

# **PEOPLE'S CAMPAIGN FOR NINTH PLAN**

*AN ANALYSIS OF HEALTH SECTOR PROJECTS PREPARED BY  
GRAMA PANCHAYATS OF THIRUVANANTHAPURAM DISTRICT*

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## **CERTIFICATE**

This is to certify that the study entitled '*People's Campaign for Ninth Plan - An analysis of health sector projects prepared by grama panchayats of Thiruvananthapuram district*' was done by Joy Elamon, under our guidance, in partial fulfilment of the regulation laid by the Sree Chithra Tirunal Institute for Medical Sciences and Technology for the award of Master of Public Health Degree Examination, 1997-1998.

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Dated 30.6.1998.



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# CHAPTER 1

## INTRODUCTION

### 1.1 HEALTH STATUS OF KERALA

The achievements of Kerala in the field of health have been widely acknowledged. Its status in terms of health indicators like crude death rate, infant mortality rate, child mortality rate, birth rate, and life expectancy are on par with even that of many developed countries. It has a crude death rate of 6.3 per 1000 population, infant mortality rate of 13 per 1000 live births, birth rate of 17.7 per 1000 population and life expectancy of 68.6 years for males and 72.3 years for females<sup>1</sup>. Therefore, it has already achieved the 'Health for All by 2000' goals and its general health scenario is considered to be the best among the major Indian states. Kerala is one of the economically 'backward' states in India in terms of GNP growth, yet, for the past thirty years, its governments have given high priority to basic needs such as drinking water, sanitation, housing, health and education. As a result, this state has outpaced the rest of the country in terms of health and education attainments<sup>2,3</sup>. Kerala has also achieved the country's lowest fertility rates. It can be said to have made the transition from a society with high population growth, high crude death rate and relatively high infant mortality rate to one with moderate population growth rate (almost near to zero replacement), low crude death rate and relatively low infant mortality rate. That this has come about without major economic restructuring of the society, especially that of the state income and economic productivity, sets it apart as a model of what is possible, within the severe constraints to development<sup>4</sup>.

## 1.2 SOCIAL INTERMEDIATION PROCESS AND HEALTH

The present state of Kerala was formed in 1956 by integrating the erstwhile princely states of Travancore and Cochin with Malabar district of former Madras Presidency. It is to be noted that at the time of formation of Kerala State, health status of population of these regions varied widely, with Travancore and Cochin having much lower levels of mortality and higher life expectancies than Malabar<sup>5</sup>. The significance of the Kerala experience lies in the fact that these differentials could be narrowed down and further improvements could be made in a short time period of less than three and a half decades.

Population, environment, genome and social organisation are now considered as the basic determinants of health<sup>6</sup>. This model is in agreement with the view expressed by McKeon on the vital influence of socio-economic environment on health<sup>7</sup>. Two different studies, one by Krishnan and Kabeer<sup>5</sup> and the other by Kerala Sasthra Sahithya Parishad<sup>8</sup> highlight this as one of the major factors responsible for the achievements of Kerala in health sector. The former points out that "It might be feasible to bring about health and demographic transitions in such societies within a period of about 35 years if an appropriate mix of social policies in conjunction with the development of health infrastructure are implemented vigorously". Panikar and Soman are of the opinion that "... the initial breakthrough in mortality decline had occurred before the concept of development became articulated in government policies"<sup>9</sup>. They go on to add "The improvement of health status seems to be attributable more to the expansion of medicare facilities rather than to the effects of development policies".

Other researchers have considered both these views and conclude that there are many socio-economic factors unique to Kerala, which have made Kerala's health model possible. Kerala has a higher level of literacy when compared to other Indian states. This is especially true of female literacy. This factor is also reflected in its low infant mortality rate. All over the world, indices such as infant mortality have shown an inverse relationship with female literacy<sup>10</sup>.

Kerala has a political climate wherein the rights of the poor and the underprivileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms emphasising the dignity of people who were considered socially 'inferior', which later found expression in secular- democratic movements culminating in nationalist and socialist movements<sup>11,12</sup>. One common thrust of all such movements was on education and organisation of the downtrodden people<sup>13</sup>. The implementation of land reforms has benefited many a number of Kerala farmers, who no longer work for the feudal landlords<sup>14</sup>. Kerala has also better road transport compared to other Indian states<sup>15</sup>. The public distribution system of food through fair-priced ration shops distributed throughout Kerala assures minimum food materials at relatively cheap cost to the people<sup>16</sup>. This has assured a certain amount of nutritional status to the poor, warding off poverty related diseases to some extent. Apart from these socio- economic factors, the universally available public health system in Kerala has also contributed to the high health status of the people.

### 1.3 EVOLVING CHALLENGES IN THE HEALTH SECTOR IN KERALA

A complementary advance in the productive sectors has not accompanied the above advances in social sectors. Unemployment has increased and inflation is affecting living standards<sup>17,18</sup>. Divergence between low child mortality rates and quality of life indicators is true of Kerala, which is similar to other countries like Sri Lanka and Costa Rica. Although child nutrition is better than in neighbouring states, prevalence of high rates of growth retardation and low birth weight babies suggests that significant and widespread undernutrition persists in Kerala. A Rockefeller study noted that rates of illness appear to have declined only in those diseases, which can be prevented by immunisation<sup>19</sup>.

Another interesting feature evolving is the phenomenon of low overall mortality co-existing with considerable morbidity, mostly caused by diseases linked to underdevelopment and poverty. This has been proved beyond doubt by the surveys conducted by Kerala Sasthra Sahithya Parishad<sup>8</sup> and National Sample Survey Organization<sup>20</sup>. The former points out that the Kerala situation is peculiar in that there is co-existence of infectious diseases like diarrhoea, hepatitis and tuberculosis with that of non-communicable diseases or life style diseases like cancer and heart diseases. A repeat survey conducted ten years after the first shows that there has been an improvement in basic facilities like latrines, drinking water etc. over the last ten years<sup>21</sup>. This is reflected in the decrease in communicable diseases like diarrhoea. But, there is a growing menace of emerging and re-emerging infectious diseases like malaria, cholera, Japanese B

encephalitis and leptospirosis. It is to be noted that they have emerged in certain localised regions and not the state as a whole. Apart from these are the impacts expected from Acquired Immuno Deficiency Syndrome (AIDS) and hepatitis.

The public health system in Kerala is becoming increasingly less important and only 30% of the people are seeking medical care from government hospitals<sup>21</sup>. The number of beds in government institutions grew from around 36000 to 38000 in the ten year period from 1986 to 1996 whereas in the same period, beds in the private sector grew from 49000 to 67500<sup>22, 23</sup>. This amounts to nearly 40% growth in the private sector beds in a period of ten years as against 5.5 % in the government sector. More significantly, private sector has far outpaced the government facilities in the provision of sophisticated modalities of therapy such as CT scans, MRI scans etc.

It is true that public expenditure on health care in Kerala registered a significant and steady increase over the years<sup>24,25</sup>. The state government expenditure on health also went up over the years. However, the percentage of outlay on health to total plan outlay from the Fifth Five-Year Plan to Eighth Five-Year Plan ranged between 2.19 to 1.4. Revenue expenditure on health as percentage of total government expenditure, in fact, decreased from 10.41 in 1966 to 8.5 in 1985. In the primary level of healthcare, almost 77% of the total revenue expenditure on curative services are being spent on salaries and this percentage is 96 at the secondary level, which includes the Taluk and District hospitals. At the tertiary level, which consists of institutions like medical colleges, the spending on salaries is 83% of the total revenue expenditure in health. This has prevented the

introduction of any qualitative advancement in healthcare services<sup>26</sup>. Even though the state was going through a period of fiscal crisis<sup>27</sup>, share in expenditure on health had not gone down much. Yet, the growth of salary component has eaten up this share and has prevented any increase in capital expenditure and expenditure on medicines and other supplies<sup>28</sup>. It is in this situation that the private sector has expanded to a large extent in the health scenario of the state. The expansion of the private sector has led to an increase in out of pocket health care expenditure<sup>29</sup>.

The hallmarks of Kerala model were low cost of health care and its universal accessibility and availability even to the poorer sections of the society. The changing health scenario, as discussed earlier, is posing challenges to this model. These challenges can be summarised as follows:

1. The re-emergence of infectious diseases and the emergence of life style related diseases and their simultaneous presence.
2. Stagnation in the growth of public health care system.
3. Escalation of healthcare expenditure, especially out-of-pocket expenses leading to marginalisation of the poor.

The solutions to these challenges include improvement in quality of services with added emphasis on disease prevention and health promotion, improvement in infrastructural facilities in public health system and locally specific interventions. The Panchayat Raj (see annexure 1 for glossary of terms) now provides an opportunity for the people to demand the resources to operate a health service in which the people themselves will play the dominant role and of which they will be the chief beneficiaries. All the primary and secondary level health care institutions

in the state have been transferred to the local bodies. In addition to this is the ongoing People's Campaign for Decentralised Planning, which has earmarked 35-40% of the State's plan fund for local bodies. This has opened up a tremendous scope for facing the challenges to the Kerala model of health. The possibilities that are opened up are:

1. The control of infectious diseases and even the prevention, early detection and management of life style diseases can be achieved only by strengthening the primary and secondary level health care facilities. With the local bodies in control, this can be achieved with better community involvement.
2. Once the primary and secondary health care facilities are improved through local bodies, the tertiary care centres like the medical colleges can entirely concentrate on medical education, research, and tertiary health care.
3. The problem of resource constraints in health sector can be solved with a more need-based reallocation of resources and generating local resources through community participation.
4. A better relationship between the health workers, people's representatives, and people at large can be accomplished.
5. Once the public health system is improved, the poor who cannot afford the private health services will be benefited and social equity in health care will be re established.
6. Other determinants of health like drinking water, sanitation, housing etc. can be looked into in a more comprehensive and integrated way.

#### **1.4 CONCEPT OF DECENTRALISATION IN HEALTH SECTOR**

Decentralisation can be defined as "... the transfer of authority, or dispersal of power, in public planning, management, and decision making from the national level to subnational levels, or from higher to lower levels of government" <sup>30</sup>. The World Bank and World Health Organisation have put forward the idea of decentralisation in health

sector in different contexts. In the book titled 'Formulating Strategies for Health for All by the Year 2000' published by World Health Organisation, it is stated that "... (countries) may wish to assess the degree to which they need to strengthen local and intermediate levels of the national administration, by means of delegation of responsibility and authority to the community and to intermediate levels as appropriate, and by the provision of sufficient manpower and resources" <sup>31</sup>.

