initiated to identify comorbidities. Through this process, the crucial role of GPs in healthcare delivery was realised.

The decentralisation of health services offers a promising pathway to enhance community involvement, which is crucial for overcoming barriers to health-seeking behavior and improving the quality and accessibility of health care. Health systems can better cater to local preferences and needs by shifting responsibility and decision-making to local levels. It helps reduce the duplication of services by clearly defining target populations, streamlining healthcare delivery, and addressing inequalities between rural and urban areas. (Mills 1994; Wang et al. 2002; and Kolehmainen-Aitken 1999). Decentralisation, thus, brings health services closer to the people it serves.

The National Health Policy 2017 also underscores the importance of strengthening PRIs to enhance their role in health governance. Similarly, the Karnataka Integrated Public Health Policy 2017 also emphasises the critical role of community participation, PRIs in health service management, and NGOs in health planning and execution.

The Grama Arogya Program is also aligned with the flagship Ayushman Bharat program under the National Health Mission (NHM)[9], which aims to achieve universal access to equitable, affordable, and quality healthcare that is accountable and responsive to the needs of the people. Several activities are performed under the program ranging from raising awareness, screening for tuberculosis, screening for non-communicable diseases, etc. The entire list of activities performed is given below:

Figure 11: Activities under Grama Arogya Program



OBJECTIVES AND METHODS

Following a case study approach, this brief seeks to analyse the implementation of the Grama Arogya program to document the process of planning, implementation, and coordination and highlight the emerging barriers and opportunities.

Specifically, the study aims to understand the following aspects:

- What is the process of institutionalisation of the program?
- What are the barriers and facilitators to implementation?
- What can other states learn from this process, and what can be improved?

The case study was developed in two steps. First, information available on the scheme was analysed from government documents, orders, and websites. Second, structured Key Person Interviews (KPIs) were conducted in 4 districts at the State and GP levels between June 2024 to July 2024.

State level: This entailed conversations with various officials in charge of the program and staff at the main Non-Governmental Organisation (NGO, i.e., Karnataka Health Promotion Trust (KHPT) who have supported the program.

[9] Ayushman Bharat is a Centrally Sponsored Scheme under which the covered beneficiary can take cashless benefits from any public/private empanelled hospitals across the country.

GP level: ASHA workers, Panchayat Development Officers (PDOs), Community Health Officers (CHOs), Anganwadi workers and Data Entry Operators Officers (DEOs) were interviewed to understand various aspects of their roles and responsibilities.

Table 7: Sample Profile for Health Screening

Respondent	Level	District	Number of interviews
Case Worker & DD	State	NA	1
KHPT State Lead	State	NA	1
PDO	GP	Koppal, Udupi	3
ASHA worker	GP	Yadgir, Koppal, Udup	3
CHO	GP	Yadgir, Koppal, Udupi	3
DEO	GP	Koppal, Udupi	2
Anganwadi worker	GP	Koppal	1
Elected Representative	GP	Koppal	1

Annexure highlights some of the key parameters considered for analysis. These themes constituted the KPIs for the study.

Limitations

This case study focuses on the health screening component under the Grama Arogya Program and does not look at the other initiatives such as the Sahita Careline for mental health promotion and raising awareness about nutrition, child marriage, and menstrual health of the program.

The rest of this brief is structured as follows: Section 3 briefly describes the program's implementation. Section 4 then looks at some of the challenges faced in implementing health screenings and solutions developed by the state to deal with the challenges. Section 5 of the study explores the success and impact achieved through the program. Section 6 provides some recommendations highlighting key features for replicability and sustainability. Section 7 concludes.

UNPACKING THE PROGRAM

This section delves into the Implementation of the Grama Arogya Program and explores the structure of operation, roles and responsibilities, funding mechanism, monitoring and evaluation mechanism, and capacity building to achieve the program’s objective.

3.1 Implementation Process

Structure of Operation

The program brought together the RDPR Department, the Department of Health and Family Welfare (DHFW), the Department of Women and Child Development (DWCD), various village-level committees and community groups, and the Karnataka Health Promotion Trust (KHPT) as the non-state partner.

The Grama Panchayat Task Force (GPTF) was the primary body involved in planning and executing the Program. It consisted of members from all three departments, i.e., RDPR, DWHF, DWCD as well as community members from various village committees and self-help groups. Annexure 2 lists the various members of the GPTF.

Funding

Major costs incurred during the implementation of the program involved organising health camps and the provision of health kits to conduct health screenings. To fund these costs GPs were directed to use 15th Finance Commission (FC) grants, their Own Source Revenue (OSR), or contributions from local donors, in accordance with the guidelines issued by the state government (Government of Karnataka, 2022).Each health kit costs approximately ₹16,500 and represents a one-time expenditure for the GPs.

District Health Officers (DHOs) and Chief Officers (COs) were responsible for conducting tenders and overseeing the procurement process of health kits. In 2023, the RDPR Department provided the necessary funds for all districts to purchase these kits.

The ongoing maintenance of the health kits, particularly the replacement of consumables such as batteries for glucometers, was the responsibility of the GPs funded through the 15th FC grants and OSR.

Capacity Building

Training for effective program implementation was conducted through a mixed model of satellite training and a cascading training model. State-level consultations were organised as a part of satellite training, during which Joint Directors, Deputy Directors, and DHOs received training alongside district-level officials. Following this, master trainers from the districts trained over 2,000 Taluk-level functionaries. These master trainers then conducted further training at the Block level, who in turn trained all the GPTFs. Training sessions were a collaborative effort between KHPT, the RDPR Department, and the HFW Department.

Monitoring and Evaluation

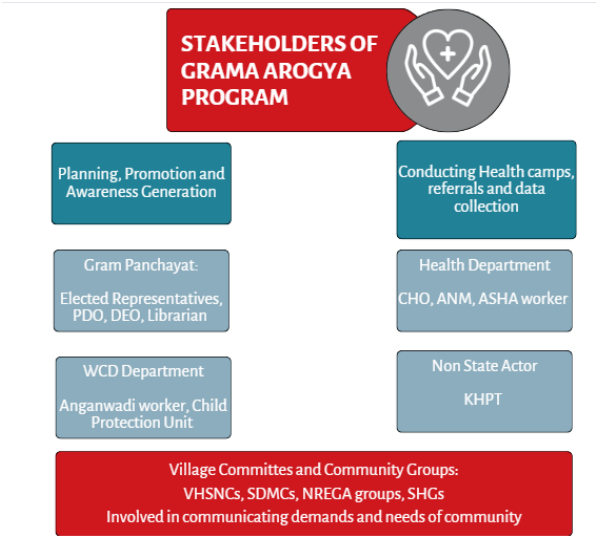
Data collection is a key aspect of the Monitoring and Evaluation(M&E) framework, with KHPT and RDPR playing significant roles. KHPT established a robust system for gathering data on services provided through health camps, which was integrated into the Panchayat reporting software. Initially, The Pragma portal, an internal KHPT system, recorded detailed information on screening activities, including attendance and referrals. This data was then periodically analysed, and feedback was provided to field-level functionaries through supportive supervision and regular field visits to ensure data quality.

In parallel, RDPR utilised the Panchatantra 2.0 portal, which has been operational since April 2023, for data entry at the GP level. Data was manually collected at health campsites and entered by DEOs at GP offices.

2.2 Role of Key Stakeholders

Figure 12 shows the broad division of roles and responsibilities of different stakeholders for the implementation of the program.

Figure 12: Division of Responsibilities under the Grama Arogya Program



Source: KHPT Grama Arogya Report 2021

Department of Rural Development and Panchayati Raj

The Chief Executive Officer (CEO) of the Zilla Panchayat oversaw the overall execution of the program, ensuring micro-plans were prepared and monitored at the GP level, and directed district-level officers to support the program.

At the Taluk level, the Taluk Panchayat Officer bridged district directives with on-ground execution, organised training for GP members and Anganwadi workers, and ensured effective health camp operations and accurate record-keeping.

On the ground, the PDO managed day-to-day implementation within the GP, including organising Health Special Grama Sabhas, procuring and using health kits, and coordinating awareness campaigns (Government of Karnataka, 2022).

Elected Representatives

Elected representatives played a pivotal role in the successful implementation of the program, leveraging their unique position within the community. They have a direct connection with the citizens, which enhances their ability to influence and mobilise the community, especially in areas where there is resistance.

"In areas where there is resistance towards the programs, citizens are more willing to listen to their elected representatives than someone else. "- KHPT Lead

Department of Women and Child Development

DWCD's involvement was supported by Anganwadi supervisors and Child Protection Unit officials. These functionaries were instrumental in addressing critical social issues, including child marriage, nutrition, gender integration, violence, and menstrual health awareness. Additionally, Anganwadi workers were present during health screenings, contributing to the program's holistic approach.

