

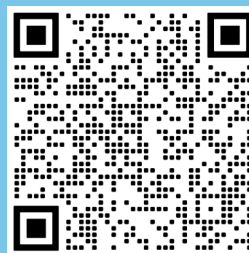


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DECENTRALIZATION AND HEALTH: LESSONS FROM THE KERALA EXPERIENCE



25TH YEAR OF PEOPLE'S PLAN CAMPAIGN IN KERALA



DECENTRALIZATION AND HEALTH: LESSONS FROM THE KERALA EXPERIENCE

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25th Year of People's Plan Campaign in Kerala
Decentralization and Health: Lessons from the Kerala Experience

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PREFACE

With an illustrious track record in healthcare, Kerala has set an internationally acclaimed model for other Indian states and developing nations. At the core of the state's success in the health sector lies the concerted efforts of multiple stakeholders streamlined through well-structured decentralisation and multi-level planning.

With the ever-evolving challenges in healthcare including novel infectious diseases and pandemics, chronic non-communicable diseases and higher suicide rates, the state government is carving a new trajectory for healthcare as a part of its Navakeralam Karma Padhathi. Aardram Mission, a flagship program of this initiative aims at strengthening the primary healthcare system with an emphasis on enhancing the quality of patient care and creating patient friendly health delivery systems.

As Kerala stands at these crucial crossroads, it is essential to evaluate the performance of the two-decade long experience of decentralised governance and its impact on the healthcare system. This is highly essential as the last evaluation which assessed the effect of decentralisation on the health system was published over a decade ago. Taking this into consideration, this book has been developed to explore the perceived impact of the decentralisation process on the health system of Kerala and understand the specific contextual factors and mechanisms which facilitate better outcomes in local health facilities. The book also seeks to evaluate the major trends in allocation and utilisation of funds in the micro sectors of health across the various levels of local governance. It includes four major studies which assess the outcomes and impact of decentralised planning on the health sector in Kerala. These studies touch upon various aspects including the perspectives of elected members, investment patterns of the



various government levels, developing new approaches to assess PHC performance under a decentralised government and the transitions in the healthcare sector.

KILA acknowledges and appreciates the meticulous efforts of the health care experts and their team in preparing such a well researched and executed study. We also thank every individual involved in the planning, design and publication of this work.

Dr. Joy Elamon
Director General, KILA



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M B Rajesh

Minister for Local Self Governments,
Rural Development and Excise
Government of Kerala

25 years of People's Planning- A Success story of decentralisation of power in India

The People's Plan Campaign is a unique initiative that has transformed the landscape of developmental politics in Kerala. This great experiment encapsulated the democratic achievements, Kerala made over the decades. It included the land reforms initiated by the first Communist government led by EMS Namputiripad, the government which was the product of larger movement for land in the pre-independent era and also included the innumerable struggles for land- rights and surplus land in the post – land reform period by the tenants across the state.

In 1996, the state launched the People's Plan Campaign, which was designed and implemented as a successful methodology for transferring fund, functions and functionary that constitutional amendments in 1992 envisaged as the necessary condition to make the devolution of power possible. The campaign and the related process empowered the local level leadership and people at large to plan and implement their own development projects, ensuring inclusive development. Potential of our decentralized government system which was nurtured by the People's Planning process got its effective manifestation during the time of 2018



flood and Covid. Along with the Kudumbashree movement, decentralisation of power through the people's planning has achieved remarkable success in enhancing the quality of life of people of Kerala and expanding the vistas for economic wellbeing and social development.

Today, in yet another transformative moment of Nava Keralam, new responsibilities are placed confidently on the shoulders of local governments in Kerala. Government expects local governments to become the leaders of economic development by fostering the growth and employment on par with that of developed nations, as it has been in the case of human development. In the journey of creating a Nava Keralam, we also pin hope on our local self-government institutions to make Kerala waste free by clearing the waste produced in our own neighbourhoods through the sustainable systems.

The series of 25 books published by KILA is a valuable contribution to the knowledge base on decentralization, documenting the experiences of the People's Plan Campaign and capturing the essence of decentralization and the role of local governments in development. I am confident that these books will serve as a valuable resource for other states and countries that are striving to achieve sustainable development through decentralization.

I congratulate the team at KILA and the local governments of Kerala for their outstanding work and am proud of the achievements of decentralization in Kerala. I am confident that the state will continue to scale new heights in the years to come.



1

INTRODUCTION

Decentralisation is a broad term that has been used in literature under different contexts with varying interpretations. It is typically defined in public planning or management to imply transfer of power from higher to lower levels of administration or from national to sub-national or regional levels.¹ According to Rondinelli, it “involves the transferring or delegation of authority to plan, take decisions and manage functions from the central government and its agencies to field organisations of those agencies, lower units of government, semi-autonomous public bodies, development and functional authorities, local governments or non-governmental organisations”. This definition not only describes the process, but also specifically alludes to the reasons behind the shift of power (p.13).²

The World Health Organisation defines health system decentralisation as “moving decision-making away from centralised control and closer to the users of health services”.³ The definition implies that it is a fiscal, political and administrative phenomenon that involves a shift from a centralised governance. Since the 1980s, there has been a re-emergence in the discussion surrounding decentralisation in literature, both as a means to achieve sustainable development and as one of the more important aims of good governance (p.1).⁴ Internationally, health is one of the social sectors that has been influenced by and discussed widely in the context of decentralised governance, especially in the developing countries.



There was also a growing discourse during this period regarding the relevance of governance as a key determinant in addressing the problems faced by health systems from resource-poor settings like poor allocation of public funds to the health sector, inefficiency of the public healthcare sector, rising inequalities in health and increasing costs of health services (p.1).^{4, 5} The World Health Report of the year 2000 proposed that a well-functioning health system has four major responsibilities namely stewardship, financing, creating and managing resources and service delivery.⁶ The fundamental line of argument which favoured decentralisation as a reform measure was that, as the distance between the point at which decisions are made and the point of generation of necessary information is reduced, we enhance the efficiency of planning (p.5).⁷ It was argued that decentralisation would bring about greater focus on the needs of the communities, enhance community participation, speed up development programmes, improve healthcare coverage, enhance accountability, flexibility, responsiveness and equity of health systems.⁸

Through the 73rd and 74th constitutional amendments in 1992 (Eleventh and Twelfth Schedules respectively), Government of India introduced local selfgovernance in the rural and urban sectors. Kerala introduced new legislative provisions to implement the change and introduced a comprehensive, statewide bottom-up planning process for the Ninth Plan – the People’s Planning Campaign. Under the new legislative provisions, all the 29 subjects mentioned in the eleventh schedule (rural governance) and 18 subjects mentioned in the twelfth schedule (urban governance) were transferred to the respective local governments in Kerala. The subjects included health and sanitation (including hospitals, primary health centres and dispensaries) under rural governance, and



public health, sanitation conservancy and solid waste management under urban governance (p.8). ⁴

The context of the health sector also needs to be considered when we discuss the initiation of decentralisation in the state. The consistent health achievements of the state had been widely discussed internationally, earning it the status of a 'model' in health sector. However, by the early 1990s, the overall health picture had started showing a number of disturbing trends - comebacks staged by many infectious diseases, shift in the morbidity pattern of the state towards chronic non-communicable diseases, higher suicide rates and reports of deteriorating quality of the public health sector. The decentralised planning movement was seen as an opportunity by health activists to intervene in this situation and one of the original goals of the People's Planning Campaign was to ensure that the health services function more effectively (p.684-6). ⁷ The present study aims to examine the perceived impact of multilevel planning and decentralised governance on the health system of the state from the perspectives of a wide range of stakeholders, in the context of the two-decade long decentralisation process.



2

BRIEF BACKGROUND AND NEED FOR THE EVALUATION

Globally, during the 1970s, the central role of the state in development, the dominating influence of medical elite in health policy formation and the exclusivity of the medical paradigm to achieve health for all were being debated and alternative paradigms were being sought. The Alma Ata declaration of 1978, which focused on primary healthcare, gave impetus to this reform process in the health sector. In the 1980s, however, neoliberal ideas began to dominate the health sector, steering the reform process to a more market oriented paradigm.

Decentralisation, as a reform measure in health, was initiated in several countries of Africa during the 1980s, mostly with the support of international donors.^{8,9} A study which explored the health sector reforms which happened in the sub Saharan Africa over a period of ten years between 1985 and 1995 found that decentralisation of planning and management of primary and secondary level health services in the public sector to the district level was one of the major organisational reforms in most of the countries. The establishment of large teaching hospitals as self-management enterprises was another major reform. The support for these reforms during the period came from two international sources. One was from the World Health Organisation, which espoused some degree of decentralisation of policy making and strengthening of the district health systems in order to make the primary healthcare policy



making more relevant. The second major driver of reforms was the push for political and economic liberalisation by the international financial institutions. The degree of decentralisation varied between de-concentration, delegation, partial devolution of political power and outright privatisation across countries.⁹ India has a long history of decentralisation due to the strong association of the idea of Gram Swaraj with the national independence movement. As early as 1957, we had established a three -tier system of local governance in the form of Panchayati Raj institutions. However, this did not result in actual devolution of power, functions and resources to the local levels. The movement received an impetus due to the 73rd and 74th constitutional amendments in 1993, which provided the necessary legal framework and also devolution of specific powers related to 29 subjects including health.

13

The constitutional amendments and the Panchayat Extension to Scheduled Areas Act (PESA, 1996), introduced by the Government of India, which gave new lease of life to the decentralisation process in the country, followed in the wake of economic liberalisation. To quote the World Bank on the topic of decentralisation in India, “Given India’s size and diversity, decentralisation is very important for the country’s strategy for poverty reduction”.¹⁰ Thus, the revival of national interest in decentralisation during this period was largely motivated by the new paradigms of governance and development and the neoliberal agenda of downsizing the state. However, despite the amendment, the progress towards decentralised governance was still slow for the majority of the country. The one exception was Kerala, which comprehensively undertook the devolution of power, functions and resources at one go in an act of political faith.¹⁵



Decentralisation experience of Kerala - unique

The experience of decentralisation in Kerala was unique in many ways. The primary factor was political motivation which drove the process in the state. The initiative of the Left Democratic Front in implementing it, not just as an administrative process, but as a mass mobilisation, is explained by the historical positions of the front in this regard. As early as in 1958, they envisioned a strong local governance system to ensure that democratic processes would flow to the grassroots level, which is clear from the recommendations of the first Administrative Reforms Committee of the state headed by late Shri E M S Namboodiripad.¹⁵ According to Isaac and Franke, the Kerala experience differed in the following four main respects.¹⁶

- i Kerala reversed the theoretical sequence of implementing decentralisation, when it took the plunge and devolved the power and resources, instead of waiting to build the administrative capacity of the LSGs.
- ii Planning process which happened at the level of the local bodies was used as an instrument of social mobilisation in support of decentralisation.
- iii The introduction of a campaign to spearhead the planning process (People's Planning Campaign) also sought to nurture a civic culture that promoted grassroots level institutions.
- iv Simultaneously the state also initiated the process of institutionalising decentralisation in the legal and administrative systems.

A report submitted to the XIII Financial Commission naming Kerala as a classic case study of democratic decentralisation in 2009, mentions the following achievements.¹⁴



- i Development of a participatory planning methodology
- ii Strict adherence to rule-based devolution of funds which ensured the smooth flow of resources across the state with extra focus on backward performing pockets
- iii Increase in pro-poor spending
- iv Significant improvement in public service delivery in health and education
- v Enhanced transparency in the planning process
- v The open and normative process involved in the selection of beneficiaries which has improved the targeting of benefits
- vi Considerable contribution to the public, mostly in kind
- vii The implicit social contract which has created an active willingness in the community to manage public assets
- viii Kudumbashree - the working model of convergence between the networks of neighbourhood women and LSGs – synergy of participation and democratisation; an innovative activity that developed the introduction of lease land farming
- ix Enhancement of the capacity of elected members
- x Decentralisation which reduced the costs and increased the efficiency of the system which is especially visible in public works

The report also mentions some challenges, the major ones being the following:

1. Weak official capacity of Gram Panchayats which are the strongest LSGs
2. Management of professionals in the service sector
3. Thinning spread of resources to meet the demands of the population, reducing substantial investments in appropriate projects



4. Lack of keen interest in the local development process by the affluent and powerful sections of the local communities who control the means of production. This is also because platforms like Gram sabhas and ward sabhas, many a time, get reduced to being platforms of beneficiary identification instead of those of development dialogue
5. Failure of LSGs in achieving local economic development
6. Weak and unreliable local statistical system
7. Persistence of marginalisation among specific groups
8. Weak record keeping and monitoring systems

We briefly summarise the findings from the four major studies which have assessed the outcomes and impact of decentralised planning on the health sector in Kerala

Table 1
Studies which have assessed the outcomes and impact of decentralised planning on the health sector in Kerala

Author, year	Objectives	Major findings
Narayana D and Kurup KKH, 2000 ¹⁷	To analyse decentralisation of the healthcare sector in Kerala and the associated problems as perceived by the elected members	The elected representatives agreed with the general usefulness of decentralisation efforts. Decentralised planning was generally appreciated. Corruption was thought to be less and project implementation was considerably faster. A shortcoming mentioned was that the lack of expertise hinders preparation of



		projects and that as of now projects are mostly prepared by the doctors working in the PHC or hospitals. The findings suggest that three basic problems of decentralising the healthcare sector, namely the spill-over effect, role and relevance of a pre-existing body (Hospital Development Committee or HDC), and the level of minimum healthcare service to be provided by the healthcare institutions, have not been adequately addressed
Elamon J, Franke RW, Ekbal B, 2004 10	Using an analysis of investment patterns of the various government levels involved in the campaign, supplemented with case study materials, the paper attempts an evaluation of the decentralisation project against its own stated goals namely (1) creating a functional division among government levels appropriate to	The paper concluded that the campaign had achieved each of its objectives to a great degree. A major finding was that public health and healthcare delivery services now function more effectively as a result of the popular campaign approach to decentralisation of health services undertaken in Kerala between 1996 and 2001. Through the five years of the campaign, PHCs had improved in hundreds of localities. Physicians and community activists worked together, and relations among them improved. The campaign mode of decentralised planning resulted in a remarkable outpouring of volunteerism in many localities. Another important finding was that of women becoming more



	the health tasks each level can best perform; (2) generating projects that reflect the felt needs of the people, as voiced through local participatory assemblies; (3) maintaining or increasing levels of equality in health, especially with regard to income, caste, and gender; (4) stimulating communities to mobilise voluntary resources to supplement devolved public funds; (5) stimulating communities to create innovative programmes that could become	assertive and active in local assemblies and political meetings. Shortcomings arose from the inexperience of many local communities in drafting effective projects as well as problems deriving from the fact that some sections of the health bureaucracy could not be decentralised.
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	models for others; and (6) making the health services function more effectively overall.	
Varatharajan D, Thankappan KR, Jayapalan S, 2004¹⁸	Although the study assessed the performance of Primary Health Centres post the introduction of decentralised planning, the objective of the paper was to develop an approach to assess PHC performance under a decentralised government.	It was found that the Gram Panchayats allocated a lower proportion of resources to health than what was allocated by the state government prior to decentralisation. While the LSG resources grew at an annual rate of 30.7 per cent, health resources grew at 7.9 per cent. PHCs were funded to the extent of 0.7–2.7 per cent of the total cost. An additional 2 per cent in PHC resources was associated with improved patient load (63.5 per cent), cost-effectiveness (50.8 per cent), medicine supply (49.4 per cent), information (32.8 per cent) and patient satisfaction (12.7 per cent). The authors concluded that decentralisation brought no significant change to the health sector. Active panchayat support to PHCs existed in only a few places, but wherever it was present, the



		result was positive. Kerala should find an alternative strategy to channel panchayats towards health before health loses its battle for resources.
Thomas BM & Rakesh K, 2011 ¹⁹	To analyse the transition in the healthcare sector during the preceding two decades (1996-2011) linking it to the interventions of the local governance	Decentralisation was successful in improving the health infrastructure and equipment in the primary and secondary healthcare facilities infrastructure facilities. It also widened the network of healthcare delivery. Another major achievement was the improvement in the provision of safe drinking water and sanitation. The authors found that decentralised governance had a positive impact on the accountability of the public healthcare system. However, the major shortcomings addressed were the persistence of issues of nutritional imbalance, elderly healthcare, lifestyle diseases and the changing morbidity pattern in the state. The authors concluded with a recommendation for a comprehensive health policy to ensure functional autonomy for LSGs to address the changing pattern of



		healthcare needs and newer diseases in the state.
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Among these four papers which evaluated decentralised planning in the health sector of Kerala, only one had explored the perspectives of the diverse range of stakeholders involved in its implementation and the beneficiaries. In this study, conducted in 2004, the authors had exclusively focused on Primary Health Centres.¹⁸ In addition to an extensive analysis of state level data from government economic reviews and other sources, the researchers had also conducted Key Informant Interviews at the level of LSGs and PHCs and client exit interviews at the PHCs, from selected local settings.