The World Bank concept of decentralisation is a little different. Since many governments cannot afford any major improvement or expansion of health services, in order to seek alternative sources of financing and for alternative ways of providing health services, the World Bank suggests the concept of decentralisation within the health system<sup>32</sup>. There have been a number of experiments world-wide in health system decentralisation. It has taken different forms, depending on the political and administrative structures prevailing in the country and also on the pattern of the health system existing in the country. Any such attempt at decentralisation in the health system has to consider the extent of functions decentralised, mechanisms of community participation, the sources of finance at the local levels, the approach to planning, the attitude of bureaucracy and political leadership and methods of inter-departmental and inter-sectoral coordination<sup>33</sup>. There have been attempts at health system decentralisation in countries like Botswana, Chile, Mexico, Netherlands, New Zealand, Papua New Guinea, Senegal, Spain, Sri Lanka, and Yugoslavia. Each of these countries had their own type of health system and its own method of decentralisation. It is not that every thing has gone smoothly and well with these strategies. A lot of achievements have been made in many countries and a lot of problems have also crept in.

In India also, there have been attempts at health sector decentralisation. Non-governmental organisations in various parts of the country have tried to introduce the concept of decentralisation in health sector<sup>34</sup>. On the whole, they were initiatives for community involvement in health activities rather than the concept of decentralisation we have discussed earlier. Moreover, these activities were at a very micro level, involving a few villages or so. Some of them have shown beyond doubt that community involvement helps in the improvement of the health status of the population. But in many cases, the sustainability of the programme was proved to be doubtful. Some of the state governments have also initiated the decentralisation process. Noteworthy examples include the states of Karnataka, West Bengal and Rajasthan. However, we cannot be sure that there was any visible improvement in the health service all over these states as a result of decentralisation. The analysis of these experiences by various researchers has pointed to the fact that decentralisation of the health services cannot be conceived or implemented without an overall policy of decentralisation<sup>35</sup>. Since decentralisation is concerned with the distribution of power and allocation of resources, it has larger political dimensions. There were attempts by different governments to decentralise administrative procedures without transferring the power for policy, legislation, and budgetary activities<sup>36</sup>. It is here that the decentralisation experiment in Kerala differs, where the power and resources to formulate the programmes for the future have been transferred to the local bodies.

It is in this context that this study critically evaluates the decentralised planning process in health and related sector being carried out at the grama panchayats of Thiruvananthapuram district of Kerala State.

## 1.5 OBJECTIVES

*The specific objectives of this study are:*

1. To analyse the process of decentralised planning in health and related sectors being undertaken by the grama panchayats in Thiruvananthapuram district,
2. To evaluate the problems and needs faced in the rural areas of the district as perceived by the people and raised in the grama sabhas,
3. To evaluate the projects in health and related sectors that have evolved through the decentralised planning process in the district, and
4. To critically analyse the pattern of allocation of resources and mobilisation of resources for health sector projects prepared by the grama panchayats in Thiruvananthapuram district.

## 1.6 SCOPE AND FOCUS

The study will focus on all the 84 grama panchayats of Thiruvananthapuram district in Kerala. We will consider the process of decentralised planning which includes the grama sabhas (Panchayat ward level meetings of people), secondary data collection, development reports, projectisation and plan formulation with respect to health and related sub-sectors. Related sub-sectors are defined as the areas, which have direct relevance to health like drinking water, sanitation, health education, and other disease prevention activities. It will also consider the financial aspects of the plan proposals with respect to resource mobilisation and resource allocation to each sub-sector.

During the period when this study was conducted, the grama panchayats had not completed the implementation of the first annual plan and so, only the

proposals prepared by them for the first annual plan are being brought under the purview of this study. The study only covers the planning process in the grama panchayats and not the higher tiers of local bodies like the block and district panchayats. The focus is on the decentralised planning process, as part of the People's Campaign for Ninth Plan and the study will not go into the details of decentralisation in the State Health Services as such.

## 2.1.1 Scope of the study

### 2.1.1.1 PROCEDURE

The study was conducted in the following manner. A list of grama panchayats was prepared in the district under the supervision of the District Planning Officer. A sample of 10 grama panchayats was selected from the list. The State Planning Board for People's Campaign for Ninth Plan was approached for the purpose of the study. The Board was informed about the study and the purpose of the study. The Board was requested to provide the necessary facilities for the study. The Board was also requested to provide the necessary data for the study. The Board was also requested to provide the necessary facilities for the study.

### 2.1.1.2 Focus group

The sample population of the study was the people who participated in the planning process in the grama panchayats. The study was conducted in the following manner. A list of grama panchayats was prepared in the district under the supervision of the District Planning Officer. A sample of 10 grama panchayats was selected from the list. The State Planning Board for People's Campaign for Ninth Plan was approached for the purpose of the study. The Board was informed about the study and the purpose of the study. The Board was requested to provide the necessary facilities for the study. The Board was also requested to provide the necessary data for the study. The Board was also requested to provide the necessary facilities for the study.

## CHAPTER 2

### METHODOLOGY

The study is divided broadly into three parts. The first part deals with the process of decentralised planning in health sector. The second part deals with the health problems of rural Thiruvananthapuram as perceived by people. Analysis of plans in terms of resources is considered in the third part.

#### 2.1 PROCESS OF DECENTRALISED PLANNING

Methods used in this part include focus group discussions, key informant interviews, review of development reports prepared by all the 84 grama panchayats of the district (annexure 2), various publications and training manuals prepared by the State Planning Board for People's Campaign for Ninth Plan (annexure 3) and by participating in a number of grama sabhas, training sessions and evaluation meetings.

##### 2.1.1 Focus group discussions

**Sample:**

The sample population for the study was the population of Thiruvananthapuram district living in the grama panchayat areas. However there was exceptions to this, as there were focus groups consisting of volunteers and employees working at the Planning cell of the State Planning Board. The sample was chosen non-randomly to access a range of diversity. Lines of variation included gender, age, employment status and role in the planning process. 160 persons were involved in twenty four focus group discussions. There were 95 males and 65 females. The mean age of

these people was 45 and the median age was 48. 102 of them were employed, 20 had retired from service and 38 of them were unemployed. Among the employed, school teachers came out as the largest single group. 120 of the participants were involved in the decentralised planning process in some way or other. Inside each focus group, the participants knew each other, except in the case of the groups of task force members and Key Resource Persons. The detailed break-up of each category of focus groups is given in Table 2.1.

### ***The process of conducting focus groups:***

1. *Sample selection strategies:* We have used four different strategies for sample selection. They are 'Piggyback focus groups', 'On-location groups', 'Nominations' and 'Snowball samples'.
  - a. *Piggyback focus groups:* Participants in four of the focus groups were selected by this method where participants had gathered for some other purposes and during the leisure time, the focus group discussions were held.
  - b. *On-location groups:* By location is meant the activities connected with the People's Campaign for Ninth Plan. Seven of the focus groups were formed and conducted while the people had come for programmes like grama sabha, training, faculty meeting or review meeting.
  - c. *Nominations:* Neutral parties like locally acceptable teachers, community leaders and Non Governmental Organisation activists were contacted to give names of people who could be included in specific focus groups. Two of the focus groups were formed like this. The group consisting of staff of the Planning Cell at the State Planning Board was formed as per the suggestions given by one of the Planning Board members.
  - d. *Snowball samples:* While forming four of the focus groups, sampling strategy used is a minor variation of the 'nomination' method, where some of those

people who have already participated in the focus group discussions were asked to give suggestions on who are to be called for the next focus group discussions.

**Table 2.1**

**List of focus groups and their characteristics**

Character	No. of groups	Selection strategy	No of participants	Male/ Female	Mean age	Employment status	Role in decentralised planning
Elected members of grama panchayats	1	On- location	7	5 males 2 female	40 years	2 were employed	as elected representatives, one person was also a KRP
Participants in the Grama sabhas	4	2 were On- location, 1 Snowball, 1 Nomination	30	21 males 9 females	45 years	16 were employed	participated in the grama sabhas
Task force members	4	On - location	26	21 males 5 females	50 years	5 employed 15 retired	task force members
Key Resource Persons	2	On- location	15	13 male 2 female	40 years	10 employed 2 retired	key resource persons
Not associated with the Programme	3	2 Snowball 1 Piggyback	29	18 males 11 female	42 years	10 employed 3 retired	
Staff of Planning Cell at State Planning Board	1	Nomination	8	5 males 3 females	41 years	All employed	
Anganwadi workers	1	Piggyback	7	7 females	30 years	Employed	2 participated in the grama sabhas
Doctors	1	On- location	6	All males	45 years	Employed	2 task force members
Para medical staff of PHCs	1	Piggyback	8	4 males 4 females	40 years	Employed	2 participated in gramasabha 2 taskforce members
Academicians Associated with the Programmeme	1	Piggyback	5	4 males 1 female	50 years		as faculty members
Women's groups	3	1 Piggyback 1 On-location 1 Snowball	20	All Females	38 years	15 employed	2KRPs 12 participated in the grama sabhas
Panchayat level govt. officers	1	On -location	5	All males	45 years	All employed	taskforce members
Doctors of other Systems of Medicine	1	Snowball	5	All males	36 years	All employed	2 taskforce members
<b>Total</b>	<b>24</b>		<b>160</b>				

**Rationale for selecting these groups:**

The sample population is being categorised into three groups- advisory/ decision making group, employees or programme implementing group and the actual beneficiaries. The first group consists of the elected representatives of the

grama sabhas and academicians who were associated with the People's Campaign for Ninth Plan. By employees or programme implementing group is meant the employees who actually deliver the programme and services like the doctors, paramedics, staff at the State Planning Board, task force members, key resource persons and anganwadi workers. The actual beneficiaries are included in the groups of those who have attended the grama sabhas, those who have not associated with the decentralised planning process and the women only groups. Separate women's groups were conducted so that they would not be sidelined in discussions where more vocal males participate. But, all other groups were mixed groups where both males and females were participants.

### ***Conducting the discussions***

In all the focus group discussions, the investigator himself was the moderator. In most of the occasions, the discussions were conducted at public places like auditoriums, classrooms of schools, some offices and Primary Health Centres. Three of the focus groups met at houses of one of the participants. Two of them were women only groups and the place was so fixed at the request of the participants. The third one was a group of those who had participated in the grama sabha and it was conducted at the house of one of the participants due to the power failure in the classroom of the school. The focus group discussions were suspended for some time during February-March, 1998 due to the General elections to the Parliament. The people were reluctant to participate in the discussions at that time and local level political party leaders doubted the apolitical motives behind these discussions. Two weeks after the declaration of the results,

people were very co-operative, irrespective of their party affiliations. Purposeful small talk and pre-session activities like filling up the registration forms were conducted which made the participants comfortable during the discussions. The sessions began with pre-determined open-ended questions by the moderator, but as the discussions went on, different and new points of view were expressed. The questions in general were regarding the process of decentralised planning, the activities so far, the constraints faced, the expectations and the suggestions for improvement and correction. Recording the focus group discussions was through written notes. In a few of the sessions, an assistant was there to help in writing down the notes. But, on the whole, the moderator himself had taken down the notes. This had hampered the flow of discussions in a few occasions. The strategy used was to make a note of the points raised at the time and, after the discussion was over, they were elaborated upon. One or two participants used to assist me at this stage, so that not much was missed.