Department of Health and Family Welfare

Accredited Social Health Activist (ASHA) workers, who were key functionaries of DFHW, actively engaged with the community by going door-to-door to inform and gather villagers for health camps. They motivated pregnant women to undergo health screenings and assisted in recording the process. Additionally, CHO and ASHA workers were present during the health camps, where they conducted screenings and referred individuals in need of further medical assistance to Primary Health Centres (PHCs).

Self-Help Groups and Mahatma Gandhi National Rural Employment Guarantee Act Groups

SHGs and Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) groups are deeply rooted in the community and were, therefore, instrumental in mobilising citizens to participate in the program. Their involvement was critical in raising awareness about health services, encouraging participation in health camps, and promoting preventive healthcare practices. These groups also serve as vital points of contact for disseminating information about the program, ensuring that even the most marginalised members of the community are informed and engaged.

Village Health Sanitation and Nutrition Committees

Village Health Sanitation and Nutrition Committees (VHSNCs), alongside other village-level health sub-committees, played a specialised role in strengthening the linkages between health functionaries and community structures. They were particularly focused on maternal and child health, collaborating closely with ASHA workers and Anganwadi Workers to address local health needs. The VHSNCs also facilitated the organisation of health camps and screenings, helping to ensure that the services reach those in need.

Grama Sabhas and School Development and Monitoring Committees (SDMCs)

The Grama Sabha, as a key village-level platform, promoted convergence by bringing together various stakeholders, including citizen groups and government functionaries. It provided a forum for discussing community health needs and planning the delivery of services accordingly. SDMCs contribute by supporting school health initiatives, particularly those related to child nutrition and hygiene, further reinforcing the program's objectives.

Karnataka Health Promotion Trust

KHPT worked towards enhancing the skills and knowledge of GP members and frontline health workers through a comprehensive training module. Additionally, KHPT established a robust system for monitoring health camp services. The Sahita Careline, managed by KHPT, offered

specialised mental health support to vulnerable populations, contributing to community well-being. KHPT also developed a range of communication materials to raise awareness on health issues.

3.3 Health Screening Camp

Source: MGNREGS Karnataka X page

This section examines the setup of health screening camps, covering the infrastructure, screening procedures, and the health kits utilised for the screenings.

Infrastructure

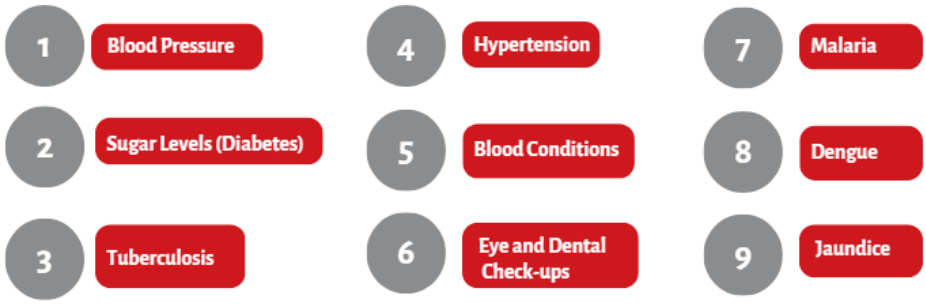
The infrastructure for the health screening camps, including canopies, chairs, food, water, and other necessary consumables, is organised in advance, ensuring the comfort and convenience of the participants. During our visit, it was clear that ASHA workers are central to these camps. They often work closely with CHOs and other health department staff, including nurses and the PHC Medical Officer, who are essential for patient care and health assessments. GP staff, such as the PDO, secretary, and general members, are also commonly involved, overseeing the organisation and ensuring smooth operations at the camp. Elected GP members, like the Adyaksha and Upadyaksha, are often present, providing leadership and local governance support.

Screening Process

Upon arrival, participants are encouraged to sit and relax for 5 to 10 minutes, a practice designed to ensure accurate blood pressure and sugar level readings. This approach minimises the risk of variations that might occur if measurements are taken immediately. Figure 3 below

highlights the health checks conducted during the camps.

Figure 13: Health Checks Conducted during Screening

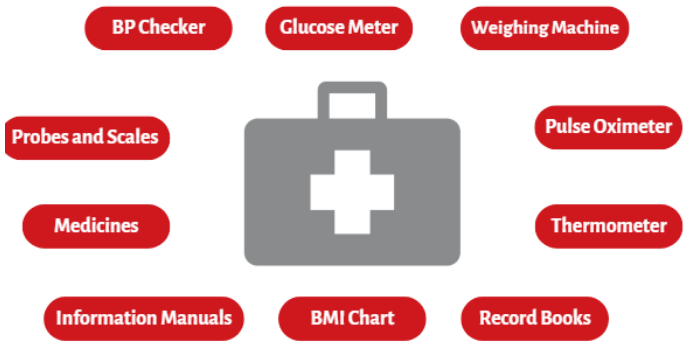


If a participant's condition is severe or cannot be treated on-site, they are promptly referred to a nearby hospital for further evaluation. Persistent abnormalities lead to referrals to PHCs for more detailed assessments. Minor conditions are managed on the spot with the provision of necessary medications and advice.

Provision of Health Kits

KHPT developed a comprehensive health management kit that included the nine point-of-care devices. (See Figure 3) These tools were designed to facilitate accurate and efficient health screenings.

Figure 14: Components of a Health Kit



CHALLENGES AND INNOVATIVE SOLUTIONS

In implementing any large-scale and ambitious government program, challenges are inherent to the process. Challenges often emerge as the program progresses, necessitating an iterative approach to refinement and improvement. Through our field visits and on-ground observations, we identified several issues which surfaced during the rollout. The following section outlines these challenges and provides insights into Karnataka's efforts to address them, ensuring the program's objectives are met effectively and sustainably.

There are broadly six key barriers that were found during our study.

Bottlenecks in Convergence at State Level

A key challenge was the difficulty in holding joint meetings at the state level with the Health Department, which hindered coordinated efforts and decision-making. While grassroots-level convergence had shown better integration and impact, achieving the same level of coordination at the state level was difficult. This fragmentation often affected the seamless execution of plans, which were not uniformly implemented across all regions.

Unmet Targets

Guidelines stipulated that five health camps should be organised per month; however, due to human resource constraints, achieving this target has proven challenging. The PDOs were often overwhelmed with numerous responsibilities, leading to delays in organising screening camps. This strain was compounded by the frequent unavailability of ASHA workers and other functionaries. During our team's visit to the Yadgir district in July, it was reported that no health screenings had been conducted since April 2024. In other districts, interviews indicated that, on average, only 1-2 camps were held monthly.

The footfall at health camps also showed significant variation, ranging from as many as 200 attendees in some camps to as few as 30 in others. Camps held in locations where awareness was low or where there was a lack of health-seeking behavior among the population experienced lower attendance.

Dependency on Individual Interest and Engagement

The program's success depended on the interest and engagement of individuals at various levels. In some GPs, the local leaders and functionaries were not proactive, resulting in delays in the program. Similarly, at the ZP and state levels, the lack of active follow-up and engagement by senior officials also contributed to stalled progress.

Reliance on KHPT

The program encountered challenges related to the ongoing reliance on KHPT, especially in areas where clearer prioritisation and definition of roles and responsibilities were needed. While RDPR provided oversight, there remained an expectation for KHPT to manage many operational tasks, including briefing and program coordination. This reliance on KHPT occasionally led to delays in program implementation and could impact the state's ability to lead and sustain the program effectively once KHPT transitions out.

Health Kit Quality and Procurement

Issues related to the procurement and distribution of health kits were present, with some CEOs still facing difficulties in its procurement. Further, concerns were raised about the quality of certain components, with reports of some equipment being non-functional.

Data Utilisation and Quality Concerns

In some cases, PDOs did not use the collected data and were unfamiliar with how it was utilised by the health department. This highlighted the variability in data utilisation for planning, depending on the roles and responsibilities of individuals involved. There were also instances of duplication of data when health workers entered the data into the NCD portal, leading to inflated screening numbers in certain areas. Additionally, there were concerns about the data quality, with reports of manipulation in some health camps to meet targets. In

some cases, there was no formal verification process, and data was recorded without additional checks.

Source: KHPT Grama Arogya Report, 2021

Karnataka is trying to address these challenges through a combination of strategic interventions:

First, KHPT's focus has transitioned towards a **sustainable exit strategy** to ensure the program's sustainability and effective integration into routine government operations. This strategy involved facilitating the transfer of program responsibilities to relevant government departments while continuing to offer strategic guidance and expertise. They are supporting the establishment of local health members within each Grama Panchayat to sustain the program's impact.

Second, in response to the varying footfall at health camps, after the finalisation of plans, efforts have been concentrated on **raising awareness about upcoming health screening events**. ASHA workers are central to this initiative, conducting door-to-door visits to inform community members, especially those in high-risk categories. KHPT supported these efforts by helping to disseminate information. Awareness is also being promoted through posters and traditional methods, such as drum beating, to ensure broad community outreach.

