Short Communication

Leveraging Local Self-Government for Implementing Cancer Screening and Continuum of Care – A Model from Kerala State, India

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The emergence of cancer as a major public health problem in India has raised concerns among policymakers regarding reducing cancer-related morbidity, mortality, and catastrophic treatment expenditure. Along with increasing awareness of cancer warning signs, early detection offers immense scope, particularly for common cancers of the breast, cervix, and oral cavity. Local Self Governments (LSG) can play a prominent role by allocating funds for cancer prevention, infrastructure strengthening of primary health centres for screening and training healthcare providers. Yet another screening model implemented in an LSG in the Thiruvananthapuram district, Kerala, involved sensitizing elected representatives, resulting in dedicated plan funds not only for cancer screening, but also for expenses related to follow-up investigation at the nearest Apex Cancer Centre (ACC). In collaboration with the Preventive Oncology Wing of the ACC, the LSG implemented community-based screening, followed by diagnostic evaluation at the ACC. 4,717 individuals were screened through 53 screening programmes. 237 screen-positive subjects completed follow-up investigations at the ACC using project funds. This model demonstrates that enhancing awareness and strengthening the capacity of LSG's on their role in prevention, early detection, and continuum of care may substantially improve the effectiveness and sustainability of cancer control initiatives in the country.

Access this article online

Website: www.cijmr.com

DOI: 10.58999/cijmr.v5i03.481

Keywords: Cancer screening, Local-self-government, Follow-up Investigation expenses, Kerala

Introduction

The burden of cancer is increasing globally, and its effects are also evident in India, despite the fact that nearly 70% of these cancers are attributed to risk factors that are preventable and, to a major extent, modifiable as well (1). The fifth round of the National Family Health Survey (NFHS-5) has reported alarming findings on the prevalence of subjects who had undergone screening in India. It was reported that female cancer screening for breast and cervical cancers was 0.9 and 1.9%, respectively, whereas for oral cancer, the prevalence was 0.9%. Among males, 1.2% underwent oral cancer screening (2). Considering the cancer burden in India, integrating primary prevention and early detection measures assumes significance due to its cost-effectiveness, mortality reduction, and improved quality of life. In spite of all this available information, controlling common cancers, namely breast, cervix, and oral cancers, remains an elusive goal. Fear of being diagnosed and financial concerns have been reported to be barriers for screening in addition to the psychosocial barriers prevailing in the community (3). Coordinated measures to control the problem require the efforts of health care providers and policy makers.

Kerala State, in the southwest corner of India, representing 3% of the total population of the country, has been globally acknowledged for its health system, universal coverage, and a robust mechanism for strengthening primary health care (4). However, the increase in cancer along with other non-communicable diseases in recent years in the state points to the challenges that the health systems have to endure in the state. It was estimated that around 82,250 new cancer cases had occurred in the state in the year 2021 (5). Kerala has taken considerable strides in implementing welfare programmes for society. In 1994, the Kerala State Assembly enacted the Kerala Panchayat Raj Act on the

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Submitted: 18/07/2026 Revision: 22/07/2026
Accepted: 04/08/2026 Published: 25/09/2026

How to cite this article: Jayakrishnan R, Chennath KM, Thomas G. Leveraging Local Self-Government for Implementing Cancer Screening and Continuum of Care – A Model from Kerala State, India. Central India Journal of Medical Research. 2026; 5(3):132-134.

basis of the 73rd and 74th constitutional amendments (6). This was considered a milestone in the development of Kerala, as it empowered Local Self Governments (LSGD) with dedicated funds for development projects, including disease prevention, on the basis of decentralized planning and implementation of welfare schemes for society. The Kerala Cancer Control Strategy for the period 2018-2030 is a major initiative of the Government of Kerala that provided a framework for cancer control activities in the state (5). The strategy also emphasized the role of a decentralized mechanism for cancer control and for screening of common cancers. As a result, District Cancer Control Committees have been constituted in all districts with the District Collector as Chairman and District Panchayath President as the patron. This reiterates the significance of LSGD in demonstrating leadership and governance to reduce cancer burden in the state.