#### ***Analysis of the reports of focus group discussions:***

After the discussions were over, the contents in the reports were categorised into: 1) the process of decentralised planning which includes the conduct of grama sabhas, secondary data collection, writing of development reports, development seminars, task forces and how they have prepared the projects, prioritisation of the projects and plan formulation, 2) opinion of the participants about these activities, and 3) their expectation, suggestions and comments about the programme.

## ***Pilot testing of focus group discussions***

It was difficult to pilot test the focus group discussions as in the case of quantitative surveys. Moreover, each group is different from one another and the questions and discussions varied across groups. But, an effort was taken to pilot test the focus group discussions. In the first interview, an expert was there to observe and to assist in the discussion. After the second focus group discussion, the questions used and the reports were presented before a panel consisting of three experts and two participants from the previous focus group. The suggestions evolved in this meeting were incorporated in further focus group discussions. The first two discussions were not included for analysis.

### **2.1.2 Key Informant Interviews**

Key informant interviews were envisaged to gather further information regarding the People's Campaign for Ninth Plan. A total of sixteen persons were interviewed as key informants. This was needed because each of them was involved in different aspects of the programme. Several rounds of interviews were conducted so as to clear the doubts evolved while conducting the focus group discussions and also while reading the publications of the State Planning Board. The questions were generally on the conceptual framework of decentralised planning, health system in the state, financial aspects of planning, transfer of power to the local bodies, administrative changes involved in decentralisation and local level planning, doubts and fears raised by the people and the media, future

activities, resource mobilisation and the areas which needed correction in decentralised planning process.

### ***List of Key Informants***

1. Members of the State Planning Board	3
2. Consultants at State Planning Board	3
3. Elected representatives	2
4. Key Resource Persons of People's Campaign	4
5. Panchayat co-ordinators of People's Campaign	4

### **2.1.3 Review of development reports**

There are 84 grama panchayats in Thiruvananthapuram district and each of them had prepared development reports which carried the details about their panchayats and also the activities they had carried out during the People's Campaign for Ninth Plan. On an average, there were around 100 printed A-4 size pages for each of these reports and a thorough reading of these provided the background for the analysis of the process of decentralised planning. Each development report carried comments on the secondary data available in the grama panchayat area and these have been compiled to throw light on the database situation prevalent in the localities, which is very important in the local level planning process. There were several training manuals, handbooks and publications brought out by the State Planning Board, which also provided information about the programme.

#### 2.1.4 Sessions attended

In addition to the methods adopted for information collection, actual participation in the activities proved to be helpful. In most of the occasions like grama sabhas and development seminars, I was an observer while in some of the training sessions and review meetings, I was to act as a participant observer.

1. Grama sabhas	24
2. Training for Key Resource Persons	4
3. Development Seminars	4
4. Training for medical and para medical personnel	3
5. Faculty meetings	9
6. Review meetings	7

#### 2.2. HEALTH PROBLEMS OF RURAL THIRUVANANTHAPURAM

Chapters on health and related sectors in the development reports of all the 84 grama panchayats of the district are considered. From these, the health problems as perceived by the people can be categorised into problems related to infrastructure, different systems of medicine, malnutrition, old age and chronic illnesses, disabilities, social sanitation, drinking water, latrines and health education. The development reports give the rankings of these problems in terms of their severity. Grama panchayat wise tabulation of all these problem rankings is done in order to analyse the ordinal importance of the perceived problems. Apart from these rankings, there is another classification considering the magnitude of seriousness of each problem. They are also analysed based on the geographical distribution of these problems across the district.

### 2.3. ANALYSIS OF PROJECTS IN TERMS OF RESOURCES

A total of 4125 number of projects has been prepared by the grama panchayats for the first annual plan and from among them, 322 are categorised as health and related sector projects. The distribution of the total plan outlay and the different sources of resources are tabulated. Sub-sector wise comparisons of this distribution is then undertaken. A systematic analysis of projects of a dozen grama panchayats is done. There are twelve development blocks in the district and one grama panchayat from each block is selected randomly. The projects are analysed based on the guidelines issued by the State Planning Board and the training manuals on project preparation. Finally, a critical evaluation is done so as to provide the suggestions of policy implications.

## CHAPTER 3

### DECENTRALISED PLANNING PROCESS IN HEALTH SECTOR

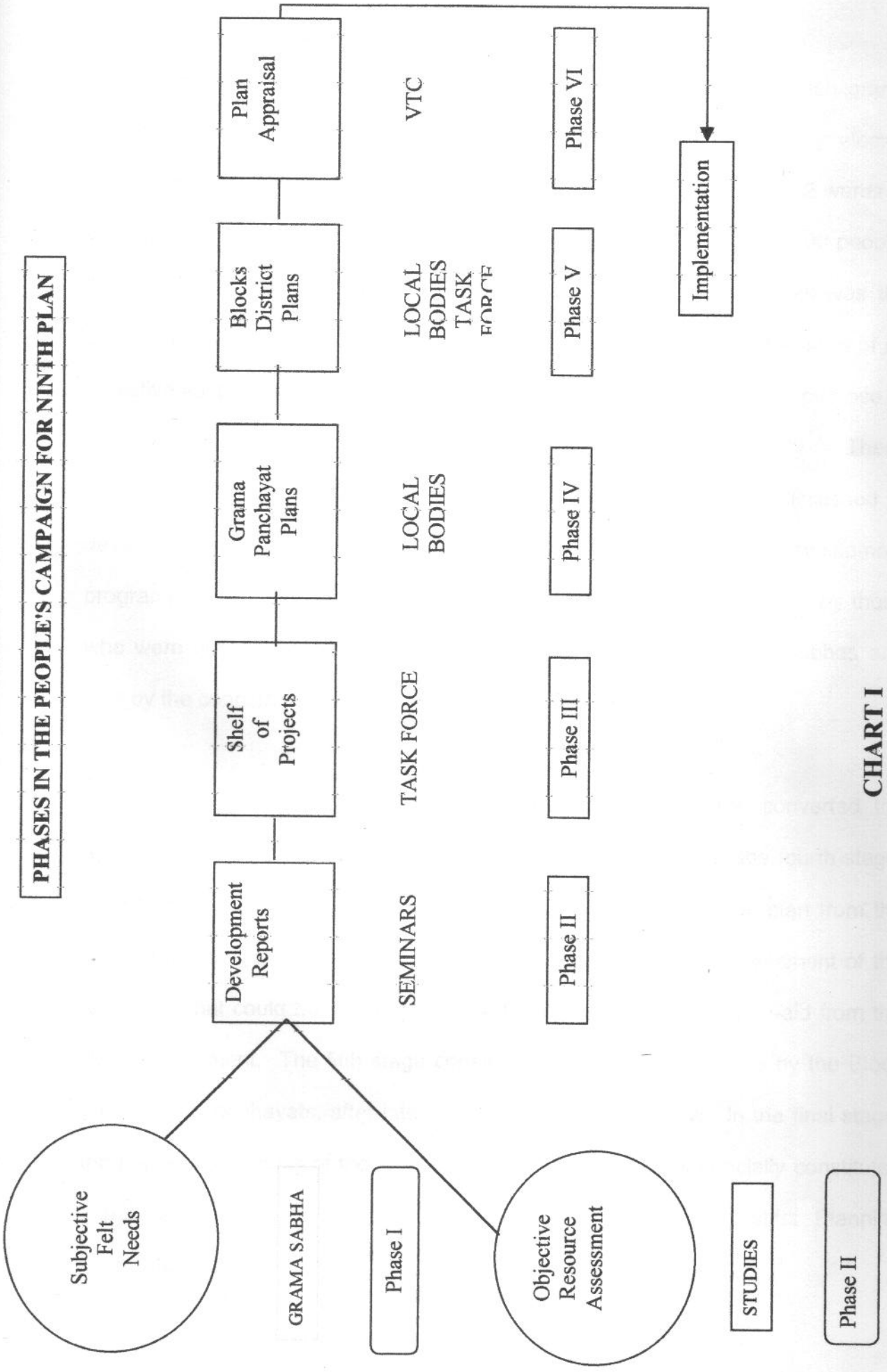
#### 3.1. PHASES IN THE PEOPLE'S CAMPAIGN FOR NINTH PLAN

The importance of decentralisation in health sector planning was discussed in the last chapter. Now we shall briefly describe the actual planning process through which health sector plans were formulated under People's Campaign for Ninth Plan during 1996-1998.

In July 1996, the Government of Kerala resolved to devolve 35-40% of the Ninth five-year plan outlay to programmes drawn up by the local bodies. The local bodies were to prepare comprehensive, integrated area programmes covering all development sectors, which came within the ambit of their subject matters. In order to empower the local bodies to prepare plans in a scientific, participatory and time bound manner, the government also initiated a mass campaign. This campaign named the People's Campaign for Ninth Plan sought to empower the local bodies by rallying experts, volunteers, and other departmental officials in the local level planning activities.

A five-stage programme for plan preparation was also chalked out. A diagrammatic representation of these different phases of planning programme is given in **Chart I**. Identification of the felt needs of people in localities through discussion in grama sabhas constituted the first step in local level planning.

**PHASES IN THE PEOPLE'S CAMPAIGN FOR NINTH PLAN**



**CHART I**

Grama sabhas are meetings conducted at the ward level in each grama panchayat. These were to be initiated and conducted by the locally elected representatives of the people. On an average, there are around 10-12 wards in each grama panchayat, each with a voter population of around 1000-1500 people. Grama sabha was followed by a second phase where the main task was the preparation of a development report for every grama panchayat on the basis of an objective assessment of the resource potential and problems. For this purpose, a number of participatory studies were undertaken in each locality. These development reports and demands from the grama sabhas were discussed in development seminars, which drew up recommendations for development programmes for each sector. The development seminars were attended by those who were nominated from the various subject groups in the grama sabhas and also by the concerned officers working in the grama panchayat area.

The next stage was the constitution of task forces that converted the recommendations of the development seminars into projects. In the fourth stage, local bodies prioritised and selected projects to be included in the plan from the shelf of projects prepared by the task forces, after making an assessment of the resources that could be mobilised for the Plan, including the grant-in-aid from the state government. The fifth stage consisted of preparation of plans by the Block and District panchayats, after integrating the plans from below. In the final stage, the plans and projects of the local bodies were appraised by specially constituted expert committees at block and district levels, before the District Planning Committees approved them.

We have outlined in brief the various phases of the planning process. We shall now examine with reference to the experience in Thiruvananthapuram district, how the health sector plans were formulated through the above process. This discussion mainly draws upon my own direct participation in the process and also discussions with other local level health activists who participated in the programme.