Third, to address the lack of clarity in roles and responsibilities, **micro plans have been developed** for health camps. These micro plans serve as a detailed blueprint, specifying the location of the health camp and identifying specific target groups within the community who are most in need of health services. The plan outlines the primary activities and assigns specific responsibilities to individuals, ensuring a coordinated and effective execution of the event.

The PDO leads the planning process, often in consultation with key stakeholders, including ASHA workers, Anganwadi workers, health department representatives, and Elected Representatives.

Fourth, to sustain momentum and **ensure continuous skill enhancement**, refresher training sessions were held online every second Saturday. Hosted by the RDPR and facilitated by KHPT, these sessions allow participants to revisit key concepts, learn about the latest updates, and address any challenges encountered in the field.

Fifth, comprehensive data collection, verification and utilisation procedures are being developed. Data entered into digital systems was cross-checked with manual records. The Taluk Panchayat officer verified the data using their Panchatantra 2.0 login and sent notices if screenings were not conducted. Additionally, data from previous screenings was used to monitor health trends, identify prevalent issues, and ensure follow-ups for individuals with chronic conditions.

To ensure that all required metrics for future planning were collected, the data typically included basic health indicators such as BP readings, blood sugar levels, weight, and other relevant measurements. It also encompassed detailed information like the number of participants, the count of individuals tested for BP, and demographic breakdowns including gender and age distribution. Additionally, the data records personal details such as address, along with health history and any specific conditions identified during the screening.

SUCCESSES AND IMPACT OF THE PROGRAM

Source: KHPT Grama Arogya Report

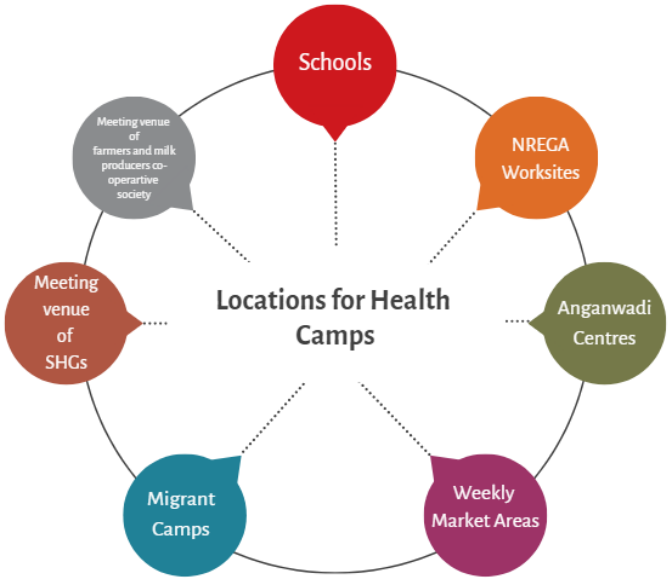
The Grama Arogya Program in Karnataka has been instrumental in strengthening the involvement of local government in healthcare. While this case study did not specifically measure outcomes and successes, it is important to highlight some key observations from interviews and site visits. These observations are outlined below:

Making Health Camps Accessible

Health camps have been strategically implemented at various locations within the village to maximise accessibility and ensure that even the most vulnerable populations can attend. These locations are carefully selected based on their proximity to areas where community members, especially those with limited mobility or resources, are more likely to visit.

The health camps are therefore brought to the doorsteps of laborers, miners, migrant families, individuals with special needs, senior citizens, pregnant women, gender minorities, and those affected by HIV/TB.

Figure 15: Sites for Conducting Health Screenings



Dealing with COVID-19

The GPTF has played a crucial role in overcoming vaccine resistance by actively engaging with the community. Their efforts in providing accurate information, addressing concerns, and demonstrating the benefits of vaccination have been vital in persuading individuals to get vaccinated.

> *"In areas where ASHA workers could not manage on their own, the GPTF proved invaluable. Their strong connection with the community allowed us to expand their role and sustain the momentum of the program." - KHPT Lead*

GP Developing Ownership in Healthcare

GPs have increasingly taken ownership of healthcare by investing in and maintaining health kits, providing preventive care, and conducting follow-ups to prevent disease escalation, thereby reducing the burden on PHCs. They have played a pivotal role in promoting nutrition, menstrual health, and mental well-being through awareness campaigns, ensuring that these critical health aspects are addressed at the community level.

Sensitive to Community Needs

GPs effectively responded to community health needs by promptly addressing requests and concerns conveyed through village committees and community groups. For instance, in Koppal district, when an increase in dengue was reported, GPs promptly organised meetings and health camps.

Convergence of Stakeholder Expertise at GP level

The program has thrived by leveraging the combined expertise of various stakeholders at the GP level. By integrating efforts across departments and committees, the initiative ensures a well-rounded approach to healthcare. This synergy allows for more effective screenings, enhanced awareness campaigns, and targeted needs assessments, resulting in a cohesive and responsive healthcare system that addresses community needs efficiently and comprehensively.

REPLICABILITY AND SUSTAINABILITY

The case study of the Grama Arogya Program highlights several key characteristics and strategies that are essential for the long-term success and resilience of the program. These are described below:

Convergence across departments

The program successfully converged the functions of various departments and stakeholders at the GP level. Going forward, similar convergence at the state level would be useful to leverage combined strengths for effective implementation.

Refresher Training at ANSSIRD

Capacity building for Panchayat functionaries, Anganwadi workers, and elected representatives is important for effectively using health kits, disseminating information, and conducting screenings. Moreover, to ensure the long-term sustainability of the program, it is recommended that refresher sessions be conducted in person at the State Institute of Rural Development (ANSSIRD) on a regular basis. This approach will reinforce the training previously received and help maintain consistent knowledge and practices across the state.

Penalties for Non-Compliance

To ensure the quality of health kits is maintained, it is essential to establish formal penalties for functionaries who fail to comply with procurement and maintenance protocols of health kits. Introducing such measures will promote adherence to standards and initiatives taken by the GPs to maintain the quality of consumables in the health kit by utilising available funds.

Regular Committee Meetings

Village committees and SHGs must remain active and hold regular meetings to discuss community needs. This ongoing engagement ensures that the needs identified can be effectively communicated during Grama Sabhas, allowing the program to be tailored to actual community requirements. Regular meetings are fundamental to achieving the goal of convergence, ensuring that the program remains responsive and relevant to the community's needs.

Ensuring Effective Follow-Up and Access to Treatment

A screening program will have limited value if individuals need further treatment but cannot access these services. Promoting inclusivity by holding health camps in accessible locations for the most vulnerable is paramount. Moreover, it is essential to develop sufficient infrastructure to ensure that patients can reach PHCs and Community Health Centres (CHCs) for treatment. It is crucial to guarantee that all those requiring treatment receive it in the most effective, appropriate, and timely manner. Without adequate facilities and health personnel to provide necessary treatment, the benefits of the screening program will be compromised. Additionally, patients will need follow-up at specified intervals for repeat screenings to ensure ongoing health management.

Ensuring Quality Equipment to Prevent Diagnostic Errors

To maximise the effectiveness of preventive health screening camps, it is crucial to ensure the use of high-quality equipment. This prevents false positive results, which can cause unnecessary anxiety for patients, and false negative results, which can lead to a delay in necessary care and further compromise health. By maintaining high standards for diagnostic tools, the screening program will effectively identify and address health issues, fulfilling its purpose of providing timely and accurate preventive care.

Further, effective monitoring and evaluation of data ensure that information is utilised to promote preventive care and reduce the burden on PHCs.

CONCLUSION

The Grama Arogya program has emerged as a successful model of convergence, bringing together various stakeholders to ensure that health initiatives reach the most vulnerable members of the community. By fostering collaboration between local government, departments, and the community, the program demonstrates how coordinated efforts can effectively address public health challenges. This model provides a valuable opportunity for other states to learn from Karnataka's experience, promoting a more integrated approach to community health.

Building on the program's existing efforts, there is potential to further enhance its impact by strengthening data monitoring mechanisms. Moreover, as roles and responsibilities are clearly defined and aligned, it will support the ongoing efforts to meet program targets and ensure sustainable improvements in healthcare delivery across the state.

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Case Study 5: Perspective Planning

INTRODUCTION

In Financial Year (FY) 2022-23, the Government of Karnataka embarked on an ambitious initiative to streamline local development planning through the Perspective Planning (*Doorasdrushti Yojane*) process. This initiative aims to align Grama Panchayat (GP) development with the Sustainable Development Goals (SDGs) by creating detailed, participatory, and data-driven plans that guide GP activities over a five-year period. The initiative integrates digital tools and emphasises local participation, reflecting the state's commitment to decentralised governance and sustainable development.