However, the study did not acknowledge or address the potential interaction of local contextual factors of the diverse settings with the actual mechanisms of implementation of planning. It also did not engage with some of the major stakeholders of decentralised planning such as the community members and other non-governmental interest groups. The perspectives of these stakeholders on their participation in the implementation and subsequently on its outcomes, if captured, could have significantly contributed to our knowledge regarding the process. The study findings concluded that decentralised planning, in effect, did not contribute significantly to the health sector, partly due to the less than encouraging response of the health system and partly owing to the lack of technical expertise and active lobbying from the side of the panchayats.



In 2016, the Government of Kerala launched the Nava Kerala Mission to address the problems faced by the key social sectors, one of them being health, through the help and involvement of the LSGs. One of the schemes launched under this was the Aardram Mission which aims the strengthening of the primary healthcare system. The programme places emphasis on enhancing the quality of patient care and in creating patient friendly health delivery systems.

As the state cruises along a new trajectory to refurbish the health system, it is critical to evaluate the performance of the two-decade long experience of decentralised governance. This is also pertinent since the last evaluation which assessed the effect of decentralisation on health system was published over a decade ago. This makes it pertinent to explore the perceived impact of decentralisation planning on the health system of Kerala and understand the specific contextual factors and mechanisms which facilitate better outcomes in local health sectors.



3

RESEARCH QUESTIONS AND OBJECTIVES

3.1. Research Questions

This research study explored the following four major research questions:

1. What has been the perceived impact of shift to multilevel planning and decentralised governance on the health sector of Kerala?
2. How has multilevel planning and decentralised governance influenced the accountability, responsiveness and inclusiveness of the health sector in Kerala?
3. Which major contextual factors influence accountability, responsiveness and inclusiveness in local health sectors under multilevel planning and decentralised governance?
4. What are the major trends in allocation and utilisation of funds in the micro sectors of health across the five levels of local governance (Gram Panchayats, block panchayats, district panchayats, municipalities and corporations) and districts between 2002 and 2019?

3.2. Objectives

This research study had the following objectives:



1. To explore the perceived impact of multilevel planning and decentralised governance on the health sector of Kerala
2. To assess the influence of multilevel planning and decentralised governance on the accountability, responsiveness and inclusiveness of the health sector in Kerala
3. To explore the major contextual factors which influence the enhancement of accountability, responsiveness and inclusiveness of local health settings in Kerala
4. To evaluate the major trends in allocation and utilisation of funds in the micro sectors of health across the five levels of local governance (Gram Panchayats, block panchayats, district panchayats, municipalities and corporations) and districts between 2002 and 2019



4

METHODOLOGY

4. 1. Operational definitions

4.1.1 Multilevel planning and decentralised governance in health

For the purpose of this study, we defined multilevel planning and decentralised governance in health as all the activities involved in bottomup planning and decision-making aimed at the betterment of health of any defined local community, which occurred at the four administrative levels of Local Self Governments namely the municipalities, the district panchayats, the block panchayats and the village panchayats and all those institutions (e.g. public healthcare facilities), platforms (e.g. Gram sabhas), institutional structures (e.g. hospital management committees) and other organisations (e.g. Kudumbashree) which were administratively affiliated to them.

4.1.2 Health sector

For the purpose of this study, we defined the health sector as comprising those institutions responsible to steer the activities aimed to address health and its determinants (including healthcare) in any defined local community. Thus, we included both Local Self Governments at the four administrative levels and the public healthcare facilities functioning under the LSGs within this definition. Although the private sector in itself did not form a part of this definition and was not included within the purview of this enquiry, when its role in a particular context was perceived to be relevant, it was examined.



4.1.3 Stakeholders

In this study, we defined the stakeholders as belonging to one of the five groups - the community, the Local Self Governments, the political parties, the public healthcare facilities and other interest groups - who were expected to be directly or indirectly involved in the planning and governance process in the health sector.

4.2. Conceptual framework

We conceptualised decentralised planning in the health system as an active, dynamic, constantly evolving process driven by certain fundamental theoretical assumptions deeply embedded in the local social and political contexts.

An initial conceptual framework incorporating the key domains to be explored was developed to guide the research process. This initial version was iteratively modified as the study progressed. We adopted the structure of this framework and the inter-relationships from the framework suggested by the United Kingdom Medical Research Council for process evaluation of complex interventions.²⁰

As part of the study, we examined the implementation of planning and governance in the health sector in selected local settings and explored its evolution over the past two odd decades since People's Planning Campaign in 1996. An exploration of the local contextual factors which have influenced the effect of change in local health sectors was done. We also explored the interaction between the Local Self Governments (LSGs) and the local public healthcare facilities in the process of implementation. The roles and perceptions of each of the five stakeholders in the process were examined to understand how the shift to decentralised planning influenced the health sector. We have conceptualised the outcomes



primarily as the accountability of the health sector, responsiveness of local healthcare facilities inclusiveness in health sector.

4.2.1 Accountability

Accountability was conceptualised as the presence of mechanisms to track and report on the answerability of the system in the following two main domains.²⁴

- i. *Democratic/political accountability* – did the institutions, procedures, and mechanisms ensure that health sector represented the felt needs of the community?
- ii. *Performance accountability* – did the accessibility, availability, affordability, acceptability and quality of public healthcare facilities meet the expectations of the stakeholders and community members?

4.2.2 Responsiveness of local health facilities

Based on the WHO framework, we conceptualised responsiveness primarily as the interpersonal process between the practitioners in the public healthcare facilities and the patients they served. ²⁵ It was conceptualised in the following seven aspects of healthcare in the public healthcare facilities:

- i. Respect for autonomy of patients
- ii. Choice (and ability) of the patients to seek advanced care
- iii. Respect for dignity of patients
- iv. Clarity of communication
- v. Prompt attention
- vi. Quality of basic amenities in public healthcare facilities
- vii. Access to family, community and social support for healthcare



4.2.3 Inclusiveness of the health sector – this domain emerged out of the democratic accountability component and we examined three main aspects:

- i. The extent to which the marginalised groups perceived themselves to be participating in the democratic process of health planning
- ii. The extent to which the marginalised groups in each of the settings experienced responsive healthcare at the local public healthcare facilities

4.3. Study design

The study employed a concurrent nested mixed methods study design. It was conducted in a single phase which simultaneously pursued two tracks:

I. Qualitative phase

The main components of this phase were:

- Qualitative exploration using grounded theory approach: expected mechanisms and outcomes of decentralisation in the health sector were explored.
- Multiple Embedded Case Studies using the framework of realist evaluation: the role of contextual factors in enabling or constraining the mechanisms of decentralised planning and its influence on the local health sectors were explored

II. Quantitative phase

A household survey conducted in the community, as part of the case study component, constituted the quantitative phase of the study.



4.3.1 Qualitative phase

4.3.1.1 Qualitative exploration using grounded theory approach

In this step, we developed a theoretical understanding of the expected mechanisms and their relationships with the expected outcomes of decentralised planning specifically for the health sector, based on the perspectives of the policy architects, early champions and advocates of the Peoples' Planning Campaign and decentralised planning in health. An initial panel of eight to ten participants was selected, purposively using theoretical sampling based on the nature of their involvement with the process as assessed from early government documents, academic and/or non-academic literature and anecdotes. The process was continued through snowball sampling until theoretical saturation was achieved.

4.3.2.2 Multiple Embedded Case Studies using the framework of realist evaluation

Definition of the case: The case in this evaluation was a health unit working under a Local Self-Government. We chose multiple case studies to represent all the districts of the state and different levels of administration - Gram Panchayat, block Panchayat, district panchayat and municipality. Within each case, the analysis was embedded on five units namely, the local government, public healthcare facilities including the AYUSH Department, major political parties, other major interest groups like Kudumbashree/civil society organisations active in each community and the community.

We used this approach to develop and test a programme theory formulated from multiple settings. The theory elaborated on the configuration of specific contextual factors and the mechanisms through which they operated to result in local health sectors that were perceived



as more or less accountable, responsive and inclusive than what existed before.²¹ We followed four steps in the process:

- i. *Development of the programme theory:* Using the initial five case study reports from different administrative settings of LSGs, we developed a programme theory regarding the contextual factors and their interaction with potential mechanisms which enhanced accountability, responsiveness and inclusiveness in health sector. For this purpose, we used the perspectives of the stakeholders – oral histories, testimonies and in-depth interviews – and relevant document analysis, from each of the selected local settings.
- ii. *Collected data from multiple settings to assess the actual implementation of the process:* Data was collected from multiple settings through a combination of stakeholder interviews, non-participant observations of LSGs and public health facilities, household surveys among eight to ten most vulnerable households in each setting and through analysis of relevant documents to assess the actual implementation of decentralised planning.
- iii. *Testing the theory:* In this phase we assimilated the data collected from multiple settings to test the programme theory developed at the first stage. The aim was to develop a comprehensive theory incorporating the interactions of the diverse contexts and mechanisms that would result in more or less accountable, responsive and equitable health systems.
- iv. *Interpretation of the theory and comparison with the framework on expected mechanisms:* We then compared and contrasted the expected mechanisms which emerged in the qualitative exploration phase with the mechanisms observed in the final programme theory to understand critical differences and to



identify the core contextual factors which may have contributed to these differences.

4.4. Selection of study settings for the case study

The study settings for the evaluation were selected from the fourteen districts of Kerala based on the following two characteristics:

4.4.1 Type of district

We purposively categorised districts of the state into three – Group I (with a significant tribal population, i.e. where more than 10 per cent of the tribal population of the state reside), Group II (with a significant coastal population, i.e. those districts which have a coast line extending for more than 10 per cent of its total length) and Group III (neither a significant tribal population nor a significant coastal population). Study settings were selected in such a way that at least one district from each of the three groups was represented.

4.4.2 Level of administration

Four levels of administration were represented in this study – municipalities (urban), district panchayats, block panchayats and Gram Panchayats (rural). The public healthcare facilities functioning under each of these LSGs also formed a major component of each case study. All the levels except Gram Panchayats (GPs) were selected using simple random sampling. For the selection of Gram Panchayats from each of the selected blocks, we approached the Block Development Officer and the District Medical Officer to rank the GPs according to their perceptions regarding the functioning of the health system. Any major disagreement in the ranking was sorted out through consultations until a consensus was reached and the best and the worst GP in each block were selected for the case study. Each study setting comprised a separate case study



and a total number of 25 cases were finalised during the theory testing phase of the realistic evaluation.

Table: 2
Study settings

Type of district	Districts	Municipality	District panchayats	Block panchayats	Gram panchayats
Coastal (8 settings)	Thiruvananthapuram			1	2
	Alappuzha	1			
	Malappuram				2
	Kozhikode		1		
	Kannur			1	
Tribal (7 settings)	Idukki	1			
	Palakkad			1	2
	Wayanad		1		1
	Kasargode				1
Non-coastal Non-tribal (10 settings)	Ernakulam	1		1	
	Thrissur			1	2
	Kollam		1		
	Pathanamthitta	1			2
	Kottayam	1			
Total (25 settings)	14	5	3	5	12

4.5. Details of the household survey

Community was one of the stakeholders in this evaluation study. Three major outcomes namely, the extent of democratic accountability, responsiveness and inclusiveness of health sector were assessed from the



community's perspectives using household survey and in-depth interviews. The households were selected in such a way in each of the selected settings, in addition to economic backwardness (BPL households were selected) there was representation of the most vulnerable social groups. The households were selected on the basis of one of four primary axes of vulnerability namely:

- i. One or more family members suffering from chronic conditions
- ii. Single woman-led (one or more family members may not be suffering from chronic conditions)
- iii. Elderly member or couple living without adequate support (one or both may or may not be suffering from chronic conditions)
- iv. Affected by recent floods (2018) (one or more family members may not be suffering from chronic conditions)

The households were selected randomly from at least three separate purposively selected lists of vulnerable households prepared by different sources from each setting – SC/ST promoters, ASHA workers, Kudumbashree volunteers and/or Anganwadi workers. The household survey included a simple checklist to assess their information status about entitlements and platforms of participation in governance and their past experience of participation in the governance structures. At least one consenting family member was also interviewed from each household and testimonies regarding their most recent experiences of negotiating with the health system were documented. The interviews focused on their three most recent healthcare experiences in a public healthcare facility. Among those household members who had not had a recent experience in a public healthcare facility, the reasons for not choosing a public healthcare facility were explored and their most recent three healthcare experiences in any facility were recorded.



4.6. Exit interviews of patients visiting local public healthcare facilities

The domain of responsiveness was further enhanced using exit interviews of patients visiting public healthcare facilities during one day of the study period from selected settings. A minimum of five patients visiting the facility (within a maximum duration of four hours) were interviewed after their healthcare visit was completed, to explore and document their experience in the eight domains of responsiveness based on the visit. A total of thirty exit interviews were done from six selected study settings. The patients were also enquired about the changes that they had perceived in the healthcare experience in each of the settings over a period of time.

4.7. Criteria for document analysis

The major documents analysed, as part of the case studies, were minutes of the Village Health, Sanitation and Nutrition Committees, Gram sabhas, Working Groups of Health, Drinking Water and Sanitation, Hospital Management Committees, Health Standing Committees and Development Seminars, Draft and Final Health Plans, and Development Reports. The documents from each of the study settings for the past three years (except Development Reports, which were collected from as early as 1996), were analysed on the basis of the following criteria:

- i. Frequency of meeting – the frequency of meetings was evaluated against the minimum expected frequency of each of the platforms to convene.