### **3.2. GRAMA SABHAS**

It was in Nanniyode, a grama panchayat in Thiruvananthapuram district that the state level inauguration of the grama sabha was organised, on September 17, 1996. However, the majority of the grama sabhas in Thiruvananthapuram were delayed for various reasons and were organised only in the month of November. There was a general reluctance on the part of the elected representatives to convene the grama sabhas. Various reasons have been cited for this reluctance. Since Thiruvananthapuram is the capital of the state, the political leaders have easy access to the Government secretariat. This had given them the feeling that they could get whatever their localities want without much of these 'decentralised process'. Another reason attributed to was the urban nature of the district, which has led to the apathy of the people towards such public programmes. As the campaign picked up in other districts, particularly in northern districts, grama sabhas were convened in Thiruvananthapuram also. Available data shows that the average participation in a grama sabha in the district was only at the level of state average- 181 persons. Nearly 35% participants were women while 25% were so in the state as a whole. Only 3.5% of the participants belonged to scheduled castes/scheduled tribes (SC/ST). It is to be noted that these weaker

sections constituted 13.22% of the district population. There were inter-panchayat variations and in most of the cases, these inter-panchayat differences could be explained in terms of political affiliations of the panchayat committees alone. On the whole, participation in the grama sabhas was found to be negatively correlated to the degree of urbanisation. Even then, the determining factor seems to have been the commitment and interest of the elected representatives themselves as well as the involvement of some of the non-governmental voluntary organisations at the local level. In places where there were 'neighbourhood groups', the participation in the grama sabhas was found to be comparatively high.

The discussions in the grama sabhas were organised in subject groups. In all the grama sabhas in the district, there were separate discussion groups for the health sector. Related subjects like drinking water, nutrition and sanitation were also included in the subject group on health. Each participant could choose the subject of his/her interest for participation. On the basis of discussions with Key Resource Persons (KRP- they are the people selected by the panchayats who underwent training at the state level) from the district, on an average, 20-30 persons participated in the discussions on health sector in each grama sabha. In every discussion group, there was at least one trained volunteer who acted as the facilitator.

The objectives of the discussion were three-fold. First, there was an attempt to collect certain elementary statistical information directly from the participants. Second, the major health problems were to be identified. Third, the causes and solutions to these problems were discussed on the basis of experiences of these

people. The quality of deliberations varied from panchayat to panchayat. The quality of resource persons proved to be a key factor in determining the effectiveness of the discussion.

Certain selected issues that were taken up for discussion in a typical grama sabha are reproduced below. This listing is made on the basis of a semi-structured questionnaire that was supplied to the resource persons at the time of their training. They were to adapt their questions to the local conditions and use it as a reference list to guide the discussions.

- *Health infrastructure facilities:* what are the public health institutions in the ward? Where are they located? How many private hospitals and clinics are there? Has any one in the ward to travel more than 2 Kms. to get medical assistance? Are there enough staff, essential drugs and beds in the hospital? What is the status of access to inpatient treatment?
- *Quality of services:* what do people think of the style of functioning of the public health institutions in the ward? What are the shortcomings? Are employees regularly available at the sub-centres? Do they visit the households? Is the doctor regularly available at the PHC?
- *Sanitation:* what is the approximate percentage of households without latrines in the ward? What are the chief reasons for a number of households never building latrines? Do any areas in the ward have problems of stagnating / sewage water and accumulating water?
- *Drinking water:* in which parts are there chronic shortage of drinking water? In parts affected by drinking water shortage, how far have the people to go to draw water? How is the problem tackled? Any suggestions for a permanent solution?

- *Nutrition:* are there any areas in the ward where malnutrition is observed?
- *Preventive measures:* what contagious / easily communicable diseases affect people of the ward regularly? Are the children in the ward immunised properly and regularly?
- *Health education:* are classes in health education conducted regularly?
- *Other specific problems:* is there any public crematorium or graveyard? Any other sources of pollution?

The major conclusions of the discussions were recorded and the resource persons who attended the health sector discussion groups in the grama sabhas collated the reports from the different grama sabhas in the panchayat and integrated them into a common report.

There was an argument that the structured questionnaire had taken away the spirit of decentralisation. The opposite view was that if there were no such questionnaire, the discussion would not have been focussed. Moreover, the questionnaire was prepared at the training camps held at the state, district and block levels. It was never suggested that the grama sabhas should follow this questionnaire, but it was meant only to help them. In spite of all these, not all the health subject group discussions were focussed. At least in some places, personal interests and political interests overshadowed the main theme. On the whole, people were not satisfied with the present public health system available in the panchayats. In some of the subject group discussions, the over involvement of the trained key resource persons were seen, even though they were specifically told that their role is to act as facilitators only.

### 3.3. PROCESS OF COLLECTING SECONDARY DATA

As a prelude to the preparation of the development report, secondary data on health sector was collected in all panchayats and municipalities. Then, in most of the panchayats, discussions were organised among the health workers in order to assess the ongoing health programmes in the area and their perceptions of the health problems.

We shall discuss in some detail the nature of secondary data available at the local level on health and related sectors and also their reliability. No attempt, however, is being made to draw up a statistical profile of health sector in the district on the basis of data collected by the local bodies.

The published secondary data in health and related sectors at the grama panchayat level is virtually non-existent. Only available information is with respect to certain aspects of health infrastructure, number of hospitals, Community Health Centres (CHC), Primary Health Centres (PHC), sub-centres, beds, doctors, and paramedics by public and private sector and also by systems of medicines. These are available at the block level. Similarly, for drinking water facilities, there is information available on water supply schemes by type and technology, maintained by Kerala Water Authority. Village directory from the Census reports provide a major village wise secondary data on population, sex ratio, literacy, industrial classification as workforce and certain other medical and drinking water infrastructural facilities. This unenviable situation with respect to availability of published data is indeed a major constraint to panchayat level health sector planning.

As part of the micro level development experiments that have been organised in various parts of Kerala, attempts have been made to generate local level health database through primary health surveys. Examples of panchayats like Thanaloor in Malappuram district are noteworthy. However, any such primary survey as part of the People's Planning had been ruled out due to severe constraints of time. Instead, after detailed field inquiries, a procedure for collecting unpublished secondary data available in the various registers of the local level departmental offices and health institutions was worked out.

A detailed questionnaire for the collection of secondary data from the local level administrative offices was prepared. It was a common schedule containing questionnaires for all the development sectors. Total number of pages for the questionnaire came to 84. Volunteers were given training in data collection. In some panchayats, small squads of volunteers went from office to office filling up the relevant forms. In certain other panchayats, conferences of local level officers were convened and they were asked to fill up the forms relevant to their offices. A critical review of the completed forms revealed a significant variation in the quality of data collected. All grama panchayats did not care to fill all the forms, and the reference year of the data collection also varied mainly reflecting the delays in offices in updating the data. Despite these limitations, the secondary data gave a statistical basis to the analysis in the development reports. Majority of panchayats also utilised the information collected in the preparation of the reports.

Another set of data to be included in the development reports were based on the meetings with health officials. These were supposed to review the ongoing

programmes in the sector. The review meetings of health officials in the panchayats were not as effective as initially envisaged. The reason was the reluctance of many of the key health officials like medical officers to come for such review meetings with panchayat authorities. This was the consequence of a conflict between the medical officers and the panchayat authorities. During the devolution of powers to the local bodies, there was confusion regarding the role of elected representatives as the administrative authority of Primary Health Centres. This had led to a partial non- co-operation of the medical officers in the beginning of the campaign in at least a few panchayats. This was amicably settled later and as the implementation of plans began, they have been actively participating in the programme in most of the panchayats.

### **3.4. NATURE AND AVAILABILITY OF SECONDARY DATA**

Various focus group discussions and key informant interviews revealed the nature of the secondary data. In the following section is presented a listing of the major such sources of information, the type of information available therein and a general remark on actual availability of such information and finally, the quality of information.

What we find is a high potential for preparing a comprehensive database for each of the panchayats. Inter-departmental co-ordination would be of much use in this regard. Yet, the experiences people had while collecting secondary data on their grama panchayats have been reported as totally unsatisfactory in most of the cases. Actual availability of the information was to be a major hurdle in secondary data collection. The reliability of the data was always questioned.

**Table 3.1**  
**Data sources at the grama panchayat level**

<b>Sources of Information</b>	<b>Type of information</b>	<b>Actual availability</b>	<b>Quality of information</b>
1 Panchayat Primary Census Abstract	Demographic profile, no. of households, density of population, literacy rate, sex ratio, no. Of houses	Available	Not up-to-date (only up-to-1991)
2 Panchayat-wise Statistics (Economics and Statistics Dept.)	No. of public wells, Public tube and bore wells, Public taps, Ponds, wells by Kerala Water Authority	Available for reference (was not available at the time of preparation of the development reports)	Reliable, but the data base is only on public sources, actual availability of water can not be ascertained
3 Annual administrative Reports of DHS	No. of institutions, staff and other infrastructural facilities	Not published for the last few Years, not panchayat-wise	Actual availability of staff and facilities in each center are not reliable. In most cases only sanctioned facilities are recorded.
4 Annual administrative Reports of PHCs	Routine functioning of the PHC	Not available in most places	Not up-to-date
5. Family health register of sub-centres	Information regarding all the families- housing, latrine water availability, electrification, morbidity, preventive measures, names of all people, age, education, job status, income, marital status, general health status	Not available at present due to Certain administrative problems	Not up-to-date
1 Communicable Disease register	Details regarding the commonly prevalent diseases	Available at sub-centres and PHCs	Not always up-to-date, A lot of unreported cases
7. In-patient register, out-patient register, disease classification register	Morbidity status, areas/regions with prevalence of certain diseases	Available at PHCs and CHCs	OP register and disease classification registers are totally unreliable
8 Antenatal and infant register at the sub-centre	Maternal and child health details, nutritional status, immunisation status, birth-rate and death rate	Available	Up-to-date in immunisation, CDR and birth rate, maternal and child health details, not completely reliable in all places, nutritional status not reliable
9. Eligible couple and sterilisation register	No. of eligible couples, No. of couples who have undergone temporary and permanent methods of sterilisation	Available at sub-centre and PHC	Up-to-date, reliable in places where there are JPHNs
10. Anganwadi register	Details of children 0-6 yrs of age, antenatal mothers, maternal and child health, nutritional status, immunisation status, CDR, birth rate	Anganwadi-wise and Sector-wise details are Available	Up-to-date and reliable
11. Mmicro-planning report at sub-centre	Pregnant women, new-born, maternal mortality, communicable diseases, immunisation status	Not always available	Details regarding communicable diseases not reliable
12. Sanitation register (grama panchayat)	Double pit latrines among below poverty line households, those who do not have latrines	Available	Only those below poverty line are Considered, not always up-to-date
13. Water tap register (grama panchayat)	Drinking water programmes Taps available	Available	Not up-to-date, actual availability of water is not considered
14. Still birth register (grama panchayat)	No. of stillbirths	Available	Deliveries taking place in the panchayat are only are considered.
15. Birth and death register	Births and deaths taken place in the panchayat area	Available	Births and deaths may take place outside the panchayat area and they are not included
16. Pond and well register	No. of ponds and wells	Not always available	Not up-to-date

It is to note that, on the whole, the registers kept at the Anganwadis were considered to be reliable. The registers at those sub-centres where there were Junior Public Health Nurses actually working were accepted by the people to be reliable, but the details given by them regarding morbidity status and nutritional status were unacceptable. This was also true regarding the morbidity registers kept at the Primary Health Centres. Even the Medical Officers were of the opinion that those were totally unreliable. This, in fact, affected the local level planning process to some extent. Some of the reports kept at the various government offices were found to be out-of-date. Moreover, it was found that different agencies were collecting the same information and these were not identical. As a result of these experiences, there have been suggestions to improve the database situation in each grama panchayat and even opt for primary surveys, if needed.