Local development plans are crucial for decentralised governance empowering communities to actively participate in decision-making and ensuring that local governments are more accountable and responsive to their needs. By adopting a community-driven approach in planning, local governments can build trust, deliver better services and foster better coordination with other government departments including streamlining various state and central schemes and funding sources. These plans outline long-term objectives, budget, action steps, and importantly, provide an opportunity for citizens to influence local development.

While several states have designed and prepared annual Grama Panchayat Development Plans (GPDPs), Karnataka is one of the first to design a comprehensive planning process over a period of five years aligning local goals with SDGs and digitising the entire process. For this purpose, the Rural Development and Panchayat Raj Department (RDPR) introduced a new software called Panchatantra 2.0 (P2), a platform that digitizes all key functions and operations of the GP including the planning module. The P2 software is a major component in facilitating the preparation of the *Dooradrushti Yojane.*

Box 9: Karnataka's *Dooradrushti Yojane* Initiative

According to the Karnataka Grama Swaraj and Panchayat Raj Act, 1993, Article 309(b), all GPs are mandated to prepare a five-year vision plan within 3 months of their formation (i.e., when the elected members take office). In FY 2022-23, an expert committee at the state level finalised on eight themes that localised the SDGs. Each theme would have a detailed format which would guide the identification of problems and setting of goals in the GP. The plan has identified an overall of 648 indicators in eight sectors that would inform the current status and the development goals of the GP. The eight themes aligning with the local SDGs are:

- Poverty Free
- Livelihood and Skill Development
- Health
- Education Women and Child Development
- Environment and Natural Resources
- Social Justice and Socially Secured Panchayat
- Self Sufficient Infrastructure Panchayat
- Good Governance

The vision plan is to include planning of all activities such as schemes and other major initiatives related to GP development. Based on the vision plan, GPs are required to make an annual action plan every year called the Integrated Participatory Annual Action Plan (IPAAP) (Government of Karnataka, 2022d).

This case study seeks to understand and document the background, processes, and implementation of the Perspective Planning initiative.

1.1 Objectives and Methods

The primary objective of this study was to understand the implementation process of Perspective Planning at the GP level, identify key challenges and opportunities, and document innovative practices that have emerged during the process. It is important to note that this case study does not seek to undertake an evaluation of the *Doorasdrushti Yojane* and the extent to which GPs have conducted this planning exercise.

Instead, the study sought to understand:

1. How are the GPs perspective planning process structured, and what role does technology (P2) play in facilitating it?
2. What challenges and opportunities are arising in the planning process?
3. What best practices have emerged from successfully prepared perspective plans?

The case study follows a mixed-methods approach and consolidates evidence using analysis of government documents, orders, and literature, semi-structured interviews conducted between June 2024 and August 2024, and government data. The study focused on five districts namely Kolar, Koppal, Yadgir, Udupi, and Mysore, across Karnataka's four divisions, selected based on a mix of Human Development Indicator scores.

A total of six GPs were selected based on the recommendations of district and taluk level functionaries who were aware of successful Perspective Planning practices. Key Person Interviews (KPIs) were conducted with state-level officials, Panchayat Development Officers (PDOs), and other GP functionaries involved in the planning process. See Table 7 for more details.

The findings were supplemented with data collected from various government portals, including the P2 platform.

Table 8: Sample Profile for Perspective Planning

Respondent position	Level	District	Number of respondents
Senior level Officer	State	-	1
Panchayat Development Officer	GP	Kolar (PP 1), Koppal (PP 2), Yadgir (PP 3), Udupi (PP 4, PP 5) and Mysore (PP 6)	5
Other GP functionaries (SDA, DEO and Bill Collector)	GP	Kolar (PP 1), Udupi (PP 4),	3

The remainder of the case study is structured as follows. Section 2 gives a brief background into the implementation of the perspective planning process including the institutional structure and roles of different stakeholders. This is followed by Section 3 which outlines our Field Visit and observations. Section 4 and Section 5 discuss some of the key challenges encountered in the planning process and the corresponding solutions reinforced by the state to mitigate them.

UNPACKING THE INITIATIVE

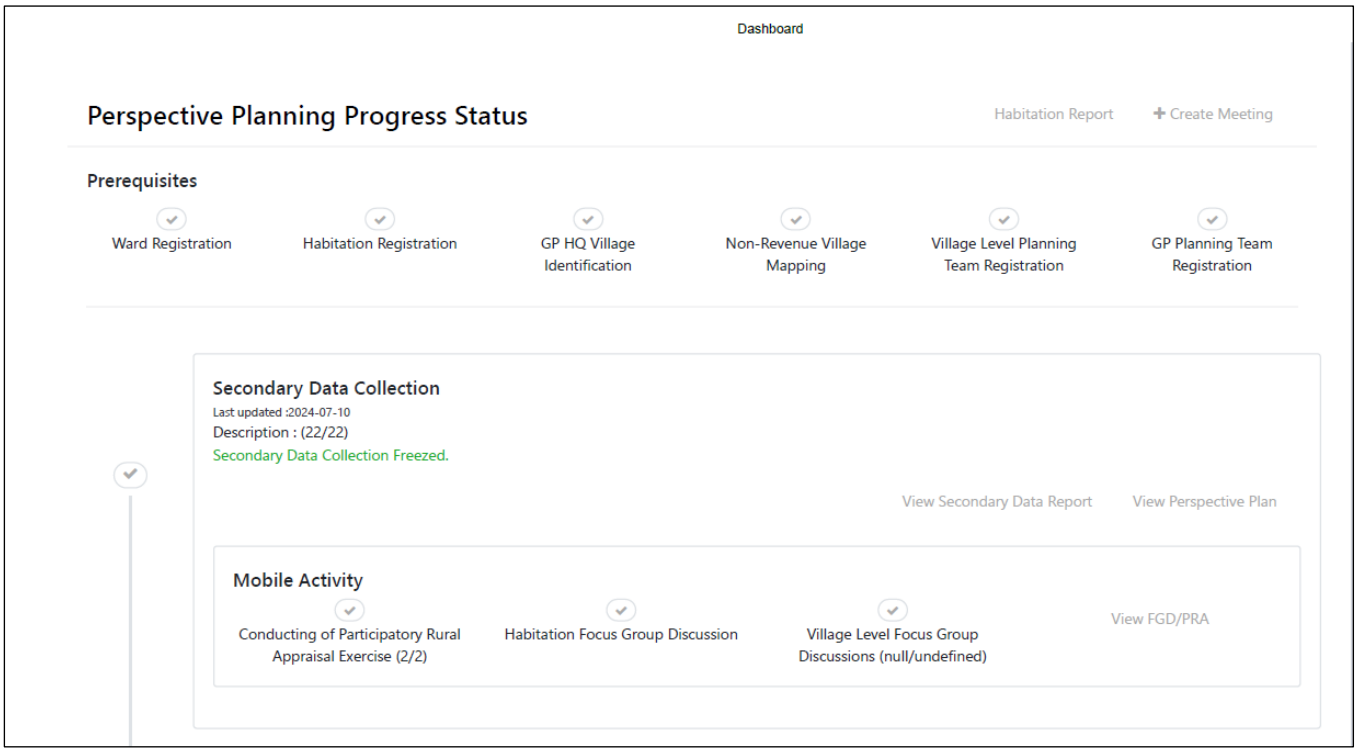
2.1 Implementation Process

Structure of the Perspective Planning Process

The Perspective Planning (*Doorsdrushti Yojane*) process is designed to guide GPs in developing comprehensive five-year plans that align with local needs and SDGs. All GPs received an order stating that Perspective Plans should be made from the year 2023 to the year 2028. The order also called for training where this initiative was introduced, after which further training was given.

The process involves multiple stages, from the initial training of GP functionaries to the final uploading of plans on the P2 portal.

Figure 16: Planning Dashboard on P2 Portal (First section of the process)



Source: CPR team

The portal guides the process through each step with a detailed process map, where on-ground activities are recorded. The planning module in the portal includes a dashboard for the five-year plan, allowing the GP and higher levels to monitor progress. After completing each step, the Panchayat Development Officer (PDO) and other staff enter the relevant data into the portal. Once a step is finished, the portal unlocks the next step in the process. Since the plan accounts for all GP development activities, schemes, and other initiatives, different line departments are also involved at the GP level.

Training and Capacity Building

The process begins with extensive training at the taluk level for GP functionaries, including the PDOs, President and Vice President, all elected representatives, Self-Help Group (SHG) representatives, and also line department staff in the GPs. Each taluk has 2-4 Master Trainers, who receive training at the state level by ANSSIRD. The training includes both conceptual and technical components, ensuring that participants understand the planning process and are proficient in using the P2 portal for data entry and monitoring. The training is either given offline at the taluk panchayat, or through SATCOM or YouTube. Every time there is a change or addition in the process of planning, there is training given to adapt to the change.