- ii. Representation – representation in each of the platforms was assessed based on the nature of attendees and the extent of attendance
- iii. Originality of content – originality of content was assessed on the basis of two criteria: -
- iv. how far the documents alluded to the local health needs of the setting
- v. the extent of repetitiveness in the minutes
- vi. Emphasis given to inclusiveness – here we explored the extent to which the health problems and needs of the marginalised and vulnerable sections of each setting found representation in the minutes
- vii. Extent of detailing – the comprehensiveness of the documents in terms of the extent to which problems have been detailed and the degree of thoroughness with which the solutions have been strategised
- viii. Major themes – the major themes which have emerged from each of the documents.

4.8 Secondary data analysis

Raw data pertaining to the allocation and utilisation of funds to the health sector through the local self-governments between 2002 and 2019 was collected from the Information Kerala Mission. This was analysed in detail to explore the trends in the allocation and utilisation of funds in the health sector across districts, different levels of administration and across micro sectors in health over the two-decade period. The analysis also focused on how the Special Component Plan (SCP) and Tribal Sub Plan (TSP)* were used in health between 2012 and 2019.



*Special Component Plan (SCP) and Tribal Sub-Plan (TSP) are funds which cater exclusively to Scheduled Castes (SC) and Scheduled Tribes (ST) respectively.

4.9 Analysis of qualitative data and household survey

- i. *Qualitative exploration using grounded theory approach:* The audio recordings with the key informants were transcribed verbatim and translated to English, inductively coded and thematically analysed using the method of constant comparison to explore the perceived impact of multilevel planning and decentralised governance on the health sector of Kerala, in comparison with their original expectations from the shift.
- ii. *Multiple embedded case studies used in realist evaluation:* We drafted individual case study reports after the first five case studies and developed a tentative programme theory on how decentralised planning and governance has been implemented in the different settings and how it has influenced the three major outcomes namely - accountability, responsiveness and inclusiveness. In the following ten case studies, we embedded the case studies on the five units of analysis in each setting and expanded the theory to explore the major contextual factors which favoured/deterred the accountability, responsiveness and inclusiveness of local health settings in Kerala. In the final ten case studies, we tested this theory to develop the frameworks which explained the theory for each of the three outcomes.
- iii. *Analysis of the household surveys* – the data from 116 households surveyed was analysed in detail, to be presented in tables.



5

RESULTS

The results from this evaluation are broadly divided into four main sections according to the study phases, as presented in the following table:

Table:3
Organisation of results

Study phases	Data sources and methods	Sections of results	Sub- sections of results
Qualitative exploration using grounded theory approach	Key informant interviews, policy documents pertaining to PPC	Perceived impact of multilevel planning and decentralised governance in the health sector consequent to the shift	• Health sector before the shift to multilevel decentralised planning and governance • Perceived changes in the health sector consequent to the shift • Gaps perceived in the process and outcomes evaluated against the original expectations of the shift
Multiple embedded case studies used in realist evaluation	In-depth interviews with multiple stakeholders. Exit interviews, household	Accountability, responsiveness and inclusiveness in the health sector	• Impact on accountability, responsiveness and inclusiveness in the health sector consequent to the shift • Contexts, mechanisms and outcomes favouring/ deterring accountability,



	survey analysis, document analysis		responsiveness and inclusiveness in the health sector
Secondary data analysis	Description of raw data from IKM	Trends in the utilisation and allocation of funds to health sector between 2002 and 2019	Trends in the utilisation and allocation of funds to the health sector in the three specified time periods (2002-07, 2007-12 & 2012-19): • Among the micro sector categories in health, across districts • Among the micro sector categories in health, across levels of administration. • Nature of allocation and utilisation of SCP and TSP funds in health

5.1 Perceived impact of multilevel planning and decentralised governance in the health sector consequent to the shift

This broad theme emerged from the qualitative exploration conducted among key informants (predominantly early advocates, activists, community leaders and policy actors who worked actively during Peoples' Planning Campaign) and they indicated that the perceived impact of the shift cannot be fully conceived without an understanding of the situation that existed in the sector, before this period. The functioning of the system was different from the present situation in many respects:



5.1.1 Health sector before the shift to multilevel decentralised planning and governance

The situation which existed in the health sector from the perspectives of the key informants had six major defining characteristics as described below:

5.1.1.1 Health was conceived differently: Health was largely understood as healthcare and there was hardly any discourse about health in a development context. Health was almost entirely considered as a concern of the healthcare systems, both government and private, and the significance of broader determinants in producing good health were not a serious consideration at the ground level.

5.1.1.2 Different approach to health governance: In the centralised system of governance which existed before, bureaucracy played a major role which led to considerable procedural delays in planning and decision-making. More power rested with the officials. There were also instances reported by the key informants about undue interference in the functioning and administration of the system to protect the vested interests of a few. The beneficiaries of the system were distant from the governance mechanism which worked to solve their concerns. The community did not have any significant role in the actual process of health planning and decision-making. There were few channels between the system and the beneficiaries to interact and for the system to understand the actual needs of the community they served. This resulted in the health system being less accountable to the community and less responsive to the needs of the people.

5.1.1.3 Different focus and priorities of the state health system: The focus of the state health system was primarily the running of vertical programmes with very little horizontal integration. The alternate systems of medicine



(AYUSH) had a relatively negligible role with hardly any integration with the health system. There was no way for the system to ensure that the prioritisation and decision-making were based on the needs of the community. Moreover, this was not a priority at all.

5.1.1.4 Inadequacies in infrastructure, manpower and poor work culture in the public health sector: The general perception of the key informants was that the healthcare infrastructure of the state was negligible before the shift. Manpower shortage was widely reported in all cadres of the system and the work culture of the system did not prioritise the beneficiaries.

5.1.1.5 Accountability of health professionals: The key informants opined that health professionals were relatively less accountable for their performance. There was no system of regular monitoring of the performance of the professionals and they were not answerable to the system. Provision of healthcare of acceptable standards and the satisfaction of the beneficiaries were low priorities for the professionals in the public health sector. Poor healthcare infrastructure which existed in the system was used as an excuse by the professionals to justify the poor functioning of the health facilities. The doctors had few independent responsibilities other than provision of healthcare and did not have any role in health planning.

5.1.1.6 Doctors' apprehensions about any change in the system: The doctors were highly apprehensive about potential changes in the health system as a transferred institution functioning under LSGs in decentralised governance. They anticipated a change in authority and felt that their position in the system would get challenged after the change.

5.1.2 Perceived changes in the health sector consequent to the shift

The major changes perceived by the key informants in the health sector of the state fell under the following:



5.1.2.1 *Approach to health as a sector (part?) of governance:* Consequent to the shift to decentralised governance, health institutions were transferred under the LSGs and this brought them closer to governance structures. This greater proximity brought about a change in the way health was conceived and approached in local communities with two major implications.

- a. *Health became a point of political visibility:* The first implication is that, after the shift, the health concerns of the local communities and the functioning of local health facilities became core concerns of the LSGs. Health got greater visibility and it got highlighted during elections as one of the indicators of the performance of a local government. Local communities started holding LSGs accountable for their concerns including health, livelihood, drinking water, sanitation, housing and so on.
- b. *Health beyond healthcare:* The second implication is that action on health moved beyond the provision of healthcare. The role of factors outside the control of the health system became identified and acknowledged as determinants of health. This led to more collaborative and concerted local efforts on health determinants like drinking water, sanitation, hygiene and waste disposal. LSGs and other community-based organisations like Kudumbashree had a prominent role to play in the action on health determinants. The other benefits of this wider collaboration included greater community awareness, concerted efforts for the prevention and control of communicable and noncommunicable diseases and the acknowledgement of the significance of health of women, children and adolescent girls. Thus, through collaboration with LSGs, work in the health sector managed to reach those areas of action which remained largely untouched until then. The study participants also



considered the gradual growth witnessed in urban health, a consequence of this greater awareness about the wider definition of health.

5.1.2.2 In the public health sector: The key informants perceived positive and significant changes in the functioning of the public health sector consequent to the introduction of decentralised governance. The changes were attributed to the fact that the shift to decentralisation led to the creation of a political context in local communities amenable to discussion, action and transformation. The state health system got greater focus and support and this reflected as positive and sustained changes in the health sector. The changes were observed in the following areas:

- a. More efficient decision-making: The key informants perceived that the process of planning and decision-making became speedier, since they happened in local contexts according to needs predominantly identified from immediate settings. The role of bureaucracy got constricted and this reduced undue procedural delays.
- b. Better allocation for health and optimisation of resources: The involvement of LSGs widened the choice of available resources for health and effected greater optimisation of resources. The conventional approach to planning included the arbitrary sharing of resources among various departments or sectors or projects. This was replaced by the allocation of funds based on needs assessment.
- c. Projects and programmes in health: The shift to decentralisation ensured that there was greater integration between the health system and the LSGs and this reflected in the nature of projects planned in health and in the implementation of health programmes. The projects in health became more contextual and there was greater



horizontal integration between different health programmes under the system.

- d. Greater accountability and responsiveness: The more proximate role of local governments ensured that there was greater democratic, fiscal and performance accountability in the functioning of the local health sectors. The emphasis on documentation of the planning process meant that the discrepancies at all levels of the system got greater attention and this enhanced the transparency of the system. Local health facilities especially Primary Health Centres, which hitherto had poor infrastructure and shortage of manpower, underwent a positive transformation in many settings across the state. The healthcare system became more responsive to the needs of the community due to their involvement in the planning process, which reflected in service delivery. The key informants had a general consensus that the betterment which occurred in infrastructure and manpower at local health facilities consequently led to improved service delivery.

5.1.2.3 In the process of health planning: It was expected that the introduction of multilevel decentralised planning would ensure that health planning became more democratic and comprehensive. Democratisation of the planning process was expected to enhance the role of the community and bring in views from a diverse set of stakeholders which included local experts from the community, technical experts in health and elected representatives.

As expected, health planning after the shift became more systematic and structured. It had to be grounded on the needs of the community. In order to achieve this, the first step in the process was decided to be a situation analysis and needs assessment in the community. This naturally needed the



creation of opportunities and platforms where citizens could interact with the system and participate in governance (e.g. Gram sabhas). Such platforms encouraged discussions about the issues affecting local communities and enhanced transparency in the process of selection of beneficiaries for various plans.

Participation in the planning process was not just restricted to interaction with the community but also to the active involvement of the experts from the local community. The early focus on committees like Voluntary Technical Groups which created platforms for voluntary participation of local experts where in-depth discussions would happen about topics of local significance, reflects this aspect. Working groups were platforms where the inputs of relevant technical experts could guide the planning process.

5.1.2.4 Greater integration between the public health sector and the LSGs: The shift did result in greater convergence and collaboration between the public health sector and the LSGs. The provision of greater responsibilities for the LSGs to act in the health sector and the changes envisaged in the role of medical officers, as implementing officers, helped in achieving this.

5.1.2.5 Greater focus on marginalised groups: The key informants expected that the shift would organically lead to empowerment of the most powerless social groups which would then reflect in their ability to access health as a resource, to navigate the health system with greater ease and negotiate for their better health. It was expected that decentralisation would lead to more inclusive governance and greater agency for vulnerable sections like women, scheduled castes, scheduled tribes, fishermen folk and other socially and economically backward groups. However, in many settings,



they perceived it as a greater focus placed by the LSGs and the public health services on the marginalised groups in developing projects.

5.1.3 Gaps in the process and its outcomes, in comparison with the original expectations

5.1.3.1 In the conception of health: Despite the reconfiguration of health, there were shortcomings in the approach towards the sector. Moreover, the newly acquired position of health as a matter of political relevance, created its own set of issues. The gaps in the implementation of the process and the subsequent outcomes were perceived by the key informants on the basis of what was originally envisaged by the shift.

- a. Inability to formulate a shared vision about health: Despite two decades of health planning, there are discrepancies persisting amongst the stakeholders about the vision they are pursuing for the health of any community. The perspective of the local health system, the LSGs and the community regarding which health needs to be prioritised continues to reflect this poor consensus. For instance, while the stakeholders from the health system prioritise primary healthcare in rural communities, both the exit interviews of the beneficiaries and the in-depth interviews conducted as part of the household survey, reflect the community's aspiration for specialty care and advanced curative services to be available in their vicinity. The LSGs more often than not, do not support the community's perspective, either due to their poor orientation to the concept of primary healthcare or to protect their electoral chances. Thus, there is an absence of convergence between the health functionaries and the LSG community dyad with regard to what constitutes positive transformation in the health sector. This emphasises the need for



community mobilisation and building a deeper discourse around what constitutes positive health action.

- b. Political motivation and vested political interests affect the focus of plans in health: The need for greater political visibility primarily drives the LSGs and hence they often support and invest in plans which are heavily tilted towards curative services. The participants also observed that the local governments did not work towards a long-term vision for the health of the community. The possibility of change in governance in the subsequent elections meant that LSGs often conceived ideas only until the end of their term. Health professionals hold transferrable positions and only a few medical officers think beyond their immediate future in the local health facility and work towards the long-term health of the community.

5.1.3.2 The process of health planning: Most participants responded that despite improvements in the planning process, the actual implementation had deficiencies. The participation of technical experts and local experts were inadequate in many settings. The narratives also suggested that many a time, actual planning was reduced to a technical component to complete the requirements of documentation. The spirit of participatory planning had declined which reflected in superficial discussions, inadequate brainstorming and repetitive solutions which lacked creativity.

5.1.3.3 The public health sector of the state: The key informants observed that despite improvements in infrastructure and service delivery, gaps still persisted. Poor motivation and training of health professionals, manpower shortage which still persisted in many settings, delays in the release of state funds, in turn affecting the proper implementation of plans, and the vested interests of political parties have limited the potential of the public health



sector. These circumstances presented the need for a more comprehensive programme for primary care in the form of Aardram Mission.

5.2 Accountability, responsiveness and inclusiveness in the health sector

In this section, we present the findings from the realistic evaluation through multiple embedded case studies, which we conducted in 25 settings across the state, through which we have examined the implementation of the process of decentralisation and its impact on accountability, responsiveness and inclusiveness in the health sector. Through the evaluation, we have arrived at a general set of contextual factors and mechanisms through which the three outcomes could be facilitated under decentralised governance. The results are discussed below for (four?) major sub-sections:

1.1.1 Impact on accountability, responsiveness and inclusiveness in the health sector consequent to the shift

1.1.2 Contexts, mechanisms and outcomes influencing accountability, responsiveness and inclusiveness in the health sector

5.2.1 Impact on accountability, responsiveness and inclusiveness in the health sector consequent to the shift

The findings in this section have been collated from major sources – in depth interviews with stakeholders from the five embedded units within each case (local governments, public health sectors, political parties, other interest groups and community), exit interviews at local health facilities, household survey data and documents.

5.2.1 Accountability of the health sector

The reflections from the stakeholders from the local self-governments, political parties and other interest groups like Kudumbashree and CSOs suggest that their activities in health are primarily driven by two questions:



- i. How can the health sector rise to the needs and expectations of the community (democratic accountability) ?
- ii. How can they work in conjunction with the public health sector to enhance the accessibility, availability, affordability and quality of the planned activities to all the beneficiaries (performance accountability)?