### **3.5. DEVELOPMENT REPORTS**

We shall next review the development reports with reference to health sector. Having collected the reports of grama sabha discussions, secondary data and review of ongoing programmes, they were consolidated into development reports.

The development reports prepared from each locality were in a sense a high watermark in the planning exercise. On an average, each of the printed development reports contained 100 pages and nearly a quarter of them even met academic standards in their quality of analysis and presentation.

Before we move on to analyse the perceptions of local level health problems as presented in these development reports, it might be useful to give a

general idea of a typical development report. The structure of the reports was more or less uniform with the first part covering a review of the administrative and local history highlighting the role of social movements that affected the village during the present century. This section of the reports brought out the importance of popular heritage and history in meeting the contemporary development challenges at the local level. One chapter was devoted to the analysis of natural and human resources of the locality. The second part had twelve chapters, covering various development sectors. The current status of each sector was discussed; its ongoing schemes reviewed and problems identified along with a list of suggested recommendations. Being written up by different sets of people, who were volunteers, the quality of chapters even within a report differed.

## CHAPTER 4

### HEALTH PROBLEMS OF RURAL THIRUVANANTHAPURAM

#### 4.1. HISTORICAL ANALYSIS

Having surveyed the structure of a development report as a whole, we shall now look into the analytical structure of a typical chapter on the health sector in the development report. An important feature of this analysis was the conscious attempt to bring out the inter-sectoral linkages of health sector. The chapter on health included analysis of related sectors of health like drinking water, sanitation and so on. An awareness of the inter-linkages is reflected both in the analysis of the cause of health problems as well as the integrated solutions that were often suggested.

The section on health and related sectors in the development reports of grama panchayats describes the health problems of rural Thiruvananthapuram as perceived by the people. The chapter begins with a historical analysis of health and health care facilities in the panchayats. In almost all the grama panchayats, mention has been made about the history of high prevalence of infectious diseases, epidemics and in certain cases, natural disasters during the first half of the century. The infectious diseases, which used to cause havoc in the pre-independence era were water-borne diseases like cholera and other diarrhoeal diseases and vector-borne diseases like malaria. The development reports point out the high number of associated deaths, which were a common phenomenon at that time. This is in line with the Annual Administrative Reports published by the

Department of Medical Services in the 1940's<sup>37</sup>. However, the reports note that these diseases are not causing as many problems as they were in the 40's. This perception of the people is also amply illustrated beyond doubt by the reports of the Directorate of Health Services<sup>38</sup> and the recent survey conducted by Kerala Sasthra Sahithya Parishad<sup>21</sup>. Thus the epidemiological transition is widely recognised.

History of development of health care infrastructure has been dealt with by most of the reports. It is to be noted that community participation was one of the main agents in social intermediation process, which led to improvement in health care facilities. Contribution of land for the Primary Health Centre is one among them. It was voluntary contribution by a prominent family in the locality or by donation of money by people in the area, which made it possible to start a Primary Health Centre. At least two development reports do mention the agitation people had to undertake to get health care facilities for the whole population, irrespective of caste or religion. This process has been documented by Krishnan and Kabeer<sup>5</sup>.

Description about the health sector continued with discussion on the crude death rate, infant mortality rate and maternal death rate. This was followed by a discussion of the birth rate. General qualitative comments were also made regarding the trend in the above indicators and factors contributed to these trends were also discussed. All development reports point to a significant decline in crude death rate, crude birth rate etc. These conclusions are supported by the secondary data for the district.

## 4.2. CONTEMPORARY HEALTH PROBLEMS

Having analysed the major health indicators, their improvement over time and the factors that attributed to these achievements, the focus of attention turns to discussion of contemporary problems. A discussion of the morbidity pattern in the panchayats is presented and analysed.

**Table 4.1**  
**Factors contributing to the health problems in the grama panchayats-  
frequency distribution of the rank order attributed to them. \***

PROBLEMS	Most important	Second most important	Third most important	Fourth most important
HEALTH INFRASTRUCTURE	34 (40)	36 (43)	4 (5)	
DRINKING WATER	42 (50)	32 (38)	8 (10)	
LATRINES	6 (7)	10 (12)	44 (52)	
SOCIAL SANITATION	2 (3)	6 (7)	12 (14)	
HEALTH EDUCATION AND PREVENTION			6 (7)	8
MALNUTRITION				6
MOSQUITO			4 (5)	8
OTHERS			6 (7)	
TOTAL NO. OF PANCHAYATS	84 (100)	84 (100)	84 (100)	22**

Note:

- \* The grama panchayats have stated the major problem areas in health sector as the most important, second most important and so on. This table gives the number of grama panchayats which have considered a particular problem as the most important, another as the second most important
- \*\* All the grama panchayats have not ranked the problems after the third rank, even though they have stated the problems.
- \*\*\* Figures in parentheses indicates column percentages.

Majority of the development reports have attempted to categorise the diseases by causal factors such as environmental, occupational, vector borne, air borne, water borne and so on. It is in this discussion that the age structure, nutritional status, health expenditure, quality of infrastructure, drinking water problems, sanitation etc. are brought into the analysis. We have attempted to

summarise the above discussion on the perceptions about the major health problems available in Table 4.1 and 4.2.

**Table 4.2**  
**Frequency distribution of the major health problems identified by the grama panchayats according to magnitude of their seriousness**

PROBLEM	Very Serious	Serious	Not Serious	No problem	Total no. of Panchayats
1. Health infrastructure	32 (38)	47 (56)	5 (6)		84 (100)
1.a. Drugs	27 (32)	39 (46)	18 (22)		84 (100)
1.b. Staff	24 (29)	45 (53)	15 (18)		84 (100)
1.c. Bed	28 (33)	43 (51)	9 (11)	4 (5)	84 (100)
2. Public waste disposal	19 (23)	33 (39)	32 (38)		84 (100)
3. Drinking water	40 (47)	20 (24)	24 (29)		84 (100)
4. Latrines	14 (17)	27 (32)	27 (32)	16 (19)	84 (100)
5. Malnutrition	1 (1)	38 (45)	37 (44)	8 (10)	84 (100)
6. Mosquito	15 (18)	37 (44)	32 (38)		84 (100)
7. Disabled	22 (26)	35 (42)	27 (32)		84 (100)
8. Chronically ill and Old aged	30 (35)	46 (55)	8 (10)		84 (100)
9. Health education and prevention	16 (19)	23 (28)	30 (35)	15 (18)	84 (100)

Note: \*Grama panchayats have considered each problem in health sector in terms of severity. They have been graded as very serious problem requiring immediate attention, serious problem, not much of a problem and not a problem at all. In this table, the number of grama panchayats which have considered each problem under these grades have been tabulated.

\*\* The figures in parentheses indicate row percentages.

Table 4.1 has listed the major factors contributing to the present health problems in the panchayats and has given a frequency distribution of the rank order attributed to them by the panchayats. Column 2 gives the number of panchayats who consider the relevant factor indicated in column 1 as the most

important. Column 3 gives the frequency distribution of the next important factor and so on. Table 4.2 gives a frequency distribution of the major health issues according to the magnitude of their seriousness. A fourfold classification is used viz. very serious, serious, not serious and not mentioned/ not a problem.

Drinking water emerges as the most important health issue. Non-availability of drinking water is an issue, which is considered by most of the grama panchayats as an obstacle in achieving higher health status of the population. In 42 grama panchayats of the district, drinking water shortage is considered as the most important problem. Another 32 have considered it as the second most important issue in health. From the development reports, one cannot ascertain whether the quality or the quantity of drinking water was the topic of discussion. The focus group discussions revealed that only the availability of drinking water was considered. But they point out that when there is non-availability, people resort to all sources of water for drinking which in most cases would be non-drinkable. This leads to diseases like diarrhoea, especially in summer. Water quality testing has not been a practice in the rural areas.

From Table 4.2, 33 panchayats consider that drinking water situation is a very serious problem, which needs immediate attention. There are suggestions to speed up the on-going programmes and rectify the problems in the already available system. Almost all the coastal panchayats consider drinking water shortage as their most important health problem. This is noteworthy. The critics of decentralised planning have always raised the fear that people will not be able to identify the actual problems and they will ask only for infrastructure improvement.

But what we find in the development reports is that water borne diseases are common in the coastal areas and the people have identified drinking water problem as the major health issue. In fact, as mentioned in the previous section, they have not considered health care infrastructure as the most serious health problem. Grama panchayats around Thiruvananthapuram City and some of the panchayats in the northeast and southernmost parts lying nearer to the state of Tamilnadu also have considered non-availability of drinking water as a very serious issue in health. But it is interesting to note that hilly areas in the district, except for the northernmost parts, have not considered drinking water shortage as a very serious problem. Focus group discussions in these areas revealed that the people have their own sources of drinking water like the wells and streams. Piped water supply or government sponsored drinking water programmes are not depended much in these areas.

Weakness in the health infrastructure is the second most important factor. Thiruvananthapuram district has a fairly widespread health care delivery system as per the records available. In spite of this, we find that the people consider lack of health care infrastructure and facilities as one of the major problem areas in health. 34 out of the 84 grama panchayats have considered this as the most serious problem. Another 36 have considered this as the second most important problem. Not a single grama panchayat has considered this as a 'problem-free' area. It is natural that people would always like to have better infrastructural facilities in health. This is especially true when the educational status/literacy rate predisposes to increased awareness about health and health care seeking behaviour.

In Table 4.2, one finds a clearer picture about the people's perceptions about the seriousness of the problem of health infrastructure. 32 of the grama panchayats have considered this as very serious problem, which require immediate attention. Another 47 have taken the view that the situation is not satisfactory and requires improvement. Among the infrastructural facilities, lack of availability of drugs, staff and bed form the major issues. People from 27 grama panchayats feel that non-availability of essential drugs is a very serious problem. Staff situation and bed strength are also considered to be very important issues in 24 and 28 panchayats respectively. This is despite the fact that Thiruvananthapuram district has been shown to have better health infrastructure compared to other districts in the state.