Formation of Planning Committees

Once trained, two key committees are formed: the Grama Panchayat Planning Committee and the Village Planning Committee. These committees are responsible for data collection, conducting community consultations, and drafting the perspective plan (For more details on planning committees, refer to Annexure 3).

Usually, after the GP planning committee is formed, it is divided into smaller groups with relevant members of the particular village including community stakeholders such as Accredited Social Health Activist (ASHA) workers and Anganwadi workers, SHG members, subject experts, retired officers, elected representatives, and other local government staff to form the village level committees.

Data Collection and Analysis

The village level committees undertake a rigorous data collection process, gathering both secondary data from line departments and primary data through Participatory Rural Appraisals (PRAs) and Focus Group Discussions (FGDs). This primary data collection (FGD and PRA) is conducted on the mobile application of the P2 portal. Here the pictures and reports of the FGDs and PRAs are directly entered on the mobile app. This data is automatically synced to the dashboard on the website and updates automatically. See Box 1 for more details.

The role of the GP level committee includes consolidation of activities and analysis. The data is then entered into the P2 portal, where it is analysed to inform the development of specific goals and action plans for the GP. To guide the GPs on which data to collect, a format of 648 questions/indicators was provided by the state, whose corresponding data points guide the activities/works decided for the five years.

The secondary and primary data collected is then tallied and compared and a final data point that reflects the reality best is entered.

After the data collection, the elected members of the ward are responsible for convening a sabha at the habitation and ward. Here the findings from the data collection are presented by the planning committee to the people of the ward/habitation. A list of works is then decided based on this data.

Box 10: Types of Data Collection for Perspective Planning

Secondary data collection: The questions listed under each sector are sent in an excel format to the respective line departments to fill the data fields based on their existing data. Some GPs have also noted that planning committee members have physically gone to the line department to collect the data. ASHA and Anganwadi workers provide most of the secondary data needed in the health, women and child development, and education sectors.

Focus-group discussions: FGDs are conducted at the habitation and at the village level. In the habitation level, one FGD is conducted discussing all themes, while at the village level, two FGDs are done, dividing the eight themes between the two. In the FGD, representatives of the concerned community – women, senior citizens, people with special needs, gender minorities, Scheduled Caste (SC) and Scheduled Tribe (ST) communities, etc., are convened to discuss with the planning committee.

Participatory rural appraisals: PRAs are done at the village level. In this exercise, a social map and a resource map is made to map the social infrastructure and natural resources in the village/GP. To make these maps, the planning committee also conducts transect walks.

Drafting the Perspective Plan

Using the data collected, the committees draft the perspective plan, which includes detailed action steps for each of the eight identified themes.

There are three forms in which the data is put to create the plans.

- Form 1 details the issue (for instance, people with diabetes) and how it can be prevented and who is responsible for implementation.
- In Form 2, targets are decided, existing data points are entered (number of people with diabetes) and an achievable target data point is entered (zero people have diabetes).
- In Form 3, this target is made into an action plan with short term, medium term and long-term goals (in numbers) listed for the span of five years, outlining the activity and responsible departments, the fund source and cost estimate. Form 3 is the draft perspective plan. The plan is reviewed by the GP's Finance, Audit, and Planning Committee, and then presented to the General Body. Any changes provided can be incorporated during this stage. After which the plan is presented in the Grama Sabha for feedback. There is also a period of five days given for citizens to provide feedback on the draft provided. The feedback can be entered online directly. In most GPs, the feedback is given in a written format to the GP office and the DEO enters the feedback online.

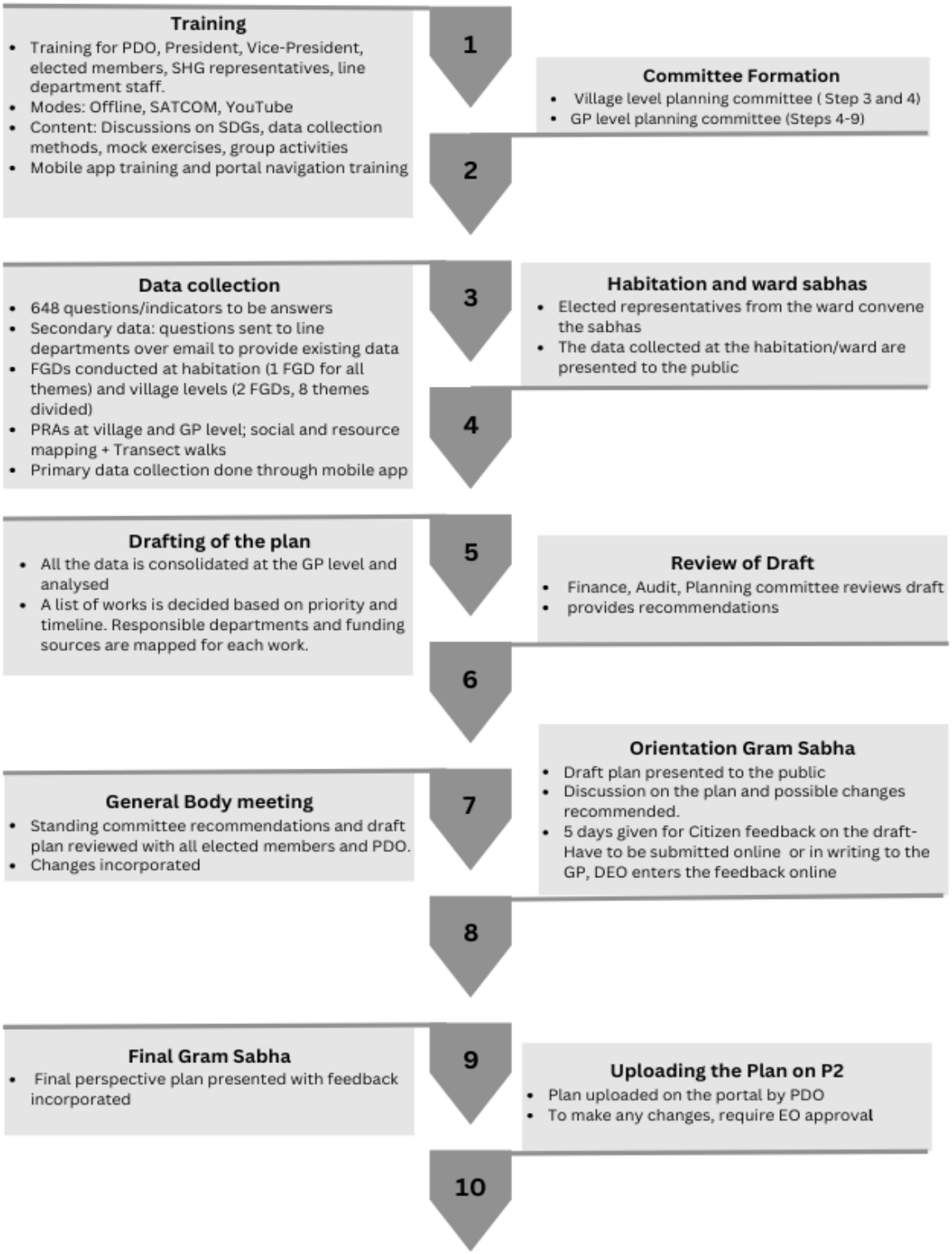
After following all these steps, the perspective plan is finalised.

Uploading and Finalising the Plan

After incorporating feedback from the community, the final perspective plan is uploaded to the P2 portal. The plan is then used to guide the preparation of the IPAAP each year[10], ensuring that the GP's activities including both which the GP is directly responsible for and those it has to do in convergence with other line departments are aligned with the long-term goals outlined in the perspective plan.

[10] IPAAP is the annual action plan that the GP makes every year. With the introduction of *Dooradrushti Yojane*, the annual action plan is to be made based on the 5-year plan following similar steps as that for the vision plan. Before the introduction of the 5-year plan, all GPs used to make annual action plans under the name 'Grama Panchayat Development Plans' (Government of Karnataka, 2022c). Now, GPs are required to make IPAAP yearly.

Figure 17: Perspective Planning Process at GP level



Source: (1) Training material (Government of Karnataka, 2022d) and (2) Own Interviews

2.2 Institutional Structure

The planning initiative requires the involvement of officials from the State level to the GP level. This section outlines the key actors involved at each level of government in preparing a

perspective plan. At each level of government there is a monitoring and nodal officer who is involved in the process of preparing the plan. These officers are appointed to oversee progress, provide guidance and address grievances that arise during planning. Table 9 details the responsibilities of these officers at each level of government.