Over the past two decades, health has been receiving greater political attention and activities in the health sector have become much more visible to the community, making it an issue of contention and debate both from a political and electoral point of view. However, their narratives also reflected that regardless of their motivation and desire to enhance the performance of the sector, the realisation of this is dependent on the intentions and abilities of the public health sector, especially the medical officers (from both allopathy and AYUSH sectors). The stakeholders from the public health sector, on the other hand, raised another set of issues pertaining to the functioning of their sector and also regarding the difficulties in collaborating with the local governments. Analysis of documents related to the process of decentralised governance in health, was also used to explore the extent to which accountability was facilitated in the way the system routinely functions. The views of the final stakeholder, namely the community, which reflected through the responses in the household survey revealed how these concerns, in turn, influenced their engagement with the health sector.

The themes pertaining to accountability emerged in five broad sections:

- **Local self-government and health sector**
- **Public health sector**
- **Integration of both the sectors for action in health**



- **Documentation in health sector planning and governance**
- **Results of the household survey analysis and its implications for the accountability question**

5.2.1.1 Local self- government and health sector

The LSGs witnessed a shift in their role in all sectors including health, consequent to the shift. Their key role in health planning and determining the allocation of resources facilitated greater support for the local health facilities specifically with regard to improvement in infrastructure and basic equipment for healthcare. In addition to the support to health facilities, the LSGs' involvement in the health sector brought about greater focus to many areas which were hitherto not given due importance. These include basic health determinants like drinking water, sanitation and waste management. Naturally, these were also the areas where the LSGs managed to attain outstanding achievements over the last two decades. A key point which was emphasised by the study participants was the fact that when the topic of contention was health, all members affiliated to the LSGs managed to put aside their political differences and think beyond, for the overall good of their community, health being one of the few sectors which managed to secure this position.

However, senior health professionals observed that, immediately after the shift, many LSGs engaged with the local health sector with a distorted sense of authority, overstepped and misused their power. Many participants observed that such instances were being reported from many settings even now, leading to power tussles, although the proportion has considerably reduced. Health professionals also pointed out the lack of adequate knowledge of the LSG members about health, which affects the development of a shared vision for the health of the community. Their poor



knowledge about preventive and promotive aspects of healthcare and overt focus on the curative side of healthcare,

Box 1: Shared vision and team work

The Family Health Centre at Neruppam, which functions under the Noolpuzha Gram Panchayat received the highest NQAC ratings in 2018. In addition to a fully functional, well maintained disabled-friendly FHC, it is also noted for contextual innovations like e-Auto, which is an autorickshaw that provides free transportation to the hospital for senior citizens, women and tribal population. The Health Centre has also started a house for Adivasi pregnant women named Pratheeksha, in the vicinity of the FHC where they can stay until delivery. It promotes health security and ensures safe delivery.

“The first thing I did once I joined this place was go and meet the Panchayat President. He was friendly and receptive and ever since, we have always been on the same team. I tell him what my vision is and he listens. We discuss the plan and decide on how to raise resources and go forward. If I sit here and plan, nothing will happen. If we work together, a lot can be achieved. So, it is very critical to build a team.”

Medical Officer, Family Health Centre, Neruppam (Noolpuzha)

This setting highlights the need to build a good team between the local health system and the LSG. It also underscores the need for good communication to develop a shared vision for the health of any community.

naturally leads them to an approach of health need prioritisation, very different from that of the health professionals. In many settings, this has either led to ongoing conflicts or a gradual detachment of the health professionals from health planning. Over the years, many LSGs have moved away from the planning culture to more of a patronage culture and this has reflected in their interactions with the health system. The participants



observed that members of both LSGs and health system needed thorough orientation about health need prioritisation for a community, team work, team building and participatory approaches, before they engaged in health planning.

5.2.1.2 Public health sector

Although there were many positive changes which happened in the public health sector which reflected in an overall improvement in infrastructure and service delivery, participants generally opined that the shift in governance did not result in fundamental changes in the functioning of the health system. The dual control over the health professionals (from both the state health department and the LSGs) meant that the overall functioning continued to be centralised, with reduced willingness in the public health sector for integration and collaboration.

The result was that the health service sector did not completely align itself to suit the requirements of multilevel decentralised planning and governance. It did not fully imbibe the spirit of participatory planning and continued to work as a separate entity for a significant duration of time, post the shift. Even after the initial reluctance was overcome, the culture of working in silos, inadequate horizontal integration and intersectoral coordination persisted. This also meant that there were little efforts by the sector to innovate in health and contextualise vertical programmes according to the local needs. Participants emphasised the lack of proper guidelines for the professionals regarding the nature of work expected out of them to suit the shift. For instance, the lack of a comprehensive manual to guide an implementing officer in a rural PHC was an oft repeated lacuna.

“That is still functioning within the vertical system of service delivery, conducting vertical programmes one after the other. So, the point is that



health services have still not undergone the professional transformation required to function in a manner suitable to an area where there is decentralised governance and decentralised planning. That is the problem,” former LSG official and an early champion of decentralised governance says.

The transfer of health facilities under local governments resulted in significant improvements in infrastructure and availability of basic equipment. This naturally created more demand for healthcare in the public sector. However, the lack of adequate manpower in several cadres of public health sector meant that health professionals were overworked and this had implications on the quality of their work. This was especially noticed amongst the public health cadres of public health nurses and health inspectors. The nature of their work within the health system provided them with little opportunities to address many of the broader health determinants outside the health sector.

The original goals of decentralised governance envisaged empowering community health workers and public health professionals. But several of our study participants observed that owing to the increase in their workload involving a multitude of activities, health professionals from these cadres actually felt disempowered and burdened. Although they were held accountable for the health activities at the community level, there were few legitimate channels or platforms through which their inputs and feedback could be incorporated into the functioning of the system. Public health nurses particularly felt marginalised and sidelined from the planning process, relative to the health inspectors who held powerful roles as bridges between the health system and the LSGs in many settings. The possibility of gender issues playing a role in this marginalisation was suggested by the participants.



The most critical change was in the roles and responsibilities of medical officers from being doctors to implementing officers. This enhanced the decision space of medical officers and made them more accountable to the health issues of the community. As technical experts, they had a greater role in the planning and fund allocation for health. This reflected in greater professional volunteerism from medical officers in many settings making them agents of change and team players. However, the nature and extent of such volunteerism differed according to the context and the support offered by the local governments.

“Be it any hospital, it is the ability and commitment of the doctors that decides its performance. A doctor used to work at our CHC a few years back. He was special. He welcomed patients with a smile. He spent time with the patients; talked to them. He humoured them a bit and gave them psychological comfort. He discussed with them about their lives, families and problems; gave them suggestions; helped them. He was also into farming, supervised the cleaning of the hospital surroundings; engaged with the panchayat constructively. He attended all meetings and actively participated in planning. During that time, there were many patients. But the doctor who is charge now is different. He is just a doctor (laughs). So, the patient flow has naturally reduced. If the doctor is good and he or she takes ownership of the hospital, it shows,” an LSG official commented.

Some of the gaps within the health service sector have been raised as being consequential in its inadequate integration with the local governance. It lacks routine assessments and regular monitoring mechanisms. The existing health programmes are poorly evaluated and many participants opined that there was inadequate expertise to decide, to evaluate, when and how. Another major lacuna is the absence of channels to ensure that regular feedback is collected from the community health workers and public health



professionals regarding the routine functioning of the system. Most of the review meetings and monthly conferences are platforms which hold the ground level professionals accountable for the shortcomings of the system, without giving them the space and opportunity to openly express their concerns and critiques.

5.2.1.3 Integration of both the sectors for action in health

Greater integration between the public health sector and the LSGs was envisaged and this was achieved to a significant extent. However, the extent of integration varied from setting to setting and also in accordance with the signals sent by the state political machinery. When the state governments promoted integration across various departments and was consultative in its functioning, it reflected in the functioning of the local settings. There was greater communication and more collaboration between the local governments and the local health facilities during those periods.

In the initial phase of the shift, the public health sector did not consider their transferred status positively. The system, especially the doctors, showed great reluctance to integrate with the LSGs. They felt that their authority was being questioned and perceived this shift under LSGs as a threat to the position they held in the system until then. In many settings this led to a power struggle between the health system and the LSGs. Several instances of conflicts between the two systems were reported during the early days of the shift. However, there was a general consensus among the key informants that these conflicts did not create a lasting negative impact. There has been a gradual improvement in the relationship over the years, although this transition happened more out of necessity rather than a genuine understanding of mutual worth. The improvement in the relationship naturally The AYUSH systems of medicine integrated with the local governments much better than the modern medicine system in the



early phase of the shift and this collaboration led to better infrastructure and service delivery. Thus, these systems benefited much more than the allopathy health system initially.

However, in the current scenario, the AYUSH health professionals perceive a drop in the extent of integration between the LSGs and the AYUSH Department. The professionals emphasised the unwillingness of modern medicine professionals to integrate with them in planning health activities for the community. The established positions of professional organisations of the modern medicine like the Kerala Government Medical Officers' Association and Indian Medical Association also reinforced this alienation. The AYUSH professionals pointed out that in many settings, the LSGs also indirectly supported this position of the Health Department which was reflected in the relatively remote and inaccessible locations of their facilities and relatively lower attention to their infrastructural needs. They also discussed the reduced opportunities available for them in planning innovative health projects in their fields.

"I have a post-graduation in mental health. There are things I can do in that field. But do you think I will be allowed to do that? Do you think any Ayurveda medical officer will be allowed to do so? No. I will say that there is some kind of medical fundamentalism that is being practised by the IMA and so on. They believe that only they are scientific and all others are quacks. So, all we can do, as Ayurveda medical officers, is keep projects for medicines. Even the ASHA workers are not allowed to interact with us," an Ayurveda medical officer practising in a rural dispensary says.

A functional relationship between medical officers and LSGs was found to be critical for positive transformation and innovations in health sector. This



observation was based on the experience of the key informants with settings which have witnessed significant positive changes or innovations.

The major gap in the dynamics between the LSGs and the public health sector was inadequate collaboration on the ground. This was attributed to the failure to build an effective team in many settings which can jointly engage in planning, and poor interpersonal communication. There were reports of the persistence of conflicts and ego clashes between the two units in a few settings, although the general perception was that the relationship has significantly improved over time. The participants observed that the changing policies of the different state governments with regard to decentralised governance over the past two decades have also impacted the extent and continuance of integration with regard to all sectors including health. The integration between the systems was found to be much better in Gram Panchayats when compared to higher levels of local governance. The participants opined that as we moved higher up the levels of governance or moved from rural to urban governance, the health system gradually narrowed to just hospitals with absolutely no integration with the local governance systems.

“It was simply the result of the teamwork. The doctor and the governance committee of the LSG were totally committed and in sync with the cause. We also had support from external agencies. The teamwork extended even to the state government level. We also had the support of NGOs and voluntary organisations, who helped give food to the patients in the early days. The palliative team was also aligned well with the community and the hospital. NRHM was a huge support. The DMO helped us strongly. The teamwork was complete and everything was favourable then - a political climate favouring change and collective action, a great humane activist doctor, a committed governance team, an efficient, powerful MLA and good



support from various departments. We don't see that teamwork here or anywhere else now," a former LSG official reminisces about the collaboration which existed during the days of the PPC.

The stakeholders from the local governance observed that poor preparedness of the public health sector to meet the requirements of the shift worsens as we move upwards from the Primary Health Centres to the District Hospitals. As we move up the ladder, the lack of professional transformation and upgradation of the health system to suit the needs of each level of decentralised governance becomes sharper. The overall inadequacy of the system to fully embrace the participatory planning process in its true spirit and the inability to openly engage with stakeholders from different sectors to address determinants outside the health system, become more obvious at higher levels, where such integration is a far greater necessity. One of the reasons that probably explained this persisting inadequacy was that the initial reluctance of the functionaries to accept the shift was perhaps not adequately addressed and hence whatever acceptance happened over time was more out of sheer necessity, rather than the result of a true understanding of the process. Another criticism raised by the participants was a general lack of initiative shown by the public health sector to adequately train its professionals specifically to imbibe the spirit of multilevel decentralised planning and governance to suit its requirements.

There was consensus regarding the fact that the professional capabilities of health professionals, especially the medical officers, were not at par with their expected functions at all levels of the system (from PHCs to the District Medical Office). Medical officers in a decentralised system were also implementing officers of the health plans. Doctors, as implementing officers, were expected to give appropriate technical inputs to the integrated



platforms which were involved in the planning process (e.g. the working groups). Our participants opined that, doctors, with few exceptions, proved to be less than adequate implementing officers.

One of the major reasons for this was that the medical curriculum did not prepare them at all to be health planners and implementers and they did not have any exposure regarding the functioning of the health systems as medical graduates. This meant that they had to be properly inducted in to the system and thoroughly prepared to deliver the expected functions, which was also not happening as a rule. However, the informants also observed that, in addition to professional capabilities, the doctors also lacked initiative and a positive attitude many a time. In many settings, medical officers excused themselves from the planning process and delegated the responsibility entirely to health inspectors or to the relevant LSGs. This again points to inadequacies in the current induction training programme for doctors.

Several reasons have been cited by our participants as possible reasons for reluctance of the medical officers to fully engage in the process – the unwillingness and unpreparedness of doctors to take up additional responsibility and greater accountability as signing authorities; poor public health orientation of doctors; relatively lower remuneration of the doctors serving the public health sector as compared to the Department of Medical Education; word overload; lack of adequate time and the potential of their private practice getting affected by the responsibilities as implementing officers.



Box 2: Doctor – An “agent of change”

Government Tribal Specialty Hospital, Kottathara, Attappady is an institution with many peculiarities. This 54- bedded hospital has been providing commendable specialty care to this predominantly tribal population since 2007. The institution and its Superintendent have won numerous accolades and awards at several national and international platforms for maintaining the highest standard of health care for a vulnerable population residing in a remote setting.

“There are 192 hamlets in this place and the doctor has personally visited all of them countless times. He has grown with this place and that gives his actions more authenticity. He also actively interferes in all aspects of health. When he goes to hamlets, he not only talks to them about the need to visit hospitals for health care, but also about the need for agriculture, nutrition and so on. He will go to the houses, sit near them and talk to them in their language. He is a non-tribe, but he has learnt the language of tribes.”

- Block Panchayat President about the Superintendent of the Specialty Hospital

“A doctor is primarily a social activist. But if this idea has to reflect in their decisions and work, then it has to be seated in their brains before they pass out of medical college, during the training period. Otherwise they will not commit. Also, the simple and basic understanding that health is not something restricted to a hospital. Health is about how and where we live. So, we have to work with a lot of sectors. What are they earning? What are they eating? How much can they afford? How to improve their livelihood? What can be done to enhance agricultural productivity? What is the reason behind the sudden rise in a certain condition? A doctor should be trained to think this way. Only then attitude change will result and he or she will be committed.”

- Superintendent, Government Tribal Specialty Hospital, Kottathara

This setting is the perfect case to demonstrate that committed and passionate medical officers can be successful “agents of change” even in the most remote and difficult settings, if they have the right attitude and the support of a good team.



“People? What have we got to do with people?” exclaimed the superintendent of a Taluk Hospital, when asked about the process of understanding the health needs of the community.