The geographical distribution of this problem gives an interesting picture. All the grama panchayats surrounding Thiruvananthapuram City consider lack of proper health infrastructure as very serious problem. This is in spite of the presence of Medical College Hospital, General Hospital, Women and Children Hospital, Sree Chithra Institute for Medical Sciences and Technology, Regional Cancer Centre, Sree Avittom Thirunal Hospital, Ophthalmic Hospital etc. in the city. This requires close scrutiny. A few of the reports have mentioned why these are still problems in these panchayats. Even though these major hospitals are nearby, for their routine health problems, these institutions are not of much help, they feel. Most of them are referral hospitals. But even then, those panchayats that have Primary Health Centres under the direct supervision or involvement of Medical College also complain of the same problem. Focus group discussions reveal that due to the availability of higher health care centres, and due to the characteristics

of the population living in these panchayats- who are mostly connected to the activities in the city, like employees, students etc.- people are very conscious about health care infrastructure. Moreover, the rise in health expenditure leads them to demand better health care facilities in the public sector. North- eastern parts of the district also have mentioned about the seriousness of the lack of proper health infrastructure. Coastal areas as a whole do not consider health care infrastructure as the most serious problem in health. There are a few panchayats demanding for urgent improvement in this area but others have noted this as a serious problem but not as the most serious. It is to be noted that these coastal grama panchayats have had recurrent outbreaks of diarrhoeal diseases and malaria epidemics in recent years and authorities had implemented various intervention strategies in these areas. Moreover, the presence of various non-governmental organisations and missionaries working in these coastal regions have also contributed to the health care facilities in these grama panchayats.

Sanitation has been considered in different angles, but household sanitation, which includes safe disposal of human excreta, is one of the major determinants of diarrhoeal diseases and a few other communicable diseases. Over the years, there have been a lot of improvements in the availability of household latrines. The Kerala Sasthra Sahithya Parishad survey in 1987 revealed that only 45% of the households had access to latrines<sup>8</sup>. Their own survey in 1996 finds that 70% of the households have now access to latrines<sup>21</sup>. This is reflected in the development reports. Only 6 grama panchayats have considered absence of latrines as their most important problem in health sector and only 10 panchayats have considered it to be second most important problem.

Though not the most important problem, at least 14 grama panchayats have noted that absence of latrines is a very serious health issue in their area. But some of them have considered this as a soluble problem. To quote from a focus group discussion, " Earlier, the absence of latrines was a major problem and it was reflected in the incidence of diarrhoeal diseases. Now that a good number of households have latrines, it is feasible to strive for latrines in 100% households with the help of local bodies. Those who do not have latrines now are the 'really poor' of the society and it is among them that more of infectious diseases occur". We could not find a geographical distribution pattern in the case of absence of latrines, though we noted that some of the coastal grama panchayats and those lying nearer to Thiruvananthapuram City have considered this as a serious problem.

Though not considered as the most important problem, social sanitation has become a concern for a few grama panchayats. By social sanitation, we consider disposal of wastewater, solid waste disposal, public waste disposal and market waste disposal. Household waste disposal has not been considered as a serious problem in a majority of grama panchayats. However, 19 grama panchayats have noted the importance of public waste disposal. It is especially important in the context of re-emerging infectious diseases.

The coastal panchayats and those situated nearer to the city have perceived this as an important issue. Mosquito menace has also featured as health problem in many grama panchayats. 15 of them consider it to be a very serious problem also. The recent outbreaks of malaria and Japanese B

encephalitis, which are mosquito-borne, might be one of the reasons for this perception. Here also, coastal areas and panchayats encircling Thiruvananthapuram City consider this as a serious issue in health.

At least 30 of the grama panchayats have looked into the problems of the elderly and chronically ill as serious problems. Another 46 grama panchayats have considered this as potential problem. This is a reflection of how much the people have gone in depth into the different aspects of health.

It is to be noted that there has not been any mention of the private health care sector in the area. In a state where 70% of the population utilise the private sector in health, this seems to be a major drawback. The focus groups accepted that this was due to their belief that it was beyond the purview of the local bodies. Consultants at the State Planning Board pointed out that there were provisions in the Panchayat Raj Act to overcome this issue, but it was overlooked at all levels.

People who attended the grama sabhas were of the opinion that though they took part in the grama sabhas, they had not come prepared to discuss the health problems. They did not think that they would be getting such an opportunity as to air their views. Most of them thought that "the 'VIPs' would be talking". It was not that they were not informed about the proceedings, but they were not optimistic up to that level.

## CHAPTER 5

### REVIEW OF LOCAL LEVEL HEALTH PLANS

#### 5.1. THE PLAN DOCUMENT

The plan document consisted of the list of projects that were finally selected by the local bodies for implementation. It was also to provide the rationale for the choice made. What were the problems that were being addressed by the plan? What was the development strategy being adopted to meet these challenges? How much resource was available to implement these strategies? How were the projects integrated into coherent programmes and the concerns of gender and weaker sections ensured in them? Such were the questions that were addressed by the plan. Accordingly, every plan document consisted of the following eight chapters and three annexures.

1. *Introduction* : a brief description of the development challenges
2. *Development strategy* : a statement of inter-sectoral priorities (i.e., sectoral distribution of outlay ) and intra sectoral priorities (i.e., sub-sectoral policies)
3. *Resource mobilisation*: an estimate of additional local resource mobilisation from the following sources: own funds, state sponsored schemes, centrally sponsored schemes, co-operatives, other financial institutions, voluntary contribution, beneficiary contribution and others.
4. *Sectoral programmes* : a listing of projects by sectors and sub-sectors
5. *Integrated development*: a discussion of possibilities of backward and forward linkage of projects and integration of related sectors.

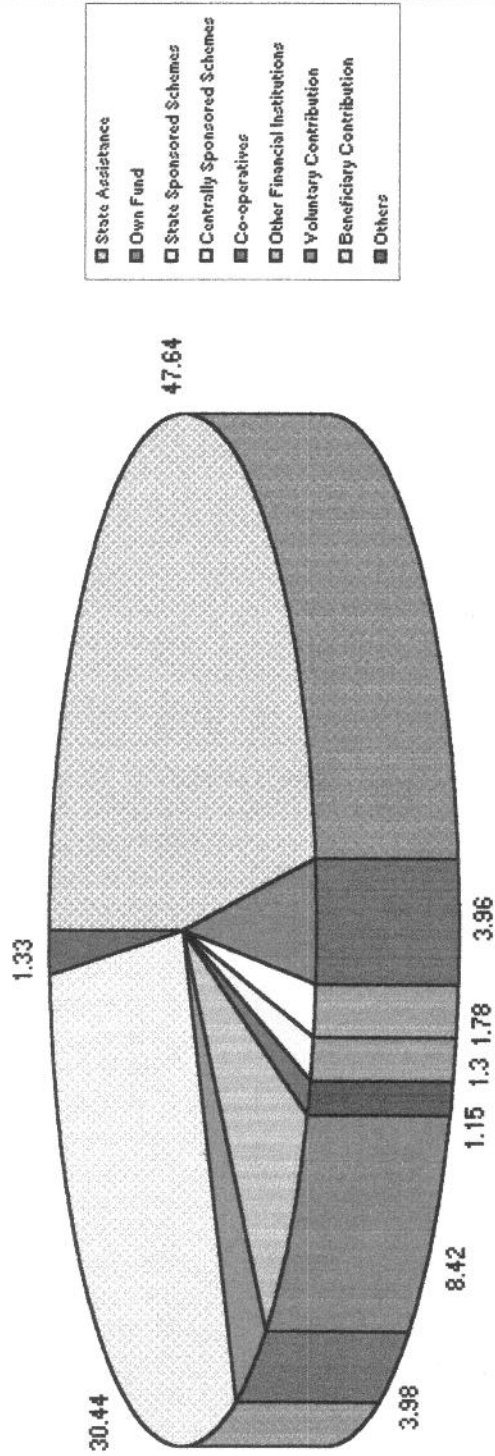
6. *Welfare of scheduled castes and scheduled tribes*: a discussion on how the guidelines for special component plan/ tribal sub-plan have been complied with.
7. *Women's development programmes*: a discussion of the gender impact of the plan and listing of projects included in the women component plan.
8. *Monitoring*: a discussion of the monitoring system.

## 5.2 RESOURCE MOBILIZATION

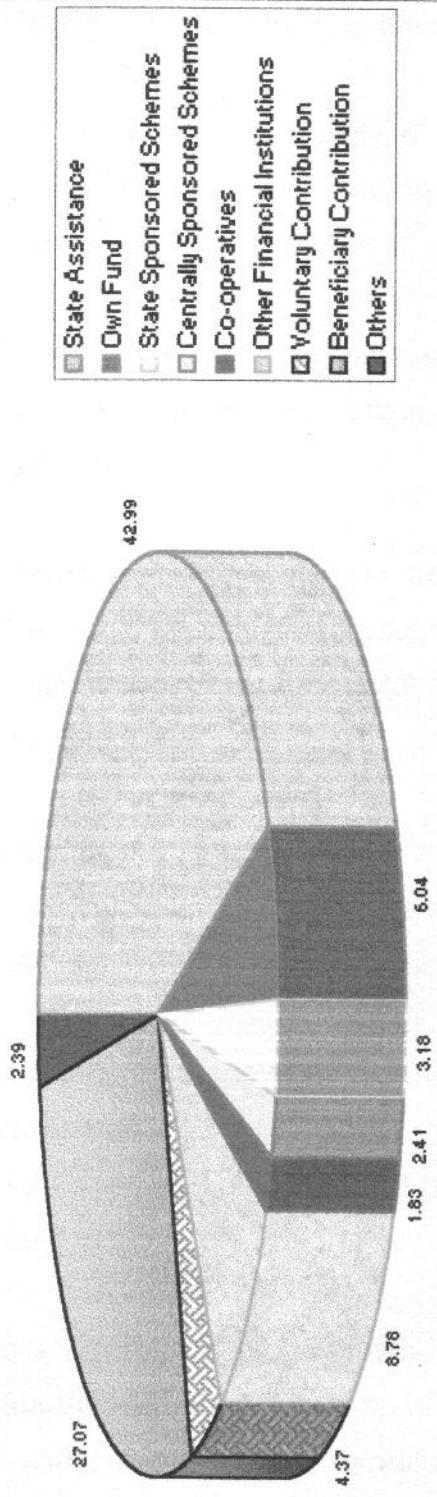
Having already discussed the local level health problems in the last chapter, we shall begin our review of the local health plans with an examination of their pattern of financing. Apart from grant-in-aid for plan assistance provided by the state government, the local bodies were to integrate the funds available from centrally sponsored or state sponsored schemes and financial and other resources that could be locally mobilised for plan resources. Figures 5.1 and 5.2 give a comparative statement of the resource mobilisation pattern of grama panchayats of Kerala State as a whole and Thiruvananthapuram district.