Table 9: Organisational Structure of Key Actors in Perspective Planning

Levels	Actors	Responsibilities
State	ASC	- Monitor and coordinate vision plan preparation, progress and training activities at district level - Issue circulars and orders required for the preparation of the vision plan - Identify and train resource persons at state level to provide training (ToT) at ZP level (ANSSIRD) - Prepare manual for the vision plan (ANSSIRD)
	Commissioner (PR) and Commissioner (RD)	
	Joint Secretary	
	Directors	
	Deputy Directors	
	Case workers	
	ANSSIRD faculty/research officers (is this the same as case workers?	
District	CEO	- Supervise the progress of plan preparation at the taluk level - Address grievances and provide feedback to monitoring officers (Senior nodal officer at Taluk level)
	CPO and Deputy Secretary	
	Other Officers	
Taluk	EO	- Coordinate with district level officers and provide all information - Guide GPs and discuss progress and grievances with them.
	Senior nodal officer (1 per 5 GPs)	
GP	PDO	- Coordinate and guide all activities happening at the GP level. - Form planning committees, and organize meetings for data collection - Draft the vision plan - Ensure all the steps of preparing the vision plan are followed.
	Elected representatives	

Source: Training Manual for the vision plan and Interviews

At the GP level, the PDOs and elected representatives ensure that every step is effectively carried out on the ground. Taluk level officers provide guidance, monitor the work at the GPs, and report to the district level. District level officers supervise taluks and address any grievances raised. At the state level, officers monitor and coordinate the progress of the vision plan through their counterparts at the district and taluk levels. The Abdul Nazir Sab State Institute of Rural Development (ANSSIRD) at the state level is responsible for the training programs and material related to the preparation of the vision plan.

These actors facilitate coordination and monitoring across levels and maintain a grievance redressal and feedback system during the planning process. Additionally at the GP level, there are committees formed to ensure that the detailed steps of preparation and data collection are carried out effectively (refer to Annexure 3).

The next section describes our field observations including some challenges encountered in the implementation of this initiative.

OBSERVATIONS FROM FIELD VISITS

During our visits to the selected GPs, we observed the implementation of the Perspective Planning process in action. In one GP in Mysore, the planning committee, led by the PDO, was actively engaged in data collection and community consultations. The process was guided by the P2 platform, which facilitated real-time data entry and progress tracking. In another GP in Udupi, the planning committee had successfully completed the PRA and FGDs, with active participation from ASHA workers, AWWs, and local SHG members. The GP had also conducted multiple training sessions to ensure that all committee members were well-versed in using the P2 portal, highlighting the importance of capacity building in the success of the initiative.

Figure 18: Data Collection Process for Perspective Planning in GPs visited. PRA Mapping and Grama Sabha Held at GP Level.

Source: CPR team

Apart from understanding the process of planning, our field visits also revealed a range of experiences across different GPs. While some GPs demonstrated strong coordination and successful implementation of the planning process, others faced significant barriers, particularly in integrating technology and ensuring effective participation from all stakeholders. The observations from these visits provide valuable insights into the practical

challenges of Perspective Planning and the innovations that have emerged to address them. These are described briefly in the next section.

CHALLENGES

Broadly, our visits indicated four key challenges with respect to the implementation of Perspective Planning. These were design challenges with respect to the planning tool, technology and infrastructure barriers, limited digital literacy, and difficulties with cross-departmental coordination. Each of these is described below:

Design of the Planning Tool

One of the primary challenges identified during the implementation of Perspective Planning is the complexity of the planning tool itself. The P2 portal requires GPs to answer 648 questions/indicators, each demanding specific data points, targets, and corresponding activities including cost estimates. This exhaustive format, while comprehensive, often complicates the planning process rather than simplifying it, as noted by a PDO. Some GPs reported difficulty in finding relevant data for all indicators, leading to the inclusion of unnecessary or inaccurate information.

> *"The design doesn't fit. It doesn't reflect the ground realities. It doesn't give us what we practically need. If we have to answer all the questions and create an action plan for each, there's no money left. We can't leave anything unanswered or put zero, so we have to assign a minimal amount to each field."* - PP 5, Udupi

Additionally, some GPs in Udupi and Mysore noted that the structure of the format which primarily has two types of questions – either yes or no questions, or those with numeric values – is often restrictive from the perspective of implementing the plan and fail to capture ground realities. Others noted that since the plan collated information in terms of data, targets, and financial costs for each activity, it lacked a mechanism to track progress in terms of outcomes that would have measured meaningful impact and increased accountability of the GP.

> *"We can't add descriptions to the answers—it's just a yes or no. The area-specific demands can't be detailed because the question applies to the whole GP. For example, if the question is 'Is there a toilet in my GP?', my only options are Yes or No. I can't specify that 3 schools have toilets and 2 schools don't. If I say No, it implies there are no toilets in any school in the GP."*
>
> *"This plan just shows financial progress. But it isn't beneficiary-oriented. We can say we spent ₹10,000 on a malaria camp, but we don't know if malaria has been eradicated. We don't know if the problem has been solved—this is just data entry, nothing is actually happening."* - PP 5, Udupi

Technology and Infrastructure Barriers

The reliance on the P2 portal for data entry and plan management presents significant challenges in areas with poor network connectivity. For instance, photos and resolutions from meetings need to be uploaded in real time during primary data collection and ward and Grama Sabhas. For PRA and transect walks, photos are taken and uploaded through the

app, while biometric attendance of elected members is recorded at the beginning and end of each sabha, with meeting resolutions required to be uploaded within the same day.

GPs in regions like Yadgir and Udupi reported frequent disruptions due to server issues and lack of reliable internet access. This was particularly worse during the monsoon season. These technical problems have led to delays in the planning process and have forced some GPs to resort to manual workarounds.

GPs also reported specific technical problems within the portal. Both taluks of Yadgir and Udupi noted frequent buffering of the portal when navigating between tabs and lack of communication between the GP and state with respect to maintenance work on the portal.

> "*Each part in P2 has some tech issues. The process did not get easier. It takes too long to take biometric attendance during the meetings. There is no network in these areas. It is different to sit in Bangalore and do this process versus in remote areas like here. There are too many bugs and no full functionality. They should have launched everything together, not incrementally."*
>
> *"When there is maintenance work on the portal, we are not informed, causing work to halt. Feedback is given, but the state level does not respond. Although there is a master trainer group where problems are reported, no effective action is taken to address them."* - PP 3, Yadgir

Lack of Integration across multiple portals

The perspective planning process and IPAAP are not integrated with the other portals, resulting in duplications of the plan and increasing workload of the GP. For instance, in addition to mapping sources of funds and activities in the annual plans, GPs also have to submit the NREGA plan and 15th FC plan annually on their respective portals.

> *"We have the NREGA & 15th FC action plan. We have to re-enter this again on IPAAP. In the beneficiary details section on IPAAP, (there is a separate NREGA section), we have to re-enter the details again."* -PP5, Udupi

Limited Digital Literacy

The transition to a fully digital planning process has exposed gaps in digital literacy among GP functionaries. Despite the training provided, some PDOs and committee members struggled with the technical aspects of the P2 portal, particularly in entering data and navigating the various modules. This has resulted in errors and inconsistencies in the plans submitted.

Gaps in Training

While the training conducted focused on the concepts of the plan and the technical aspects of the portal, some PDOs felt that their insufficient attention was given to the nature of questions and availability of data leading to incorrect entries and confusion on the ground. For instance, confusion existed between negative questions focused on what is lacking such as 'children aged 6-13 who had left school' or 'solid waste **not** disposed of in public institutions versus those which look at what had occurred – such as underweight children or 'Underweight children' or 'Reported crimes against vulnerable groups.'

"There are more than 600 questions. There are positive and negative questions, which weren't explained to us in the training, so a lot of GPs have entered this figure wrong. Also, we have to answer every question. It was difficult to do this." - PP 5, Udupi

PDOs also highlighted differences between the test sites used to teach portal navigation and on ground implementation.

Coordination with Line Departments

The planning process requires close coordination between GPs and line departments, particularly for data collection and implementation of specific activities. However, the hierarchical differences between GP staff (Grade C officers) and line department officials (Grade B officers) have hindered effective collaboration in many cases. This lack of coordination has led to gaps in the planning process, particularly in areas requiring input from multiple departments. An example of this came out in Udupi Taluk, where a PDO mentioned that Karnataka Development Program (KDP) meetings[11] are often not attended by taluk officials, leaving the GP staff out of loop regarding line department works in the GP.

"Because the GP staff are C grade officers and line depts are B grade officers, we can't insist and demand them to be part of this.... The CEO and EO should insist that line depts should be involved. They should also be given a letter to follow these procedures. That the staff should be aware that this process has started and that staff should provide data for it." - PP 6, Mysore

This lack of coordination between the GP and the line departments also makes the implementation of the plan difficult. The plan maps each activity to the responsible department, including line departments. However, often the works that fall under the purview of the line departments are not reviewed by them, leading to many activities and grievances going unaddressed.