Cancer screening programmes have been conducted by LSGD's in Kerala as part of the budget allocation for health projects necessitated by each one of them. The programmes were mostly done for screening of common cancers; however, adequate attention was not given to follow-up care activities. The net outcome had been a base-level screening without a continuum of care, as subjects either refused or delayed diagnostic evaluation. It is in this context that a Local Self Government in Kerala stepped forward to allocate funds not only for screening but also for follow-up investigations for those in need.

A Local Self Government body located in the suburbs of Thiruvananthapuram City, the Capital of Kerala, has taken the initiative to conduct cancer screening for residents of the Block Panchayath area. The block has five grama panchayaths comprising 97 wards (lowest administrative system) with a total population of 170,973 (7). The screening project envisaged by the Block Panchayath was implemented as a pilot initiative which aims to encourage the community to take part in health initiatives of the LSGD. Furthermore, the project intended to give a message that expenses for follow-up investigations should not be a barrier for individuals seeking diagnostic evaluation to rule out the disease.

The Block Panchayath allocated an annual fund for cancer screening and follow-up investigations at the ACC. Since the ACC is a public sector cancer centre located in Thiruvananthapuram district, a Memorandum of Understanding (MoU) was signed between administrative heads of the institutions in the year 2022. The purpose of this MoU was to establish a mutual framework governing the relationship between the two parties, with specific reference to their responsibilities and the associated activities. This includes expenses for conducting screening programmes in the community, and furthermore, the project ensured that follow-up investigation expenses to a maximum of Indian rupees 10,000 per subject could be covered from this fund. To avail this facility, a referral letter approved by the panchayath member and the doctor in charge of the screening programme was required, while visiting the ACC. Local hospitality related to screening programmes was organized by the Block panchayath separately.

In the initial phase, the respective Grama Panchayaths conducted meetings to identify wards to be chosen for each programme. The focus was on conducting screening for two adjacent wards at a time. Once the wards were selected, the panchayath officials coordinated with the local residence association officials, community volunteers and religious groups through Accredited Social Health Activists (ASHA) working in that area for choosing the venue and suitable dates. ASHAs are health workers from the local community engaged in understanding health-related problems in the community at the field level and to form a linkage between the community and the health systems (8). ASHAs of the selected wards were entrusted to sensitize households on the importance of the screening programme and were invited to participate in camps. The technical aspect of the programme was coordinated and supervised by the Community Oncology Division of the ACC. In the beginning of each programme, the faculty from the Division of Community Oncology conducted short awareness sessions on oral, breast and cervical cancers and an insight into the screening process.

A total of 53 cancer screening programmes were conducted in five panchayths under the block Panchayth focusing on oral, breast and cervical cancer screening. 4717 subjects attended the screening programme. On average, 85 to 125 subjects attended each screening programme. Clinically confirmed cases were referred to the respective clinics of the ACC for further evaluation and management. For subjects who were already enrolled in government health insurance schemes, treatment was given free of cost. Subjects who were not part of the scheme were registered into the scheme by the ACC. For follow-up investigations, 237 subjects were identified and referred to the ACC. The diagnostic procedures, including mammography, ultrasonography of the breast, Fine Needle Aspiration Cytology, colposcopy examination

for visualizing the cervix, Human Papillomavirus DNA test, and oral biopsy, were provided free of charge for the subjects. 201 subjects referred for further investigation reported to the Community Oncology Division of the ACC.

The cancer screening and continuum model is an illustration of how resilient the local self-government, community volunteers, health care workers and the screening team can be in creating a method that can be replicated, as long as a multistakeholder mechanism is in place to operationalize the process. Local Self Governments may collaborate with centres for screening and diagnostic evaluation facilities to implement similar initiatives across any state in India. The community has to engage with the Local Self Government in a mutually beneficial manner to understand the policy choices available and utilize the resources available to reduce the cancer burden.

Author's Contribution

First author: Concept and manuscript preparation
Second author : Manuscript design, review and editing
Third author: Manuscript review and editing

Conflict of interest

None.

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