One of the reasons cited by the medical officers which discouraged them from attempting innovations, was their inadequate training in planning, raising a potential scenario where they would be held accountable in annual financial audits. They felt that they were not really trained to be planners and hence dreaded the audit objections which could create roadblocks in their career. They admitted that they had been warned by their experienced colleagues not to attempt anything new or remotely risky as this could lead to trouble. On the other hand, the doctors and LSG members from those settings which have witnessed positive transformation and innovation in health, refuted this as an unwanted fear and an excuse to not take up responsibilities, as they felt that with some preparation and teamwork, change could be brought about along with abiding by all the stipulated guidelines.

“Many of my colleagues think that the work I do is volunteering. Actually, it is the work that I am supposed to do as an implementing officer. An implementing officer is supposed to be responsible for the health of a local community. Certain duties are expected out of him,” says a medical officer currently serving in a tribal FHC.

There are also many settings where the medical officers have voluntarily taken initiative and used their enhanced autonomy and decision space to be the agents of change. In such settings, the most critical aspect is the presence of an active, functional and dynamic relationship between the local health facilities and the LSGs, largely driven by the respective doctors. However, these settings are largely considered exceptional scenarios and the doctors



involved are perceived as volunteers as opposed to medical officers who have delivered their responsibilities as implementing officers. These settings and such doctors are not the normative situations. There have been no concerted efforts from the health system to institutionalise and normalise these exceptional cases.

5.2.1.4 Documentation in health sector planning and governance

In this section, we discuss the process of health planning and governance in local communities and these findings have emerged from the qualitative content analysis of planning related documents from each of the case study settings and from the perspectives of the stakeholders.

One of the major achievements of the shift to decentralised governance was an overall transformation in the approach to planning as compared to the situation before. The process of planning was highlighted by the study participants as a key component of governance which required deliberate and conscious involvement of all the stakeholders. The relevance of wider participation and a democratic approach to planning was greatly reiterated during the People's Planning Campaign. There was a general realisation especially among the early champions of decentralisation that the quality of outcomes of any governance system largely depended on the authenticity and quality of the planning process. This naturally reflected in the way planning was envisaged and it became more structured and deliberate. The perceived impact of such a paradigm shift in the conception of planning reflected in the health sector also, specifically in the following aspects:

- a. *Local needs assessment and need-based planning*: Decentralised governance mandates the preparation of local health plans and the first step in the process is an analysis of the local health situation by technical experts through a wide consultative process, which will then be discussed at the



working group meetings. The situation analysis incorporates local needs assessment, appraisal of the impact of the existing programmes on the lives of the beneficiaries and identification of gaps which need to be addressed in future plans. This process of planning based on an assessment of the actual situation in the community has enhanced the responsiveness of the annual projects in health. Gram sabhas aid in the need assessment process and study participants from the case study settings considered them as the most crucial platforms in the initial phase of the planning process.

- b. *Participation, discussion and deliberation:* Greater participation in planning and decision-making was a major change in the health sector. The composition of platforms involved in the planning process like the working groups, the planning committees and technical advisory groups have ensured that the presence of stakeholders from the local governance, the local health system and the community is mandatory. This attempt to democratise the planning process is perhaps one of the most significant contributions of the shift. Decisions happen organically as a result of the more structured process. In addition to participation, the presence of diverse stakeholders including local experts was meant to ensure that there was greater thought and deeper discussions to finetune the plans. This also created opportunities for collaboration across sectors.

“We brought this idea to the attention of the local and high-level political leaders. Those days even the political situation was different. The hardcore politics that exist today was not there back then. At the ground level and above, people were actually willing to support each other for development. This was especially more during the PPC phase,” a current LSG official reminisces about the PPC days.



- c. *Greater role for the community in governance:* The enhanced role of the community in governance, both direct (through Gram sabhas) and indirect (participation of local experts in working groups) platforms, has many additional benefits. The participants opined that the proximity of the community to the governance system has improved accountability of the system, created smoother interface between the beneficiaries and public health facilities and has also contributed to the general health literacy of the community.

The introduction of a democratic approach to planning was a major positive change brought about by the shift. However, the planning process is not without gaps.

- d. *Democratic deficit in the planning process:* A major gap observed by the study participants was that there has been a gradual decline in the spirit of participation and consultation in the planning process over the years. The loss of the participatory element in planning has reflected as both inadequate connect with the community and as a reduction in the voluntary participation of experts.

Gram sabhas, which are platforms of community interaction, have been largely reduced to sites of beneficiary selection for government programmes, with no room for meaningful discussions about the needs of the community. The platform for voluntary participation of local experts namely the technical advisory group has been recently removed from the planning process. However, the decline in the participation of experts – appropriate technical experts and those from the local communities – has been systematically happening over a period of time.

The change in the attitudes and the work culture of the LSGs has been largely held responsible for this decline. The local governments were



envisaged to take the initiative to ensure that the entire process of planning and decisionmaking was as participatory as possible. However, there has been a decline in discussion and collective thinking at all levels of local governance. The result is that, despite all the positive changes in various sectors including health, the lofty goals of the shift – community participation in governance and transfer of power to the hands of the people – remain distant. The decision-making power still rests at the hands of an elite minority of politicians and bureaucrats albeit at the level of local governance instead of state governance. Thus, the decline in democratic approach to planning has deterred the shift from achieving its true potential in the state.

“As part of my political career, over the years I got the opportunity to serve several committees and platforms at the district and state level. I also got the opportunity to visit around 19 states and directly experience the positives and negatives of the situation of vulnerable populations across the country residing in remote and hilly areas. I imbibed a lot from these experiences and wanted to develop our hospital as a model one based on the lessons I learnt. I shared all my lessons with the medical officers and health professionals. I attend all HMCs and give my honest suggestions. I also ask many silly doubts without shame. I don’t know much, so I have my natural doubts,” says a current Gram Panchayat president.

It is important to explore some of the reasons of this decline. One of the major observations made by the participants was the implication of changing signals from the state governments over the past two decades. The differing political ideologies and policies of the two major political coalitions which have periodically alternated at the state governance, have had a definite impact on the consistency and establishment of the



processes involved in decentralised planning and governance at the local level. With regard to the planning process, there has been a gradual neglect of the platforms like working groups and TAG over a period of time, which were envisaged as platforms of brainstorming and idea generation. The LSGs emphasised the role of Gram sabhas in the planning process which were much easier platforms for them to navigate and patronise as compared to platforms of expert participation. This enhanced the autonomy of LSGs in decision-making. This also manifested as improper composition of working groups, inadequate efforts to identify and engage local experts and devaluation of the suggestions of experts including doctors.

The participants also observed that the general decline in community participation since the days of the PPC was also because of poor efforts of the system to mobilise the community and meaningfully engage with them. The community has been rendered largely passive over time, as beneficiaries of various schemes, with little say in actual governance, despite the presence of platforms like the Gram sabha. Many participants opined that this situation was because the governance system did not really engage in a twoway communication with the community. Even in Gram sabhas, those in power interacted with the community with a pre-set agenda. This means that they chose to inform the community only what they thought the community needed to know, did not actively listen to the real concerns raised by the attendees and made efforts to project certain achievements (for instance, infrastructural changes or introduction of curative services) which ensured political visibility and better electoral chances.

Another important reason was that there was a serious lack of training in health planning for all those involved, particularly the medical



officers. This affected the health need identification and prioritisation process and the ability to work as a team. The poor ability of the medical officers to engage with the community was another major impediment. The language used by technical experts was distant and largely incomprehensible to the community and this means that the engagement with the community was largely handled by the LSGs. LSGs could have vested interests in terms of overt interest in activities that enhanced their political visibility (overt focus on construction activities, building new infrastructure without proper needs assessment and justification etc), but the distance of the technical experts from the community and the poor participation of local experts ensured that the LSG would have the final say. Such positions taken by the LSGs, in many settings, naturally led to conflicts between them and the health system which invariably alienated the system further.

- e. *Loss of authenticity of the planning process:* The planning process under decentralised governance was envisaged to be structured and systematic. However, over the years, this process has lost much of its authenticity. There has been a certain routinisation or ritualisation which has set in, where all the steps may be mechanically followed for the sake of documentation, but the true spirit of the process is not imbibed. The loss of authenticity has naturally affected the rigour of the whole exercise and this has implications for the outcomes of the process too. There are issues with the formulation of the projects, the plans generated are often not reflective of the real situation in the community and the solutions are not really responsive to the actual health needs of the people.

Inadequate scheduling of the steps in the process also affects authenticity. The differing timetables of the politicians and health



professionals demand better thought into the scheduling of planning platforms, in the absence of which, steps in the process get reduced to rituals. There is considerable lastminute rush in finalising the plans, often without in-depth deliberations, which again affect the outcomes of the process. This also leads to bureaucratisation of governance leading to poor optimisation of resources for the sector.

Many participants justified this by highlighting the importance that the plan clerk currently has in the process. In many settings, neither the LSG members nor the implementing officers are completely aware of the details of the health plan since the whole process would be micromanaged by the plan clerk. He or she could even make last-minute changes to the allocation while validating the final plan before submission. This, in effect, reduces the validity of the whole planning process.

- f. *Poor inter-sectoral coordination:* Although health has been redefined from a development perspective and the relevance of broader health determinants addressed in the governance circles, this has not translated to inter-sectoral coordination for health planning. Technical experts involved in health are limited to the concerned levels of health system. The holistic perspective regarding health needs discussions and active involvement of multiple sectors. However, this has not yet become the norm and health planning continues to be an activity involving the health system and the LSGs. A major goal of the shift was to bring about convergence across sectors, which still remains largely distant.



Box 3: Innovative integration initiated by an LSG

Comprehensive Mental Health programme of Chirayinkeezhu Block Panchayat-Suraksha is an innovative project initiated for the community in collaboration with Gram Panchayats of the block, Government Medical College, Thiruvananthapuram, and Social Justice Department, Kerala. 10.1 per cent of total suicides in India occur in Kerala (<https://www.ksmha.org/>). Suraksha creates awareness among public regarding mental health problems, identifies people with signs and symptoms of mental illness, and ensures access to treatment and medicines. Panchayat level trained coordinators recruited either by the block panchayat or Gram Panchayats are playing the major role in identifying people with issues. A psychiatrist's service is provided in the block office for fixed hours in a week and free medicines are supplied to patients through the pharmacy at the block office. This is to ensure accessible and affordable mental healthcare.

"Initially, people were reluctant to reveal details but now people come forward and disclose their problems which also indicate that stigma on mental health problems has reduced in the region," explains the block level official monitoring Suraksha, Chirayinkeezhu Block Panchayat,

- g. *Issues with utilisation of funds and transparency:* In the absence of authentic participatory planning, optimisation of resources cannot be ensured. The focus of projects gradually shifted from planned allocation of resources to complete utilisation of funds. This reduced the perceived impact of the projects to the beneficiaries for whom the plans were intended. Many of the participants emphasised the need for regular social auditing of the projects to ensure that relevant questions like for whom the plan was developed, why the plan was considered necessary, how it was implemented, whether it actually benefited the target group and so on, could be asked and those responsible could be held answerable. They also felt that the use of Gram sabhas for social audit



could really bring them back to focus as platforms of community participation in governance. A major factor which causes impediments to the prompt implementation of projects is the delay in the release of government funds.

This also gives space for corruption and loss of transparency with regard to the timely utilisation of funds.

“In those early days we gave accountability a lot of importance. We felt answerable for every penny spent in the hospital. We had documents for everything and kept a track of all the money. In addition to regular auditing and other processes, we appointed a retired person as a committed accountant to the management committee of the hospital to check all transactions and accounts. So, there were many issues during the time, complaints to the Vigilance Department and so on. But they could not find anything wrong,” a former LSG official reveals.

- h. *Gaps in the documentation process:* The documents related to decentralised planning collected from the selected settings did not adequately reflect the planning process.
- Overall the documented content was superficial, minimal, lacked details and did not follow any uniform pattern.
 - The minutes were repetitive and had little original content
 - There was hardly any horizontal integration across sectors reflected in the health planning process according to the documents.
 - There was an almost complete lack of integrated and bottom up planning happening in the local governance according to the documents. This is reflected in the absolute lack of correlation in the themes which emerged from the minutes at different levels of planning, right from the Village Health Sanitation and Nutrition Committee (VHSNC) to the annual health plan.



- The VHSNC minutes which are reflective of one of the most basic platforms of planning almost completely ignored the component of nutrition.
- Gram sabha's minutes had relatively more content than other documents and were given more priority than working group minutes. However, they were reduced to long lists of beneficiaries. There was hardly any documentation regarding what kind of discussions happened, what kind of problems were raised by the community and had no documented attempts to collect feedback about existing programmes in health. There were no indications of the two-way engagement with the community.
- The content of discussions raised in working groups was highly repetitive, meeting after meeting. They were caught in a loop of identifying the same problems which could be solved by same solutions, with hardly any attempt to innovate. The decline in the participation and contribution of local and technical experts in these platforms were evident from the content in some of the documents. Many annual plans had claims without adequate scientific and empirical backing. (For instance, "In our area, due to the increased use of pesticides, there is an alarming increase in the prevalence of cancers...")
- The Development seminars were largely reduced to platforms for approval of the draft plans. The minutes of the seminar did not document any meaningful deliberation of useful insights which could be used to refine the draft plans. This was also justified by the minimal differences which existed between the draft plans and final plans in health

Table 4
Summary of findings of the document analysis

Name of the document	Frequency of meeting	Attendance	Frequency of the detailing	Originality of contents	Major Health Schemes	Additional Observations	Direct reference to marginalised /vulnerable sections
VHSNC minutes	6-9 times / year	4 -6	Good	Repetitive	- Provision of drinking water - Chlorination - Pre-monsoon sanitation - Dry container elimination - Source reduction	Nutritional component of the platform is limited to observing nutrition days Few exceptionally well performing settings have mentioned contextual needs like reimbursement for ante-natal check-ups, leprosy campaigns and tuberculosis survey	Drinking water provision for Scheduled Castes Occasional mention of checks on sanitation of camps/houses of migrants
GS minutes	3 or 5 times / year	90-140	Poor	Fair	- Beneficiary selection for various programmes - Drinking - Sanitation - Approval of social audit on MGNREGA - Infrastructural aspects like house construction, maintenance of houses - Road construction and/or maintenance - Better provisions and medicines in healthcare	In-patient facility at Primary Health Centres is still a demand from the community Details of participants were not mentioned in all places Most meetings are limited to beneficiary selection	Drinking water programmes and special healthcare needs for Scheduled Castes/tribal population discussed

					settings • Supply of medicines for NCDs through sub-centre		
WG-H minutes	3 or 4 times / year	6 -12	Weak	Good	• Infrastructure and medicines in healthcare settings • Waste management • Prevention of communicable diseases • Supply of medicines for NCDs through sub-centre • Source reduction Yoga training for women and children's immunisation	Focus of the platform is heavily on healthcare facilities Few selected settings have reference to integration with other departments to address larger community health needs • Control of snails integrated with Agriculture Department • Few plans and programmes integrated with the AYUSH Department	
HMC minute	2 to 5 times / year	5 - 10	Good	Repetitive	• Pre-monsoon sanitation • Infrastructure and human resources of hospital • Prevention of communicable diseases • Fund allocation and utilisation • Grievances against hospitals	HMC minutes were difficult to access as the medical officers from many settings expressed their reluctance to hand over the minutes due to which there were relatively lesser documents available for analysis.	
HSC minute	9 to 11 times / year	3 - 5	Weak	Repetitive	• Drinking water Strengthening palliative care • Pre-monsoon sanitation • Waste management	The discussions in the standing committees do not incorporate or address the themes discussed in	