"When filling the PP questions, we put the line department responsible for a certain task, but they don't know this. Whatever we say is the work of another department, we can't make an action plan for that task on IPAAP. But they also don't see this plan on their portals (line depts), so the work they do is not reflected on the plan." -PP 5, Udupi

The state level officers also agreed that this gap is yet to be addressed. The monitoring and coordination structure of the process currently does not include a way to ensure coordination between the line departments and the GP level. Currently, the line departments and the GP work in silos. For instance, both the entities collect the same data separately due to a lack of trust between them.

[11] The KDP meetings are quarterly reviews held at the Grama Panchayat (GP) level to monitor the progress of development programs and address implementation hurdles. Attended by all GP members, elected representatives, and officials from various line departments, these meetings focus on the execution of schemes at the hobli and GP levels. The discussions cover grant utilisation, physical infrastructure progress, and targets for different schemes.

"There is a gap in PPs reaching the line departments - there is no role or responsibility that is given to a monitoring officer or the CEO to communicate works of the line depts to them. There should have been a dashboard where the CEO can review line department works/grievances coming from GPs and communicating this to the Line departments. But this does not exist." - State level officer

Inaccessible citizen feedback channel

Another issue reported by GPs is the design of the citizen feedback system. After the Grama Sabha orientation, the public has to provide feedback on the draft plan, but this feedback must be submitted online. Very few people have the access or the knowledge to navigate the P2 website and submit feedback online. To address this, some GPs have asked for written feedback to be submitted to the office, which the DEO then enters online. However, this workaround is complicated and cumbersome, and as a result, GPs receive little feedback.

"After the draft, it needs public feedback to be entered online. But ppl can't/ don't put it online. They can come to GP & give feedback but that does not happen. The process won't move forward without some feedback." - PP 5, Udupi

The P2 dashboard process cannot progress until some feedback is entered. Consequently, GPs have resorted to entering dummy feedback when they receive none from the public. This aspect of technology and digitisation complicates the process for both the GP and the public. The development of the portal and the planning process on ground happened simultaneously, which led to the introduction of the citizen feedback mechanism later in the process. The intent was for citizens to directly input their feedback on the portal, with an alternative for GPs to record feedback based on written submissions if citizens were unable to do so themselves. The state officials acknowledged that this is a gap in the system, however, they are confident that the use of the portal by citizens will improve over time. They recognised that the current lack of sufficient awareness and Information, Education, and Communication (IEC) efforts on the ground might be hindering the effectiveness of the feedback system. They cited the example of digitising property tax collection, which initially saw low participation but rapidly gained momentum as citizens adapted to the new process.

SOLUTIONS AND INNOVATIONS

While some of these challenges are still persisting, the state has taken several steps to ensure that feedback received from the field are incorporated into the design and implementation processes. This section details some solutions and innovations that took place during the process :

Iterative Improvements to the P2 Portal

In response to feedback from GPs, the state has implemented several updates to the P2 portal, making the tool more user-friendly and adaptable to local needs. For example, the questionnaire format was revised to separate GP-level data from village-level data, reducing the burden on GPs to provide redundant information.

"When it first started there were problems. Initially, it was only in the PDO login in 23-24 that was given, and only those PDOs who had computer knowledge could do it properly. For those who did not know computers, the DEO did the job using the PDO login. After we completed this process, we gave feedback to the state and there were some changes made. Now, there is a DEO login to enter data for planning." - PP 6, Mysore

"For example, when collecting data on GP building infrastructure, if a GP had three villages, the questionnaire required us to provide GP building information for all three village forms even if all villages did not have a GP building. Since we couldn't leave any fields blank, we were forced to input dummy data. We provided feedback on this issue, which led to a software revision. The questionnaire was then divided into 17 sectors for village-level data, plus an additional 5 sectors specifically for GP infrastructure. These 5 sectors were separated so that the data only needed to be entered once per GP, rather than repeatedly for each village." - PP 6, Mysore

Additionally, the state level discussion noted that the issue of duplication of work due to lack of integration of portal (Refer to Section 4) has been addressed now. The portals have been integrated recently and GPs have to now make the IPPAP in the P2 portal.

Enhanced Training Programs

To address the digital literacy gap, additional training sessions have been offered, focusing on the practical aspects of using the P2 portal. These sessions include hands-on exercises and personalized support from master trainers and MIS (Management Information System) staff, helping GP functionaries become more comfortable with the technology. Workshops supported by CSOs were also conducted to clarify data sources and coordinate with line departments.

Different means of providing training have been experimented with including training available through YouTube, and SATCOM for all committee members in the GP. This way, those who did not attend taluk level training, i.e. GP staff, line department staff etc., were also able to access information and understand the planning process.

ANSSIRD also provided reading materials during the taluk-level training, which were a useful reference when planning began. In Udupi, these materials were distributed to the rest of the planning committee members for further reference which was found useful for those that were literate.

Promoting Local Innovation

Some GPs have successfully innovated within the framework of Perspective Planning. For instance, most GPs have informal networks connecting across the state, where any staff encountering difficulties in the planning process can take immediate assistance from their fellow functionaries present in other GPs. This network has played an integral role in facilitating the planning process. This network has also moved beyond the GPs to levels above.

"*The DEOs got separate training on how to fill in the fields in the planning module by the MIS. I couldn't get it the first time, so I requested another session. The MIS sat with me online, shared his screen and walked me through the operations."* - PP 4, Udupi

KEY OUTCOMES AND SUCCESSES

The perspective planning process integrates various methods to ensure the involvement of all stakeholders in the GP. Following a ground-up approach where the community drives the development agenda for the GP over the next five years, this approach not only strengthens local governance by increasing community involvement in planning but also creates robust mechanisms for holding the government accountable. This planning process fosters greater ownership, transparency, and effectiveness in local governance. This section highlights some key outcomes of effective local governance in the GPs.

Increased Public Participation

The Perspective Planning initiative has significantly enhanced public participation in local governance. The requirement for community consultations at every stage of the planning process has encouraged more citizens to engage with their local government. While there is still some scope for improving public participation in the GPs visited, the fact that the planning process actively encourages the presence of representatives from diverse groups has helped in encouraging voices of marginalised groups, such as women, senior citizens, and SC/ST communities in the GP's plans.

One approach that has seen partial success in boosting participation is enforcing stricter procedures. In Mysore, the GP staff became more assertive in ensuring that issues were raised during the Grama Sabha or Ward Sabha for the works to be considered. People were also encouraged to have their neighbours bring up their problems if they couldn't attend the Sabha. The use of technology for scheduling meetings and marking attendance has further increased the participation of elected representatives in Grama and ward sabhas.

> *"We have to be strict that this problem should be mentioned in the sabha for the work to be done. This increased participation. And also, they would get line depts when their work needs to be done. So, this is very good. It depends on how we also push for people to participate."* - PP 6, Mysore

> *"Because now its online, the proceedings are all recorded. So, this makes people come in. Biometrics have to be taken, if they are not present it is shown online, and the proceedings have to be entered that day only and should be closed. So, this system has made members come."* - PP 6, Mysore

Increased GP Awareness

The primary data collection methods mandated in the planning process have increased the awareness of GP staff and elected representatives about village-specific issues. A PDO in Mysore noted that this approach was particularly beneficial for women elected representatives, who often do not visit and explore each village within the GP otherwise. This has also allowed for better prioritization and planning of works in the GP based on urgency and relevance.

> *"The transect walks were really helpful, we can see what is wrong with the basic infrastructure present on ground. There are a lot of female ERs here in the GP– The campaigning would have*

been done by the men of their family, so they wouldn't know the conditions of the village. This exercise is very helpful for all the ERs and they will get to know a lot about the village. They will only know the road that goes to the city and that goes to their farm. This transect walk helps for them to know all details of the village." - PP 6, Mysore

"Field work gave a lot of interaction- so we also got a lot of data points – was able to visit a lot of places- got an overall picture of the Grama panchayat." - PP 5, Udupi

Improved Coordination and Accountability

The structured and transparent nature of the Perspective Planning process has led to better coordination among various stakeholders, including GP functionaries, line departments, and community members. The use of the P2 portal has also increased accountability, as all stages of the planning process are documented and accessible for review.

Integration of Technology in Local Governance

The successful implementation of the P2 portal in many GPs represents a significant step forward in the integration of technology in local governance. The portal not only streamlines the planning process but also provides a platform for continuous monitoring and evaluation, ensuring that GPs remain on track to achieve their long-term goals.

REPLICABILITY AND SCALABILITY

Tamil Nadu, for instance, also recently introduced five-year plans at the GP level which serves as a foundation for annual action plans (Government of Tamil Nadu, 2016). However, Karnataka was the first to formally codify the five-year planning process within the state's PRA act and providing a comprehensive guideline and structure for the planning process. Karnataka's Perspective Planning initiative offers valuable lessons for others looking to implement similar processes. While the initiative is still iterating, for stronger local government participation, the study found a few key characteristics that are essential for a strong and sustained participation of local governments in planning.