1. *State Plan Assistance*: Every local body received a share from the total grant-in-aid provided by the state government in proportion to its population. Total state assistance received by the grama panchayats in Thiruvananthapuram district was Rs. 52,46,93,398. This constituted is 47.64% of the total plan outlay of the grama panchayats in the district.
2. *Surplus from own funds*: Apart from the above plan assistance from the state government, the local bodies had their own tax and non-tax revenues and also received non-plan grant-in-aid from the state government. The surplus, after

**Figure 5.1**  
**Resource Mobilisation Pattern of Grama Panchayats of**  
**Thiruvananthapuram District**



**Figure 5.2**  
**Resource Mobilisation Patern of Grama Panchayats of**  
**Kerala State as a whole**



- received non-plan grant-in-aid from the state government. The surplus, after meeting their establishment charges and other recurring expenditure could be utilised for financing the plans. Of the total outlay of the grama panchayat plans in Thiruvananthapuram district, 3.96% was from their own fund.
3. *State sponsored schemes:* Of the total funds devolved to the local bodies, around 25% were in the form of schemes. Such schemes provided 1.78% of the total plan outlay of grama panchayats in the district.
  4. *Centrally sponsored schemes:* As in the case of the state-sponsored schemes, 1.3% of the total plan outlay of the grama panchayats in the district was through centrally sponsored schemes.
  5. *Loans from co-operative institutions:* It was envisaged that a major share of additional resource mobilisation could be achieved through loans from the co-operative institutions. In the district, 1.15% of the total outlay of the grama panchayat plans was from this source.
  6. *Loans from other financial institutions:* Financial institutions like banks were considered to be a major source of loans, but the resources mobilised through this were only 8.42% of the total outlay.
  7. *Voluntary contribution:* Being a programme involving community participation, it was expected to mobilise resources in terms of money, materials and labour through voluntary contribution. Of the total plan outlay of grama panchayats in the district, 3.98% was mobilised through this.
  8. *Beneficiary contribution:* There are certain programmes, which are partially, sponsored by the beneficiaries themselves. This is a component of the plan finance that is prone to some exaggeration in order to artificially inflate the plan outlay. Norms were fixed so that only complementary additional investment undertaken by the beneficiary is included. Yet one finds that there are many cases of deviation from the norms. Of the total plan outlay, 30.44% has been intended to be mobilised through beneficiary contribution.

9. *Other sources*: These included assistance received from non-governmental funding agencies or para governmental funding agencies. Now, let us consider the resource mobilisation pattern in health sector.

**Table 5.1**  
**Resource mobilisation pattern in the sub-sectors of health sector as percentage of total plan outlay**

Sub-sectors	State plan assistanc	Own fund	State sponsored	Centrally Sponsored	Co-Operatives	Financial institution	Voluntary contribution	Beneficiary contribution	Others	Total
Nutrition	49	0	39.78	0	0	0	11.21	0	0	100
Infrastructure	64	5.33	3.18	0	0	3.18	8.19	.99	15.03	100
Prevention	53.6	8.02	.31	0	0	3.86	25.06	4.48	4.64	100
Health edn.	52.2	22.6	0	0	0	0	25.19	0	0	100
Integrated Projects	83.26	2.52	0	0	0	0	9.11	3.46	1.63	100
Drinking water -non-piped	65.71	2.38	1.57	0	.85	2.97	2.51	23.96	0	100
Drinking Water -piped	63.2	25.5	1.73	15.76	0	.12	7.02	5.45	.28	100
Sanitation	58.35	4.55	3.37	1.17	0	0	2.24	29.23	1.09	100
Others	73.9	6.48	0	0	0	0	2.05	17.56	0	100
Total	61.87	4.74	2.68	4.2	.17	.99	4.4	18.75	2.21	100

In Table 5.1, we have presented the pattern of financing of different types of projects in the health sector. Following are the salient features of financing in health sector brought out in Table 5.1.

1. The state plan assistance constitutes 62% of the total health sector plan outlay. The rest, around 38% is mobilised either through integrating the state or centrally sponsored schemes in the local plans or mobilising additional resources. This is indeed a commendable effort at local resource mobilisation. But, as is evident from the same table, the additional resource mobilisation is relatively higher if we take the total outlay of the local plans including the other development sectors. On the whole, state plan assistance constitutes only 48% of the total plan outlay of the grama panchayats in the district. This is primarily because potential and realisation of additional resource mobilisation, particularly from the financial institutions, is relatively higher in the productive sectors than in service sectors like health. It is seen that as much as 67% of the plan outlay of the productive sectors is met from non-grant-in-aid sources. It also would appear that the beneficiary contribution has been relatively smaller proportion of the health sector outlay than the total plan outlay of the grama panchayats.

2. There is significant difference between pattern of financing in different sub-sectors of health. Nearly a quarter of the outlay on piped drinking water schemes is met from the own funds of the grama panchayats. In sharp contrast, the funds earmarked from own funds are negligible in non-piped drinking water projects. In the latter, beneficiary contribution provides as much as a quarter of the total outlay. It is puzzling that the beneficiary contribution in the piped drinking water schemes is relatively lower. Sanitation is yet another sub-sector, which is heavily dependent upon beneficiary contribution. Of the health education outlay, 22% is from the own funds of the grama panchayats.
3. A major weakness of the local plan financing appears to be the failure to integrate state and centrally sponsored schemes. The share of these two sources in the health sector outlay is relatively higher than in the overall outlay of the grama panchayat plans. Only in the nutrition, where mid-day noon meal scheme of the state government has been brought into the plan do state sponsored schemes provide a significant proportion of the resources. The above experience brings out sharply the limitations imposed by centrally sponsored schemes to local level planning. The uncertainties of the availability of funds from the plan and the conditionalities imposed render meaningful integration difficult.
4. Yet another major weakness of the pattern of financing is the failure to ensure sufficient credit linkage. Co-operative credit accounts for only 1.15% and credit from other financial institutions accounts for only 8.42% of the total plan outlay of the grama panchayats. With respect to health sector, the contribution of financial institutions is virtually negligible. It is surprising that even for piped drinking water schemes, credit linkage is weak.
5. Nearly 4% of the total outlay are to be raised through voluntary labour and contributions. There is not much difference between the voluntary effort in the health sector and the local plans as a whole. But, within the health sector, there are significant variations between sub-sectors. Naturally disease prevention activities and health education schemes offer relatively greater scope for voluntary involvement. The share of voluntary labour in small

drinking water schemes from traditional sources or sanitation could be significantly higher.

### 5.3. DEVELOPMENT STRATEGY

Development strategy is a statement of the inter-sectoral and intra-sectoral priorities. Table 5.2 presents the inter sectoral priorities within the broad health sector.

**Table5.2**  
**Sub-sector wise distribution of state plan assistance in health sector**

SUB-SECTOR	No. of project	State plan assistanc (in Rupees)	% of total state plan assistance	% of total stat plan assistance in health
Public health**	107	10805632	4.32	29
Drinking water	152	17241563	6.89	46.29
Sanitation	61	8976975	3.58	24.1
Nutrition	2	215550	0.09	0.58
Total in health Sector	322	48045352	14.88	100

- Total state plan assistance earmarked for the grama panchayats in the district is Rs. 3900950000
- \*\* By public health is meant all activities directly linked to healthcare institutions like Primary Health Centres, Community Health Centres etc..

The largest number of projects and largest share of plan assistance and of total outlay in health sector is for drinking water schemes. The drinking water schemes consist of small-scale schemes that attempt to conserve and use traditional sources and piped water.

Public health sector comes only second with 29% of the total plan assistance invested in the broader health sector. By public health sub-sector in this context is meant the healthcare institutions and the activities conducted through them. It is surprising that nearly an equal amount is spent on sanitation

programmes. The amount earmarked for systems of medicine other than Modern Medicine like Ayurveda and Homoeo is negligible. Expenditure on nutrition is relatively negligible. Most of the local bodies have tended to treat mid-day meal scheme as a non-plan scheme.

#### **5.4. QUALITY OF PROJECTS**

We undertook a systematic analysis of projects of a dozen grama panchayats, one from each block. A total of 56 projects (22 in drinking water, 18 in public health, 12 in sanitation, 4 in health education, disease prevention and others). A serious effort in preparing a detailed project proposals was evident in the project documents we examined. Except in rare cases, all the projects were written in the format suggested by the State Planning Board. However the major weakness seems to have been in the financial analysis. Even though it was not expected that any financial analysis of the returns be made for projects in service sector like health and drinking water, it was expected that unit cost of service would be worked out and alternatives searched. However, in the majority of cases, no such attempts have been made. In the piped drinking water projects and health care infrastructural projects, no detailed estimates for designs or drawings were included in the project proposals. Most of the estimates were made on the basis of certain empirical unit costs. The activity time charts were not given in many of the projects. The specification and quantification of the objectives was also weak in many of the project proposals. There was enough evidence to suggest the absence of sufficient expertise input in the preparation of the projects.

Though the health sector programmes taken as a whole represented an integrated and holistic approach to health problems, it must be pointed out that there was not sufficient operational integration of the various projects. The forward and backward linkages were not sufficiently explored.

Finally, let us examine the environmental, gender, and weaker section's concern in the projects. Of the total state plan assistance given to grama panchayats in Thiruvananthapuram district, 28% was from special component plan (SCP) and 1% from tribal subplan (TSP). Both in the SCP and TSP of the grama panchayats, service sectors received relatively greater prominence accounting for 48.9% and 30.69% of the state plan assistance respectively.

Although there was to be a women sub component plan, in health sector, nothing much has come out in the plans. Most of the health projects contained a gender impact statement, but the impression that we received is that it was more a casual compliance with the mandatory stipulations rather than an objective impact assessment. It is the same case with child health also. In projects under education and social welfare, child development finds an important place, but not in health sector. It was pointed out that the various centrally sponsored vertical programmes like Child Survival Safe Motherhood programmes are being implemented now and so they have not been included in the plans.

Various other problems had been raised in the development reports. One important issue among them was the health problems of the elderly. But, in none of the project proposals, this component was looked into. The focus group

discussions reveal that people were finding it difficult as to how to address these problems. Except for a few health educational projects and a few financial assistance projects, nothing much has come through.

## **5.5. PRIORITISATION**

It is important to verify how the prioritisation has been done in the case of problems identified by the people. There had been an apprehension shown by the people that whatever they say would be neglected and the leaders would do as they like. Analysis of the development reports and the project documents show that the problems or suggestions not mentioned by the people have not been translated into projects. But, at the time of prioritisation of projects, there have been deviation from the rankings of problems mentioned in earlier chapter. It is to note that while selecting the projects, it was mandatory on the part of the grama panchayats to mention why those have been given priority. The grama panchayats have been found to be abiding by this directive. Generally, the reasons cited were lack of availability of resources, technical non-feasibility, lack of time as the implementation started late and lack of expertise. There have also been instances of regional interests shown by the elected members overtaking the priorities mentioned in the development reports. This paper is examining only the First Annual Plan and so, without considering the Five-Year Plan in toto, it is not ideal to state whether the people's suggestions have been totally neglected.