					• Infrastructure and human resources of healthcare settings. • Fund utilisation	other planning related platforms like working groups or grama sabhas or Village Health Sanitation and Nutrition Committees.	
Draft Report				Highly Repetitive	• Prevention of communicable diseases • Palliative care Healthcare of elderly Drinking water Sanitation • Infrastructure, equipment, facilities and medicines in healthcare facilities	Most of the content except those pertaining to funds were found to be repetitive over the previous years Integration seems to be vertical- national, state, district, block and panchayats – few instances of horizontal integration In the three years of documents which were examined, the interior decoration of facilities was found to be given overt focus – the context of Aardram	Comprehensive development and drinking water programmes for Scheduled Castes/Scheduled Tribes mentioned in a few selected settings
DS Minutes	5 to 8 times / year	15-90	Very weak	Poor	Approval of draft plan/suggestions from working groups	No content is available for most of the meetings The available content is very limited and only mentions if the draft report is approved or not. No documentation of the actual discussions/debates which happened in the seminars and what points were raised with regard to the draft reports	

Final annual plan report						The draft and final reports in most cases are almost exactly the same with few significant modifications reflecting upon the limited contribution of development seminars	
Development Reports					• Better provisions in healthcare settings • Yoga training, • Palliative care • Drinking water • Sanitation • Medicines in healthcare facilities	In-patient facilities in PHCs are an aspiration stated even in development reports, which conveys that the concept of primary healthcare has not percolated to the decision makers outside the health sector and the public.	Superficial and overarching mention of the issues of Scheduled Castes and Tribes are found in most reports, however, there is very little contextualisation of these issues in the reports. Nor the specific issues of marginalised groups are given any real priority.
Healthcare settings include both modern medicine and AYUSH VHSNC – Village Health Sanitation and Nutrition Committee GS – grama sabha WG-H - Working Group – Health HMC – Hospital Management Committee HSC – Health Standing Committee DS – Development Seminar Development Report - (Once in five years)							



5.2.1.5 Results of the household survey analysis and its implications for the accountability question

In the following section, we present the findings from the household survey where we have explored the perspectives of the most vulnerable households from the twelve Gram Panchayats selected for the case studies. In this segment, we will focus primarily on the items from the survey which highlight the accountability question. The items which highlight the responsiveness part will be discussed in the subsequent section.

Table: 5

Nature of households surveyed from the twelve Gram Panchayats

Primary axis of vulnerability	SC	ST	Others*	Total
One or more family members suffering from chronic conditions	28 (36.4 per cent)	15 (19.4 per cent)	34 (44.2 per cent)	77 (66.4 per cent)
Single woman-led (one or more family members may not be suffering from chronic conditions)	6 (33.3 per cent)	5 (27.8 per cent)	7 (38.9 per cent)	18 (15.5 per cent)
Elderly member or couple living without adequate support (one or both may or may not be suffering from chronic conditions)	3 (21.4 per cent)	4 (28.6 per cent)	7 (50 per cent)	14 (12.1 per cent)
Recent flood (2018) affected (one or more family members may not be suffering from chronic conditions)	3 (42.8 per cent)	2 (28.6 per cent)	2 (28.6 per cent)	7 (6 per cent)
Total	40 (34.5 per cent)	26 (22.4 per cent)	50 (43.1 per cent)	116 (per cent?)



* - include fishermen folk since this category included settings from the coastal areas.

Majority of the surveyed households experienced multiple vulnerabilities. That is, in addition to their social and/or economic backwardness, they also had experiences of chronic ill health or recent financial setbacks like the loss of livelihood of an earning member due to death or disease or disability. Even when the primary basis of selection was other criteria like being led by a single woman or the presence of an elderly member or couple living without support, the households reported the presence of one or more family members suffering from chronic morbidities.

Table: 6
Experience of the surveyed households with the LSGs

Experience with the local governance	Frequency (percent)
<i>Major entitlements received from the LSGs</i>	
House construction	47 (40.52)
Maintenance	13 (11.20)
Pensions	59 (50.86)
Others	17 (14.65)
Multiple benefits	33 (28.44)
No benefits	22 (18.96)
<i>Primary source of information about the provisions from the LSGs</i>	
Friends /neighbours / relatives	23 (19.82)
Ward members	30 (25.86)
ASHA / Anganwadi workers	48 (41.37)
Other sources - SC promoters - ST promoters	15 (12.93)
<i>Ease in accessing entitlements from LSGs</i>	
Easy	21 (19.10)



Difficult	80 (68.96)
Neither easy nor difficult	15 (12.93)
<i>Involvement of family members or immediate relatives in Kudumbashree units</i>	
Yes	54 (46.55)
No	51 (43.96)
Participated in the past, but not active now	11 (9.48)
<i>Has any family member been actively involved in any social or political activity in the community related to the LSGs?</i>	
Yes	2 (1.72)
No	114 (98.27)
<i>Regularly informed about the Gram sabhas</i>	
Yes	97 (83.62)
No	12 (10.34)
Sometimes	7 (6.03)
<i>Do you know the exact intention of Gram sabha? (Open ended question, coded)</i>	
For benefits	74 (63.79)
Panchayat's development	11 (9.48)
Don't know	32 (27.58)
<i>Did anybody seek your opinion in matters concerning local development like health, water and sanitation, education, housing and waste management in the last three years?</i>	
Yes	12 (10.34)
No	101 (87.06)
Missing	3 (2.58)
<i>Were you able to give your opinion in matters concerning local development like health, water and sanitation, housing and waste management in the last three years in Gram sabhas or any other platforms?</i>	
Yes	23 (19.82)
No	91 (78.44)
Missing	2 (1.72)



A significant proportion of the households have received multiple entitlements from the local governments over the past two decades and the most common among them was support for house construction. However, most of the participants expressed that they faced several difficulties in accessing these entitlements. The participation in Kudumbashree was quite high. But the involvement of members of these households in any of the local governance structures or platforms was abysmally low, which reiterates their marginalised position in society.

- a. *Democratic accountability perceived by the households:* The extent to which the surveyed households perceived that they had a stake in planning and decisionmaking in health was considered as an indicator of democratic accountability perceived by the community. Majority of the participants identified Gram sabhas primarily as platforms where benefits were announced and beneficiaries were selected. A major finding related to the accountability component is the fact that the majority responded that they were neither asked nor did they give their opinions in matters concerning local development like health, water and sanitation, housing and waste management in the last three years, in Gram sabhas or in any other platforms in the recent past (Table: 6).
- b. *Performance accountability perceived by the households:* The use of government health facilities, their affordability in healthcare, access to health insurance and other social support schemes and the awareness of grievance redressal mechanisms among the surveyed households were considered reflections of performance accountability of the local health sector. Most of the surveyed households (79.31 per cent, n=92) reported that at least one family member suffered from a life limiting condition which could be physical, mental or a cognitive disability, or any chronic disease condition needing regular healthcare (Table: 7). Majority of the



surveyed households used the local government facilities as the primary resort for healthcare. Most of the surveyed households spent more than Rs 50 during the most recent healthcare visit to the facility as direct health expenditure and these visits were predominantly for outpatient healthcare (93.1 per cent, n=108). A significant proportion did not have an active RSBY-CHIS card either because they did not have information about it or because they could not manage to renew it. Another significant finding was that the majority did not know about the existence of any formal grievance redressal mechanism for complaints related to the healthcare facility.

Table: 7

Healthcare needs and aspects related to health seeking in the public healthcare facilities, among the surveyed households

	Frequency (Proportion)
<i>Do you or anybody in this household suffer from any life limiting condition or any chronic disease condition needing regular healthcare?</i>	
Yes	92 (79.31)
No	24 (20.68)
<i>Are you seeking treatment from any local government health facility?</i>	
Yes	84 (72.41)
No	17 (14.65)
Sometimes	15 (12.93)
If yes, what expense did you incur for your last healthcare visit (including emergency visit)?	<50 - 32 (27.58) 50-500 – 42 (36.21) 500-1000 – 26 (22.41) >1000 - 16 (13.79) Least amount- Rs18 Highest amount – Rs 1 lakh
<i>Access to government health insurance schemes or any other social/financial support scheme for healthcare</i>	
Yes	59 (50.86)



No	57 (49.13)
<i>Are there any grievance redressal system (in LSGs or in the concerned health facilities) in place if you have any complaint about the health facility</i>	
Yes	12 (10.34)
No	7 (6.03)
I don't know	97 (83.62)

5.2.2 Factors and mechanisms influencing the accountability of health sectors

In this segment, we briefly summarise the major contextual factors which are identified to influence accountability in the planning, governance and performance of local health sectors.

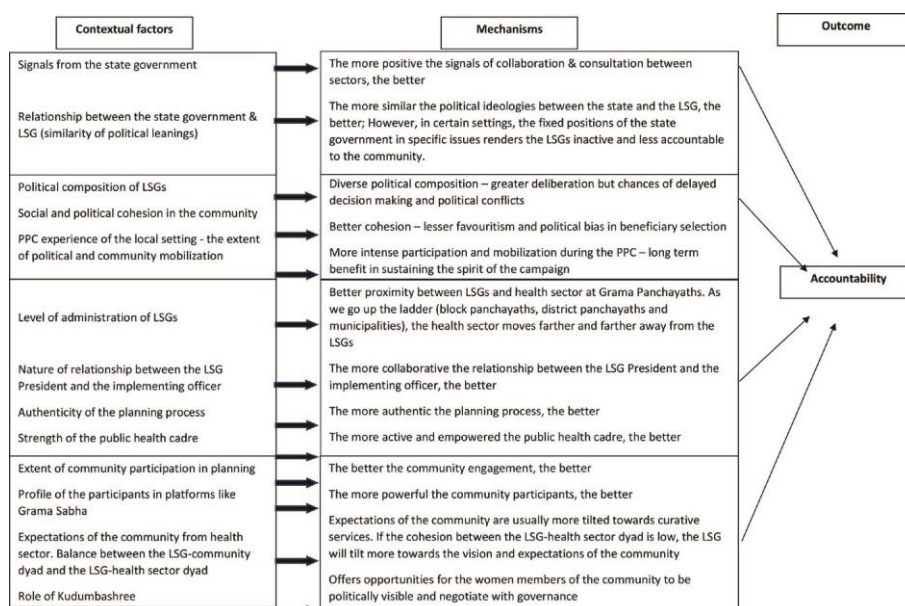
The positive signals from the state governments and the relationship between the state and local governments have been found to have a bearing on the extent of democratic accountability of the local health sectors. Diverse political composition of the LSGs (when all political and social groups have representation in planning and governance processes), greater social and political cohesion in the community and a history of community mobilisation in the past, mostly during the Peoples' Planning Campaign were found to have positive impact on the democratic accountability component.

The level of administration of LSGs and the nature of relationship between the LSG governing body, especially the president and the medical officers had a major role to play in determining the extent of collaboration between local governance and the local health units. The extent to which the authenticity of the planning process was conserved also had an impact on the extent of accountability.



The strength and commitment of the public health professionals, who act as the bridge to the community, and the extent of community participation in planning were found to be critical to accountability. Gram sabhas were found to be crucial platforms which could exert a positive influence on accountability, especially when there was good community participation. Another critical factor in terms of accountability was the expectations of the community. When the expectations of the community were in alignment of the vision of the local health sector, there was greater accountability.

Figure 1
Contextual factors, mechanisms and outcomes which enhance accountability in the local health sectors



5.3 Responsiveness of the health sector

This domain was explored through exit interviews at local health facilities, household survey and in-depth interviews with community members



conducted as part of the case studies. The findings from this domain will be explored under the following two sub sections:

- *Results from the household survey analysis and its implications for the responsiveness question*
- *Community perspectives on responsiveness in healthcare*
- *Factors and mechanisms influencing the accountability of health sectors*

5.3.1 Results from the household survey analysis and its implications for the responsiveness question

We explored the experience of responsiveness in local health facilities among households on the basis of the healthcare visit experience of one or more household members in the last three months – reception of prompt treatment, adequate staffing, ease to access the facility in terms of distance and availability of transportation, time spent by the clinical team to listen to their health concerns, provision of basic lab investigations in the facility itself, provision of basic medicines in the facility itself, the experience of any kind of disrespect in the facility, whether the clinical team explained about the condition and medications in detail and on the extent of ease of access of advanced diagnosis or treatment from major government hospitals when referred. The findings are presented in Table: 8.

Table: 8
Experience of the surveyed households with the local government health facility

<i>Experience based on the last three healthcare visits in local government health facility</i>	
Prompt treatment Frequency (proportion)	
Yes	52 (44.82)



No	28 (24.13)
Sometimes	34 (29.31)
Missing	2 (1.72)
Adequately staffed	
Yes	57 (49.13)
No	16 (13.79)
Don't know	42 (36.20)
Missing	1 (0.86)
<i>Ease of accessing the facility</i>	
Good	52 (44.83)
Fair	29 (25)
Poor	32 (27.58)
Missing	3 (2.58)
<i>Time spent by the clinical team to listen to your health concerns</i>	
Adequate	81 (69.82)
Inadequate	33 (28.45)
Missing	2 (1.72)
Provision for lab investigations	
Present	83 (71.55)
Absent	13 (11.20)
Don't know	20 (17.24)
<i>Are you getting medicines from the facility?</i>	
Yes	50 (43.10)
No	9 (7.76)
Not all medicines	55 (47.41)
Missing	2 (1.72)
<i>Experience of disrespect</i>	
Yes	20 (17.24)
No	88 (75.86)
Missing	8 (6.89)
<i>Does the clinical team explain clearly to you about your condition and medications in detail?</i>	



Yes	77 (66.38)
No	14 (12.07)
Occasionally	25 (21.55)
<i>Ease of access of advanced diagnosis or treatment from major government hospitals if required</i>	
Good	42 (36.20)
Fair	34 (29.31)
Poor	40 (34.48)

The majority reported that the clinical team took adequate time to listen to their health concerns and explain about their health condition and the prescribed medications in detail. A majority also reported that basic lab investigations were available in the local health facilities. However, it is significant to note that a significant proportion of these vulnerable households reported that they did not get prompt treatment, they did not have easy access to the facilities and they did not get the required medicines from the facilities. Another critical finding is that the majority reported that the ease of access to advanced care was not good.

5.3.2 Community perspectives on responsiveness in healthcare

The themes which emerged from the exit interviews and IDIs with community members as part of the household survey revealed that the poorer and backward sections significantly relied on government health facilities.

However, the themes also reflect that the healthcare experience at local health facilities did not really meet their expectations of good healthcare.

- a. *The local health facilities were not entirely satisfactory, but were their only resort:* The exit interviews and interviews with community members reflected the dependence of the participants on the public health sector,



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owing to their poor financial situation. However, the participants expressed that the facilities did not always meet their needs in terms of a satisfactory healthcare experience.

They explicitly expressed their trust in government facilities as their first and primary resort for healthcare, since they believed that the private sector worked primarily for commercial interests and this meant overtreatment and unnecessary medical procedures. However, they did feel that the private hospitals offered better healthcare experience to its beneficiaries. They did not consider this difference in healthcare experience between the two sectors unnatural or unjust, as they felt that the government facilities functioned primarily for the poor, who could not expect much in terms of quality.