These recommendations are described below:

- **Prioritise Training and Capacity Building:** In order to ensure that the program is successful both in terms of gathering accurate data and prioritising activities, it is critical to ensure that all GP functionaries receive regular and comprehensive training not only in the technical aspects of planning but also in community engagement and data analysis. Innovating with different training techniques including the use of videos and technology can help in ensuring greater reach.
- **Enhance Coordination Mechanisms:** Given the crosscutting nature of the plans, establishing clear lines of communication between GPs and line departments to facilitate data sharing and joint planning efforts can go a long way for ensuring lack of duplication, joint ownership, and convergence and cross-learnings.

- **Complement existing schemes:** Given that many states have existing mechanisms and infrastructure for preparing the GPDP, MGNREGA plans, etc., utilising and expanding on the existing processes will ensure a smooth transition to making long-term vision plans that expand and complement existing annual plans
- **Foster Local Innovation:** At the centre of the initiative is a recognition for localised action. It is, thus, imperative to encourage GPs to develop context-specific solutions and innovations that complement the official planning process.
- **Leverage Technology for Transparency:** Finally, utilising digital tools like the P2 portal can help increase transparency and accountability in the planning process, and ensure that all stakeholders have access to relevant information and can track progress over time. For Karnataka specifically, the sustainability of the program, continued refinement of the P2 portal based on user feedback will help address any remaining challenges and improve the overall usability of the tool.

CONCLUSION

The *Dooradrushti Yojane* Initiative marks a significant step toward introducing long-term planning at the Grama Panchayat (GP) level. By focusing on comprehensive local development, this initiative sets a strong example for other states to streamline resources and advance their long-term development objectives. The initiative promotes public participation in local governance and enables the efficient use of resources by converging existing efforts into a cohesive and comprehensive framework. It offers a unique model of local planning, allowing GPs to set long-term goals and implement activities accordingly.

In the coming years, we are hopeful that there will be greater opportunities for improving training, capacity building, coordination, and public involvement in the planning process. This will ensure that the planning process remains efficient, and impactful for GP development.

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Conclusion

This report consolidates five case studies on the emerging initiatives of RDPR, Karnataka. These initiatives have been critical for strengthening grassroots ownership in rural development. It is also promising to witness a change in the state's lens towards building grassroots mobilisation for achieving positive outcomes in education, livelihoods, women and child health and nutrition, sanitation, and data management.

Our first case study on **Rural Libraries** presents how community involvement and inclusivity can promote and build learning and reading practices in GPs. Our second case study on **Koosina Mane** highlights how the state can promote rural women's workforce participation while also supporting children's nutritional needs at early stages of development. Our third case study on **Solid Waste Management** highlights the importance of localising waste management practices and also supporting alternative livelihood sources for rural women by tapping into existing community structures. Our fourth case study on **Health Screening** further pushes the role of GPs, along with other actors in health department, in promoting positive health outcomes. Finally, our fifth case study on **Perspective Planning** shows how efficient data management practices can ease monitoring and promote transparency in delivery of welfare services.

Thus, through these case studies, we have presented the key learnings from Karnataka's innovatory convergence practices and resource management which other states in the country can leverage and build upon. Our observations, spread across several months of immersive fieldwork, can further support RDPR's vision to sustain these initiatives in the coming years.

Annexures

Annexure 1 (Koosina Mane)

Table 1: Parameters of Analysis

Institutional Structure
1. What are the current pathways of planning and coordination under the scheme?
2. Which actors are involved in the vision, decision making, and day-to-day operations of the scheme?
3. What does the feedback channel look like?
4. What are the primary sources of funding under the scheme?
5. How much money has been assigned, released, and utilised for implementation?
Training
6. Which actors are involved in training?
7. How is training conducted?
8. What are the different components of training?
Creche Operations
9. Which actors manage the day-to-day operations of the creche?
10. How do these operations look like?
11. What kinds of challenges have emerged during creche operations?

Table 2: Committees across Various Levels

Level	Committee Members	Roles and Responsibilities
State	• Deputy Chief Secretary (PR) • Secretaries (WCD) • Commissioner (RDPR) • Director (WCD)	• Issuing orders and guidelines • Facilitating monitoring using Panchatantra 2.0 • Determining actions to support the centres

	• Campaign Director (Livelihood Campaign) • Campaign Director (National Health Campaign, National Health Mission) • Director (E-Governance, RD) • Mobile Creches (Delhi) • CRISP (Bangalore) • Director (Development, PR)	
State	• Commissioner (PR) • Commissioner (MGNREGA, RD) • Representative from Mobile Creches • Representative from Contact Services Agency • Representative from CRISP • Director (Development, PR)	• Developing the implementation strategy for decentralisation and capacity building at all levels. • Providing human and financial resources. • Ensuring the functioning of social audits, public information, and grievance redressal. • Issuing orders and circulars. • Carrying out monthly progress reviews and conducting meetings with CEOs in ZPs
District	• CEOs (ZP) • District Reproductive and Child Health Officers • Deputy Director (WCD) • Secretaries (MGNREGA) • Head of the NGO selected by Mobile Creches • President (Zila Stree Shakti Union/Zila Panchayat Federation)	• Determining the list of food items, its nutritional components and distribution across centres • Identifying master trainers • Conducting monthly progress review meetings
Taluk	• Executive Officers • Child Development Officers • Assistant Director (RD) • Health Officer • National Rural Livelihoods Mission (NRLM) Coordinator	• Identifying eligible GPs for building creches. • Setting up an advice box for grievance redressal • Ensuring timely distribution of food items. • Identifying master trainers

	• Head of voluntary organisation selected by Mobile Creches • President (Taluk Stree Shakti Union/Taluk Panchayat Federation) • Assistant Director (PR)	• Conducting monthly progress review meetings
GP	• GP President • ICDS Supervisor • Headmasters of Government Schools • Primary Health Care Officers • Caretakers • Anganwadi Worker • President (GP Women's Union) • Parents of Beneficiaries • PDO	• Reviewing the progress of the creche as per the guidelines issued by the GP and providing guidance and advice • Identifying and ensuring training of caretakers. • Recommending food list to the District Committee • Conducting monthly progress review meetings

Source: Scheme guidelines

Annexure 2 (Health Screening)

Table 3: Parameters of Analysis

Institutional Structure
1. Which stakeholders are involved and how do they coordinate with each other?
2. How is the program funded?
3. How are capacities of the stakeholders built for implementing the program?
4. How is the program monitored and evaluated?
Health Screening Implementation
1. How are health camps planned?
2. Which functionaries are involved in conducting screenings?
3. What are the components of the health kits?
4. How are health screenings conducted?
5. What happens to the data collected during the health screening?

Table 4: Members of the Grama Panchayat Task Force

Functionary	Designation
Adhyaksh	Head
Panchayat Development Officer	Member
1 Elected Representative from each village	Member
Librarian	Member
ASHA worker	Member
ANM	Member
CHO	Member
School Headmaster	Member
Community members from SHGs	Member

Annexure 3 (Perspective Planning)

Table 5: Planning committee members

Planning committee	Responsibilities
Village Planning committee: • **Ward members of the village** • **Elected members of the village** • **Officers and staff of other depts in the village (Anganwadi, ASHA workers, Teachers of the village)** • **Interested Local retired officer/Staff** • **Subject matter experts (if any)** • **Active members of SHGs** • **Village resource person** • **GS or PDO**	- Coordinate with village level department officers/staff to collect information (ASHA, AWW, Teachers etc.) - Organize FGDs for all sectors (E.g. Women's group to discuss women's health needs, children's group to discuss education, farmers to discuss agriculture and other needs etc) - Facilitate FGDs to ensure a proper discussion - Conduct PRAs, transect walks, social and resource mapping - Organize ward sabhas and *Janavasthi* (Habitation) Sabhas to finalize the information collected in the steps above.
Grama Panchayat planning and monitoring committee:	- Consolidate information received at the village level to the GP level

• **GP President** • **Vice President and all members** • **President and Secretary GPLF** • **Office/staff of other development department of GP** • **Interested local retired officer/employee for 8 zones (one per zone)** • **Subject matter experts for 8 zones (one per zone)** • **Representatives of SHGs, NGOs/CBOs.** • **VRPs** • **PDO**	- Analyse the condition of the GP using secondary and primary data collected - Set targets to be achieved by the GP in the next 5 years and identify implementation timelines for it. - Identify activities to be done and the responsible line departments and committees for it. - Identify the activities that involve cost and estimate the costs for each activity. - Prepare the above process for all 8 sectors - Draft the vision plan with the above information

Source: Training material (Government of Karnataka, 2022b)

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