## CHAPTER 6

### SUMMARY AND CONCLUSION

#### 6.1. SUMMARY OF FINDINGS

The hallmarks of Kerala model in health were in terms of health indicators like mortality rates and life expectancy, low cost of health care and its universal availability. The present challenges to this model can be summarised as high morbidity with simultaneous presence of diseases of poverty and lifestyle diseases, stagnation in the growth of public health system and escalation of health care expenditure. The People's Campaign for Ninth Plan, which has earmarked 35-40% of the state's plan fund for Panchayat Raj institutions has opened up scope for facing these challenges.

The process of decentralised planning consisted of the grama sabha, which is the assembly of people in each ward of the grama panchayat, secondary data collection, preparation of development reports, projectisation of the suggestions made by the people, and finally the plan formulation. Effectiveness of these activities depended on the initiative and interest shown by the elected representatives of the people or local non-governmental voluntary organisations. Though high in number compared to the previous ones, the average participation in a grama sabha was only around 15% of the total population. If we consider this

in terms of adult population alone, the participation was around 20-25% across the different grama panchayats. This is much below the average voter turn out in Kerala elections. The participation was more in places where there were 'neighbourhood groups'. The lack of actual availability and reliability of secondary data on health sector of the grama panchayats were major hurdles in health sector planning.

Lack of drinking water emerges as the most important health problem in the district, followed by inadequate sanitation facilities and health care infrastructure. The quality of water was not discussed much, but the lack of availability of water was the main concern. The people have considered the problems faced by the elderly and the chronically ill also as emerging health problems. This seems to be relevant in the context of increased life expectancy of the population. The allocation of resources has also been more for drinking water projects, followed by sanitation.

There have been major efforts by the grama panchayats to mobilise additional resources. These include voluntary contribution, beneficiary contribution, and assistance from other financial institutions. Around 38% of the total health sector plan outlay have been from outside the state's plan assistance. There are significant variations between the quality of projects and the pattern of financing across the grama panchayats. A major weakness found in these projects was the failure to integrate state and centrally sponsored schemes in the health sector plans.

## 6.2. SUGGESTIONS FOR POLICY INITIATIVES

- 1. *Increasing the participation of people:*** As has been noted, the average participation in a grama sabha was only 15% of the total population or 20-25% of the adult population. In order to make the programme sustainable and effective in the true spirit of decentralisation and community participation in development activities, there has to be the strengthening of the grassroots level institutions like the grama sabhas. It is also important to attract the marginalised sections of the society like the scheduled caste and scheduled tribe population and women to the grama sabha. Formation and activation of 'neighbourhood groups' will be of use in mobilising people for the grama sabhas.
- 2. *Strengthening of local level database:*** There is much scope and need for the strengthening of local level database in health sector. Lack of availability of up-to-date and dependable data was found to be one of the problems faced by people in local level planning in health sector. Multiple agencies collecting the same information should be avoided. An inter-departmental collaboration along with community participation can effectively work towards the preparation of an up-to-date, high quality local database in health sector.
- 3. *Need for more expertise:*** Many health sector projects could have been made more effective with inputs from experts. Active co-operation of the local level health professionals may be sought in this regard. The voluntary technical corps, a group of 4000 retired experts from various fields, who have volunteered to assist the people in formulating the plans, could be strengthened. Official government machinery should also be made to participate more actively in the programme.
- 4. *Gender appraisal:*** There has not been much effort seen in the health sector projects to cater to the needs of maternal and child health. It is true that state and centrally sponsored programmes for these are being implemented in the

state. Yet, it would have been more useful to integrate these with the local plans in the health sector. Moreover, each health sector project should have a gender appraisal, as this is a group, which needs much attention at the local level health planning.

5. **Improving the quality of projects:** Sections on financial appraisal, activity time charts, and monitoring in the project documents has to be improved. This requires further training for the people at the grassroots level. Proper coordination between the officers concerned and the people have to be ensured for improving the quality of the projects.
6. **Health care infrastructure:** Though the people have given importance to the proximate determinants of health, and rightly so, the health care infrastructure improvement has received only a small share from the plan outlay. This has to be looked into, in the context of the fact that all the primary and secondary level health care institutions have been completely transferred to the local bodies. From now onwards, the state government's interest in improving the infrastructure will be on the tertiary centres only.
7. **Private health care institutions:** No attempt has been made to incorporate the private health care institutions in the local level planning. It is to note that almost 70% of the population depend on private sector in health in the state. Efforts should be put in to bring together all the health care institutions and various health systems for the local level health sector planning.
8. **Integration of projects:** Integration of projects was emphasised from the very beginning of the campaign. It was seen that conceptually the health sector projects had considered this aspect. But at the operational level, one finds that there was no integration of projects with other sectors or within the sector or with the higher tiers of local bodies like the block and district panchayats. There was also the lack of integration of state and centrally sponsored schemes to the local plans. This needs attention and early corrective measures have to be taken.

9. **Problems of the chronically ill and the elderly:** Though the development reports mention the importance of the health problems of chronically ill and elderly population, not much has been evolved as projects in this area. In the context of the epidemiological and demographic transition the state is undergoing, this requires immediate attention.

### 6.3. LIMITATIONS OF THE STUDY

1. This study was carried out at a stage when the grama panchayats had just started implementing their projects. It has only analysed the project documents and not evaluated the implemented projects.
2. Assessment of technical feasibility of the projects was not under the scope of the study.
3. The study has not analysed the quality of the individual projects in detail. It has only considered the general pattern of projects in health sector.
4. Thiruvananthapuram district was selected for the study due to the nearness of the place to the institute where the investigator is undergoing training and also due to the time constraints. The district may not fully reflect the situation prevailing in all other districts of the state.

### 6.4. CONCLUSION

People's Campaign for Ninth Plan has brought in a sense of need for community involvement in development activities. It is clear that the programme has facilitated the emergence of a significant amount of local level initiative in health system improvement. It is also worth noting that people recognise the proximate determinants of health as important in health sector planning. The campaign has also shown the potential for additional resource mobilisation. This is especially important in the context fiscal crisis of the state. The impact the

People's Campaign for Ninth Plan makes on the health scenario of Kerala can be analysed only after the implementation of the projects. Sustaining the spirit and tempo of the programme and correcting some of the weaknesses we have noted in our discussion is a challenging task.

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## ANNEXURE 1

### GLOSSARY OF TERMS USED

**Block panchayat:** *This is the intermediate level of governance in Panchayat Raj. It covers an area corresponding to a Rural Development Block in Kerala.*

**District panchayat:** *This is the district executive council and is the highest tier in Panchayat Raj.*

**Grama panchayat:** *It is the village executive council. This is the lowest tier in the Panchayat Raj.*

**Grama sabha:** *Assembly of all the adult members registered as voters in the area. In Kerala, the area is a ward.*

**Key Resource Persons:** *They are the persons who have undergone training on People's campaign for Ninth Plan at the state level. The local bodies select them.*

**Neighbourhood groups:** *People from 15-25 households who live nearby form a neighbourhood group. They meet to discuss the development problems in the area, to solve family and inter personal disputes and also to act as a social support group.*

**Panchayat:** *Literally it means 'an assembly of five'. Now used as a term for rural local government.*

**Panchayat Raj:** *It is a process of governance in India. At present it is based on the 72<sup>nd</sup> (panchayats) and 73<sup>rd</sup> (Nagarpalikas) constitutional amendment bills of 1992 which was later notified as the 1992 Constitution (Seventy-third Amendment) Act. The main features of this Act are 1. Panchayats will be institutions of self-government 2. There will be a grama sabha for each village or group of villages 3.*

*There shall be a three-tier system of panchayats at village, intermediate and district levels 4. Seats in panchayats at all levels shall be filled by direct election.*

*Task force: This is a group of people formed to prepare the projects. They are nominated from the Development seminars. Each development sector will have separate task force and the members include people who attended the seminar, concerned officials, locally available experts and elected representatives of the people to the local bodies.*

*Ward: The smallest unit in a grama panchayat in Kerala. Each ward will have an average population of 800-1500.*

## ANNEXURE 2

### GRAMA PANCHAYATS OF THIRUVANANTHAPURAM DISTRICT

1	Chemmaruthy	43	Vembayam
2	Edava	44	Andoorkonam
3	Elakamon	45	Attipra
4	Manamboor	46	Kadinamkulam
5	Ottoor	47	Kazhakuttam
6	Cherunniyoor	48	Mangalapuram
7	Vettoor	49	Pothencode
8	Kilimanoor	50	Sreekariyam
9	Pazhayakunnummel	51	Kadakampally
10	Karavaram	52	Kudappanakkunnu
11	Madavoor	53	Ulloor
12	Pallickal	54	Vattiyoorkavu
13	Nagaroor	55	Balaramapuram
14	Navaikulam	56	Pallichal
15	Pulimath	57	Maranalloor
16	Azhoor	58	Malayinkeezh
17	Anjuthengu	59	Vilappil
18	Vakkom	60	Vilavoorkkal
19	Chirayinkeezhu	61	Nemom
20	Kizhuvilam	62	Kalliyoor
21	Mudakkal	63	Perumkadavila
22	Kadakkavoor	64	Kollayil
23	Kallara	65	Ottasekharamangalam
24	Nellanad	66	Aryancode
25	Pullampara	67	Kallikkadu
26	Vamanapuram	68	Kunnathukal
27	Pangode	69	Perumpazhuthoor
28	Nanniyode	70	Vellarada
29	Peringamala	71	Amboori
30	Manickal	72	Athiyannoor
31	Aryanad	73	Kanjiramkulam
32	Poovachal	74	Karumkulam
33	Vellanad	75	Kottukal
34	Vithura	76	Vizhinjam
35	Uzhamalackal	77	Venganoor
36	Kuttichal	78	Thiruvallom
37	Tholicode	79	Cheakal
38	Kattakkada	80	Karode
39	Anad	81	Kulathoor
40	Aruvikkara	82	Parasala
41	Panavoor	83	Thirupuram
42	Karakulam	84	Poovar

## ANNEXURE 3

### LIST OF TRAINING MANUALS AND PUBLICATIONS \*

1. People's Campaign for Ninth Plan- Approach paper
2. People's Campaign for Ninth Plan-Hand book for the first phase
3. People's Campaign for Ninth Plan-Hand book for the second phase
4. Questionnaire for secondary data collection at the panchayat level
5. How to prepare projects-Hand book for volunteers
6. How to prepare the Plan document-Hand book for volunteers
7. Annexure forms
8. Project appraisal-Hand book for volunteers
9. Work books on health, drinking water, sanitation and social welfare
10. Voluntary Technical Corps

- *Only those publications brought out by the State Planning Board and used by the investigator for this study have been included in this list. Except the approach paper, all other publications are in Malayalam.*

ANNEXURE 4

MAP SHOWING  
DISTRICTS OF KERALA



Not to Scale