An interesting aspect was the consensus among the participants that the government health sector could be their resort only for low grade illnesses as they did not have the facilities to manage severe conditions. They emphasised that even if they had adequate financial resources, they would still consider the government facilities in their vicinity as their first resort, unless the health condition they suffered from was severe.

The participants identified local governments as the bodies accountable to ensure that the health sector functioned smoothly. However, they were not aware of any formal grievance redressal forum where they could lodge their complaints. Moreover, the participants did not seriously consider grievance redressal as a necessity, as they referred to themselves as poor and powerless, reflecting their lack of agency.

“We come to this PHC, when there is any issue. It’s not bad. The doctor comes only thrice a week. I told the member that. Then for a few days



he came regularly. But now for the past two weeks, he is again irregular. I am not going to complain again. It is okay. There is no point,” laments a middle-aged male diabetic patient at the newly inaugurated FHC.

“I come here only when my child gets cold or fever. If it gets severe or if is for the elders in the family, we go to the town. Yes, we go to the private hospital. The travel and the medicines and the hospital charge will cost us a lot. They will charge more in private hospitals. We can’t afford it there. So, we come here for small things. But the problem is, sometimes the doctor may not be here. Sometimes we won’t get all the medicines. Then here we can’t treat serious conditions, can we? That is a problem,” says a young woman with her child visiting the PHC.

“What more can people like us expect? If you ask me, there are issues. But we manage,” says an elderly woman with joint pain, visiting the PHC.

- b. Accessible, available and affordable healthcare is still elusive: It is clear from the narratives that accessibility of healthcare facilities and availability of all basic services including regular outpatient care (irregular attendance of doctors was raised as an issue from several settings), lab facilities and medications were still persisting concerns in many settings. Difficulty in accessing the public healthcare facility was a common concern raised from many settings, which also contributed to high indirect costs (transportation) for the beneficiaries.

“This hospital should be at a place on the bus route, right? We have to get down from the bus and walk so far. If we take an autorickshaw, we will have to pay more than fifty rupees. Then we come here for my wife’s medicines. This is the fourth time in a month. I didn’t get the medicines. The doctor says that it will come. How many times will I keep coming?”



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an old man who was visiting the PHC for oral hypoglycaemic drugs asks.

- c. *Shortcomings in responsive healthcare:* The participants reported several instances of experience of disrespect at the local health facilities, primarily from the hospital support staff. However, they perceived this as expected, normative behaviour in a public sector facility. Many participants attributed the poor quality of healthcare experience to causes ranging from the haughty behaviour from healthcare professionals and other hospital staff, poor communication, poor quality of basic amenities or reduced time and attention received from the doctors, to the huge number of beneficiaries at public healthcare facilities. The lack of availability of all medicines at the health facilities was a major cause of dissatisfaction for the beneficiaries because this meant repeated visits to the facilities and high out-of-pocket expenditure. The participants in general were aware of and had access to RSBY-CHIS health insurance schemes. However, they did not have adequate information about its application and did not know which local institutions were accountable for these schemes.

“Where do they have time? No one has time anymore. If we take a little more time to tell our problems, everyone gets angry. What can we do? Last month I went to the taluk hospital and the security guard acted rude with me because I requested to skip the line. I was not feeling well. I just came back. Before that the person dispensing medicines for us got angry because according to her, I should not get medicines from there. I should only get from my local PHC. How do I know?” a middle-aged woman complains.



5.3.2 Factors and mechanisms influencing the responsiveness of health sectors

In this section, we have summarised the major contextual factors and the mechanisms through which they act to influence the responsiveness of health sectors.

The awareness and health literacy of the members constituting the local governing bodies was found to be decisive in determining their commitment for the betterment of local health facilities. The attitude and public health orientation of healthcare professionals was the most important determinant of positive healthcare experience for the community members. The willingness of medical officers to think beyond their responsibilities as doctors and to engage with their duties as implementing officers of decentralised planning and governance in health, as reflected from these narratives, was another crucial aspect in influencing the healthcare experience of the community members in any facility. Medical officers pointed out that induction training to health services and periodic in-service trainings were cited as hugely influential in this process. Finally, the socio-economic profile of the beneficiaries, their social position and the power they enjoyed in the local communities did have a bearing on the responsiveness of health facilities,

Figure 2
Contextual factors, mechanisms and outcomes which enhance responsiveness in the local health sectors





5.4 Inclusiveness

This theme emerged from the community interviews conducted as part of the case studies. It was clear from the key informant interviews and the IDIs with stakeholders that the shift brought about committed resource allocation for programmes targeting vulnerable sections. This naturally led to systematic efforts to identify needy and vulnerable groups in local communities thereby bringing the social and economic sections of the society to sharper focus. Gender emerged as a discourse among local leaders and participants also opined that the shift to decentralised governance has been instrumental in providing greater opportunities for women to have successful public lives, occupy positions of power and become more powerful stakeholders both within households and in the wider society. However, what was envisaged as inclusiveness under decentralisation was considerably different from the realities of the ground especially based on the perspectives of the members from the most vulnerable households we surveyed at the case study settings. The findings under this theme would be discussed under two major subsections:

- Community perceptions about inclusiveness in the health sector
- Factors influencing inclusiveness in the health sector

5.4.1 Community perceptions about inclusiveness in the health sector:

Our study participants for the community interviews were those belonging to the most vulnerable households in the rural communities and the themes which emerged from the interviews reflected exclusion and alienation.

A. *Positioned outside the system* – alienation: A commonly perceived theme was that of feeling alienated from and positioned outside the system of governance. The participants expressed feelings of reduced agency and disempowerment. They also felt excluded from the entitlements and the



benefits enjoyed by the majority, as part of the system. This also reflected in their lives as not having adequate information about the schemes and benefits provisioned by the local governments. There was a general feeling of worry about whether they were missing out on many of their benefits because they did not have adequate information about them. Another aspect where this reflected was in feelings of poor confidence to engage with the system repeatedly, especially if the first few instances failed. The words expressed a general sense of helplessness in terms of not having anyone to ask or not having anyone to help, in their attempts to negotiate the system. In the health sector, one aspect where this helplessness was clearly reflected in the narratives was in the matter of accessing and/or renewing the RSBY-CHIS insurance card.

“Scheduled Caste people are not getting any benefit even though they are the majority in this panchayat. General category is getting priority in all lists even when the president is from Scheduled Caste reservation category. We don’t know how to do things. We are not aware of it. We couldn’t apply for the allotment of my daughter because we didn’t know how to do it on the computer,” a middle-aged dalit man with chronic illness, says sadly.

Box 4: Local governance promoting inclusiveness in health

Having won Arogya Keralam award several times for its outstanding work in health, Kollam District Panchayat is a model setting due to its innovative projects and detailed documentation. Special consideration is given to the tribal population in the region with specific programmes targeting them. One of these programmes focuses on ensuring nutritious diet for tribal mothers. The LSG supplies Rs 1,000 worth monthly food kit containing pulses, nuts, oats, etc to women, from pregnancy up to one year of childbirth. Since the inception of this project, there is no single malnutrition related death of children among the tribal population under this LSG. Through another project, food kits are supplied to destitute and chronically ill members of the tribal population. Skill development project for gender minorities for livelihood reflects that the LSG is able to



visualise health as an important component for long term inclusive development. The diverse political representation in the LSG since 1996 has facilitated authenticity of the planning process.

“There are many instances when we didn’t get notified about Gram sabha and related announcements. The Gram sabha does not directly notify us, someone near would let us know. The only relief is that we don’t waste time running around to get the benefits in the panchayat, because we are never allotted or notified of any entitlements. All we have got is a coat,” states an elderly male from a financially backward family of seven members.

B. “Processes are namesake, when it comes to us”: The narratives expressed a general sense of disappointment and lack of trust in the processes of governance. They felt that when it came to the issues of the most marginalised and the weak, all of the processes and platforms which are meant to bring their voices out are either ritualised or completely bypassed. The general feeling was that their voices did not matter much to those holding political power. The system did not take them seriously enough or consider itself accountable to them, which then reduced the specific processes and platforms meant for their inclusion to mere routines.

“I stopped going for the Gram sabhas because there are many malpractices there. They gave benefits to people who came from America; but they don’t value the needs of poor people,” says an elderly woman whose spouse is bedridden.

“What are matsya sabhas? We have not even heard about them,” an elderly man engaged in fishing residing in a coastal area asks.

C. All systems including health are particularly less responsive to them: The narratives reflected many instances where the participants felt that they



were being subjected to differential treatment by the health system, which they then attributed to their own powerlessness. Although, they considered the public health sector as their only resort in many cases, trusted and depended on it, they expressed feelings of being less significant for the system when compared to the more powerful majority, which then reflected in instances of differential treatment. “Hospital staff shows partiality by allowing their people to bypass the queue even if we stand in front,” says an elderly dalit woman.

D. “Our lives are hard, but that is just how it is:” The participants expressed disappointment and outrage at the alienation and differential treatment that they experienced in their day-to-day lives. They considered their life difficult and felt that although the panchayats did much to make the lives of the people of the community easier, somehow, they were invisible to it most of the time. This meant that their lives would be much harder than the majority due to their poor financial resources, with less access to information, greater access to illicit substances leading to rampant substance abuse, widespread unemployment and poor health. However, they also felt that raising formal complaints or expressing resentment in an organised way was not going to help much. There was a certain sense of passivity in the way the majority of the participants had accepted their situation. This also echoed as poor expectations from the system and this was particularly noted when it came to how they viewed their healthcare experience at the government hospitals. The overall quality of healthcare experience at government facilities in terms of respect for autonomy, dignity, quality of amenities, prompt attention and clear communication was generally considered lower than what they received at private facilities. But this was considered quite acceptable or a norm since they felt that government facilities were for the poor and this was all one could realistically expect.



“I have to do two dialyses a week. I depend on a private hospital for that. If I go to government hospital, I have to buy the instruments for dialysis by myself. Also, when I go to the government facility in the morning or evening, there will be no staff, an issue that is not there in private hospitals. Going to a private facility is a huge burden for us. In a private hospital, during dialysis the nurses will be with you throughout, while in a government facility, once the dialysis starts the sister will leave the room. I had two heart attacks during the process,” an elderly man with kidney disease explains.

E. Political leanings matter when it comes to who benefits and who do not:

A very commonly raised theme was the strong political segregation which existed in the rural settings which directly reflected in the way the system functioned. The themes expressed resentment among the participants regarding the rampant favouritism and lack of transparency which existed in the way beneficiaries were selected for government schemes. There were many instances of political vendetta reflected in the narratives where the participants or even small communities (colonies or hamlets) explicitly reported being targeted and punished for their political leanings and electoral choices. However, they neither wanted to approach nor believed in the grievance redressal systems which existed at the local governance level, since they believed that overt political affiliations would not allow these systems to function in a just manner. “In the Gram sabha they read my name first in the list, but they have given houses to many whose name was read towards last. Government officials don’t consider us, they keep on ignoring us saying ours will be allotted,” a middleaged Scheduled Caste woman says.

F. Gram sabhas are platforms where beneficiaries are selected: An interesting theme which reflected in the narratives was the idea among the



participants about Gram sabhas as platforms where the government would select the beneficiaries for various schemes. All the participants described the purpose of Gram sabhas as venues for beneficiary selection. Despite disillusionment regarding the platforms as places where the real beneficiaries are almost never selected, majority of the participants expressed interest in participating in the meeting for this very reason. Many were not really aware that they could actually raise issues concerning the community and that they could be platforms for such discussions. The narratives did not reflect the need or the understanding among the participants for political participation and to have a voice in matters of governance. It was also evident from the narratives that people were not satisfied in the way Gram sabhas are conducted as they felt that an elite few are selected as beneficiaries most of the time. In fact, many who were actually deserving, were not even considered. Although Kudumbashree emerged as a large social platform for women, most of the participating women considered Kudumbashree only as a credit organisation to approach during a financial crunch.

“My mother goes to all the Gram sabhas. Only she knows about it. Father can’t go anywhere,” a young woman from a financially backward family expresses her ignorance about Gram sabhas.

“Our Kudumbashree people are not interested in finding any self-help jobs. They are not interested in it and they don’t have time for it,” a middle-aged Scheduled Caste woman alleges.

“We don’t attend Gram sabhas. We have never received any benefit from the Gram sabha. We know that even if we go, we won’t get anything. Then what is the point of going for it? The panchayat will give the benefits only to people they prefer,” a widowed elderly dalit woman laments.



5.4.2 Factors influencing inclusiveness in the health sector

The political composition and ideological leanings of the local governing bodies determined the emphasis they placed on inclusiveness and equity. Politically and socially diverse governing bodies with adequate representation from all sections of society ensured better inclusiveness. The authenticity and inclusiveness of the planning process was critical in ensuring inclusiveness in outcomes. The public health orientation of the medical officers and other health professionals was inevitable to realise inclusiveness in all clinical and field activities. The characteristics of the community, for instance, the extent of cohesion among different social groups, was found to have a bearing on the extent to which socially and economically powerful groups accepted targeted action and benefits for marginalised sections. Kudumbashree, over the years, has emerged as a powerful platform which ensured opportunities for women for greater visibility and political engagement.

Figure 3
Contextual factors, mechanisms and outcomes which enhance
inclusiveness in the local health sectors



“For the concept to be effective as a social process, especially at the local level rather than the zilla panchayat level and so on, it is important to identify and engage with socially committed and interested people at the local level, discuss your ideas with them, listen to their ideas, arrive at a consensus as to what your vision is, modify it adequately so that even they feel included and then make them



come up with the plan with you having a supportive role. That is what democratic decentralisation is.”

-- A key informant interviewee

“See, actual health activities start at the level of the sub centre through ward health and sanitation committee discussions. Even there, if you examine the way the ward health and sanitation committee functions, you will see the lack of orientation and non-imaginative planning. If you have ward members who have the sense and orientation, they will direct this money for long term prevention and management activities. Make the best use of that fund.”

-- An implementing officer at the Gram Panchayat level

“What happens most of the time is that what the community perceives as a need may be totally and completely far and different from what the technical expert has realised as a need in his or her limitless wisdom. The best example is this huge demand for IP from everywhere. I mean that is the greatest demand from everywhere in all communities.”

-- Key informant interviewee

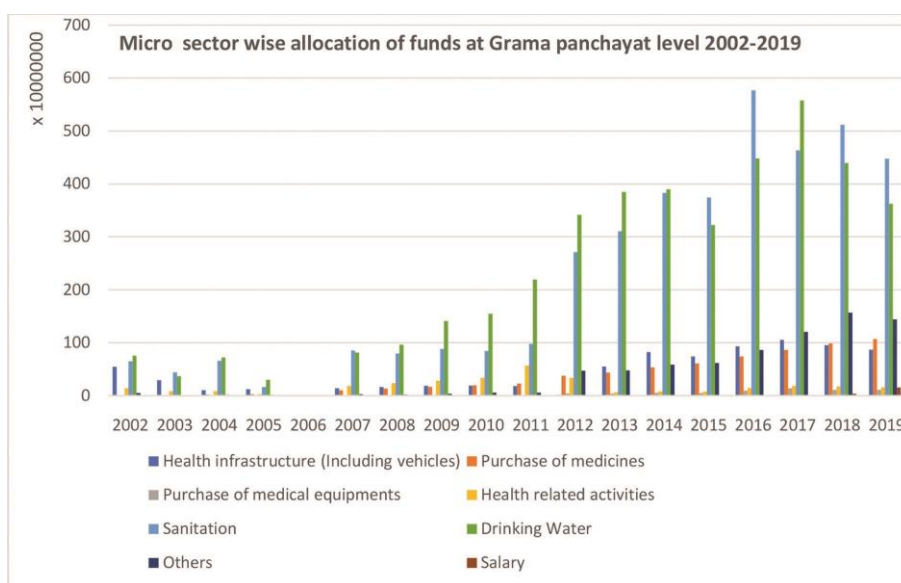
5.5 Trends in the utilisation and allocation of funds to health sector between 2002 and 2019

Secondary data on budget allocation and expenditure on health, sanitation and drinking water under every LSG in Kerala since 2002 was obtained from Information Kerala Mission. Data on eight broad micro-sectors, namely health infrastructure (including vehicles), purchase of medicines, purchase of medical equipment, health related activities, sanitation, drinking water, salary and others was analysed separately for five levels of administration (Gram Panchayats, block panchayats, district panchayats, municipalities and corporations) across all the districts of the state. Since



data from 2002-2007 was manually entered during that period and its electronic copy was created much recently, budget allocation is actually reflecting the budget during the formulation phase and may not be the budget allocated for the actual project implemented. LSG-wise allocation and expenditure are given in Annexure I, district-wise allocation and expenditure data in Annexure II and data on Scheduled Tribe and Scheduled Caste allocation and expenses in Annexure III. In the following segment, we present the allocation and expenditure data for each of the micro-sectors in health across the different levels of administration.

Figure: 4
Micro-sector wise allocation for health at Gram Panchayat levels

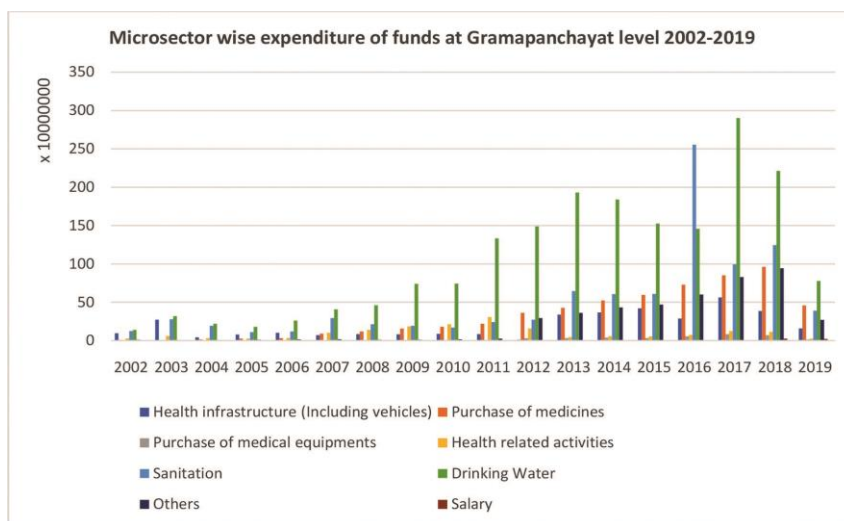


There has been an increasing pattern of allocation for all sectors across health since 2007 onwards. The two micro sectors which have received the greatest proportion of allocation are sanitation and drinking water. Figure: 5 shows micro sector-wise expenditure for health at Gram Panchayat levels. The allocation to these two micro sectors has seen a major rise since 2007



and the gap in allocation between these two sectors and the rest of the micro sectors is stark from 2012 onwards. The poor focus on health infrastructure in relation to these micro sectors in terms of allocation is to be noted, although this sector is being represented better since 2013 onwards. Another micro sector which has received greater allocation recently is purchase of medicines. There is also relatively negligible allocation to health-related activities at this level. The fund allocation towards salary of health staff entered as a micro sector in project funding only from 2018 (Figure:4).

Figure: 5
Micro sector-wise expenditure in health at Gram Panchayat levels

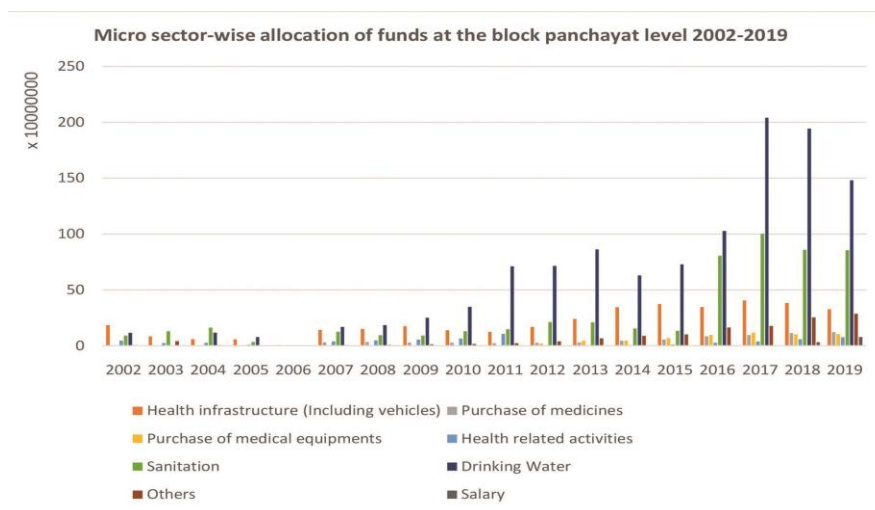


The health micro sector which utilised the most funds across all the levels of administration is drinking water. Across Gram Panchayats, an increasing pattern of fund utilisation is seen towards drinking water. Sanitation related activities were limited to toilet construction, waste processing and management while drinking water related projects include construction of wells, extension of pipelines, drinking water schemes and renovation of drinking water sources. Fund allocation and utilisation for health



infrastructure (including vehicles), purchase of medicines and medical equipment at the Gram Panchayat level show an increasing trend until 2017. Gram Panchayats are found to utilise more funds for purchasing medicines when compared to other levels of administration. Health related activities like awareness sessions, screening camps, insurance, palliative care, programmes for children, elderly, women, the differently abled, special disease eradication and research studies have received funding, albeit limited, until 2012 (Figure: 5).

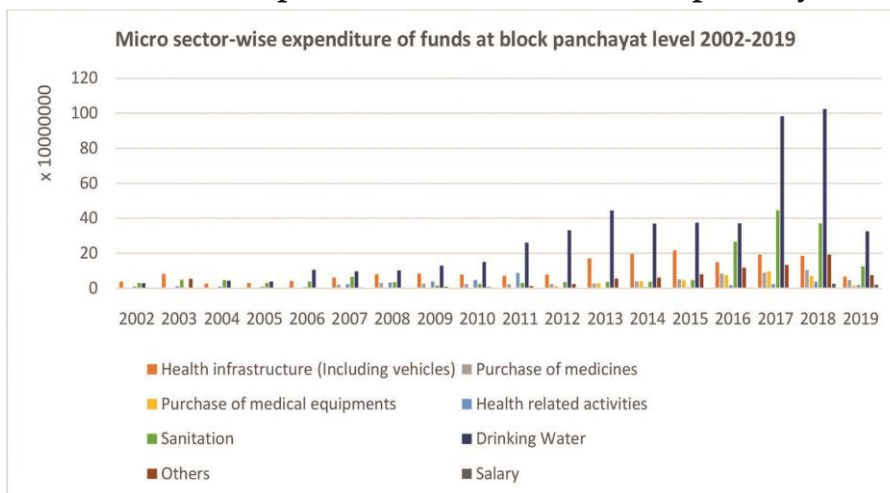
Figure: 6
Micro sector-wise allocations for health at block panchayat levels



Drinking water is the micro sector which has been allocated the largest proportion of funding at the block panchayat level. Sanitation gained prominence since 2016. Unlike Gram Panchayats, at this level, healthcare infrastructure has received relatively better allocation (Figure: 6).



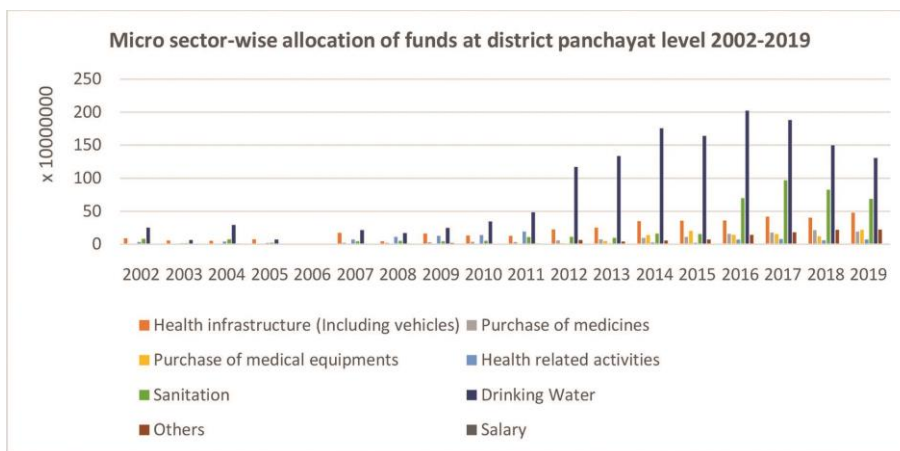
Figure: 7
Micro sector-wise expenditure in health at block panchayat levels



Similar to Gram Panchayats, drinking water has been allocated the biggest chunk of funding at the block panchayat level. Sanitation activities which were quite prominent at the Gram Panchayat level, gained prominence at the block level only from 2016. The third micro sector according to fund utilisation was health infrastructure (including vehicles), which showed a marginally increasing trend after 2012. This was followed by the purchase of medicines and purchase of medical equipment. Block panchayats follows Gram Panchayats in the fund utilisation for salaries of the health staff since 2018, although the proportion is relatively much lower than other micro sectors. Health related activities received significant funding from block panchayats until 2011, although its proportion was much lower compared to that of Gram Panchayats (Figure:7).

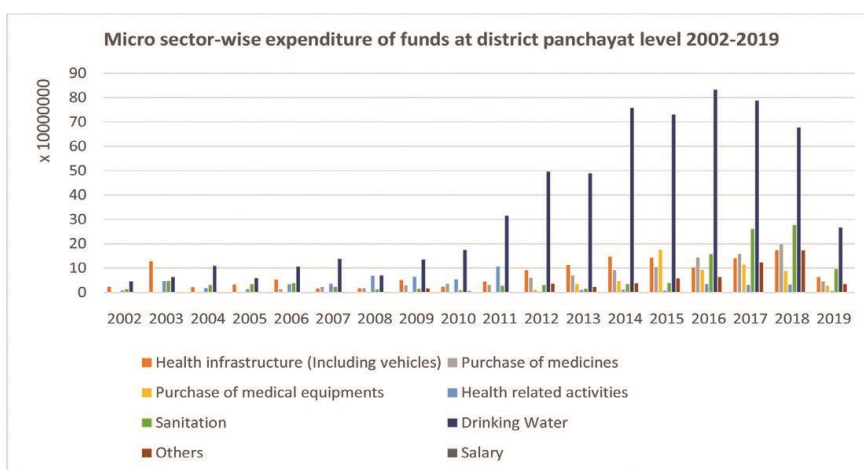


Figure: 8
Micro sector-wise allocation for health at district panchayat levels



Drinking water remained the sector which received the greatest fund allocation followed by sanitation, although it gained focus only from 2016 onwards. However, the gap between these two micro sectors in terms of fund allocation is huge. The third micro sector which had some prominence was health infrastructure (Figure:8).

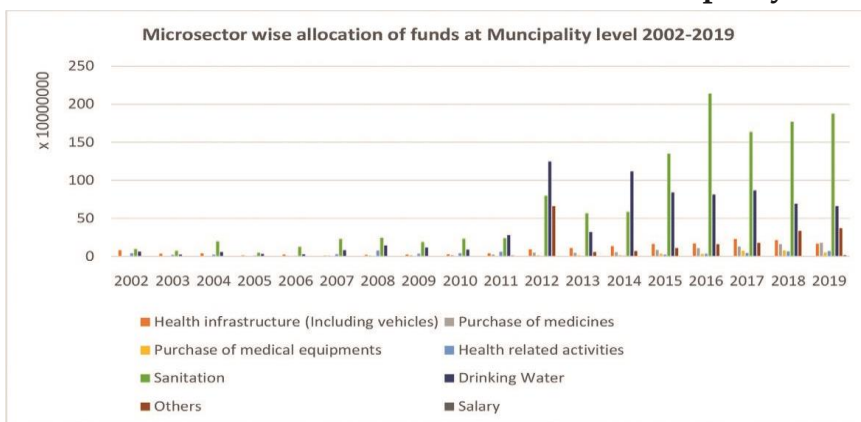
Figure: 9
Micro sector-wise expenditure in health at district panchayat levels





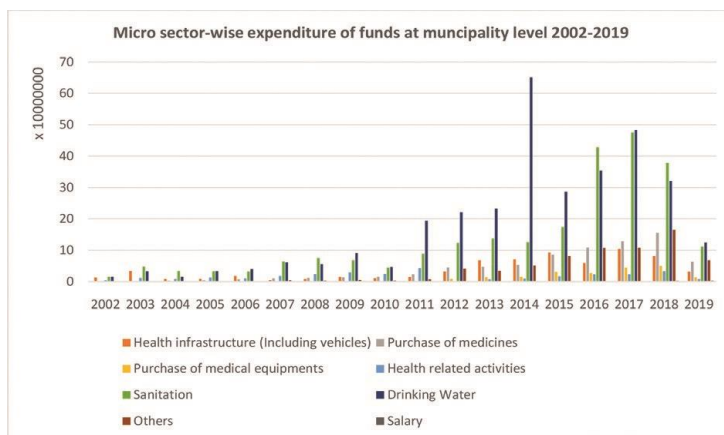
Drinking water continued to be the micro sector which utilised maximum funds in health in district panchayats also, followed by sanitation. Fund utilisation for drinking water has shown an increasing trend over the years. The next micro sector according to fund utilisation was health infrastructure (including vehicles). District panchayats follow the Gram Panchayats in terms of funds utilised for the purchase of medicines. However, the gap between these two levels is quite huge in this micro sector. District panchayats spent more on medical equipment when compared to other levels of administration and this shows a min increasing pattern from 2013 onwards (Figure :9).

Figure: 10
Micro sector-wise allocation for health at municipality levels



At the municipality level, the most prominent micro sector in terms of allocation in recent years is sanitation. The allocation to drinking water was high in specific years like in 2012 and 2014. However, the allocation to sanitation has shown an increasing trend from 2014 onwards. At the municipality level, the micro sector 'others' has significant allocation. We have categorised this micro sector as 'others' since it had a series of unrelated projects, the most prominent being the fund allocated to palliative care (Figure 10).

Figure: 11
Micro sector-wise expenditure in health at municipality levels



Although sanitation was the micro sector which received a greater share of allocation at the municipality level, utilisation was the highest for drinking water. There was a sharp spike in fund utilisation in drinking water in 2014. Since 2014, the utilisation in sanitation has increased. ‘Purchase of medicines’ is another micro sector which has utilised a relatively significant proportion of funding in the recent years (Figure :11).

Figure: 12
Micro sector-wise allocation for health at corporation levels

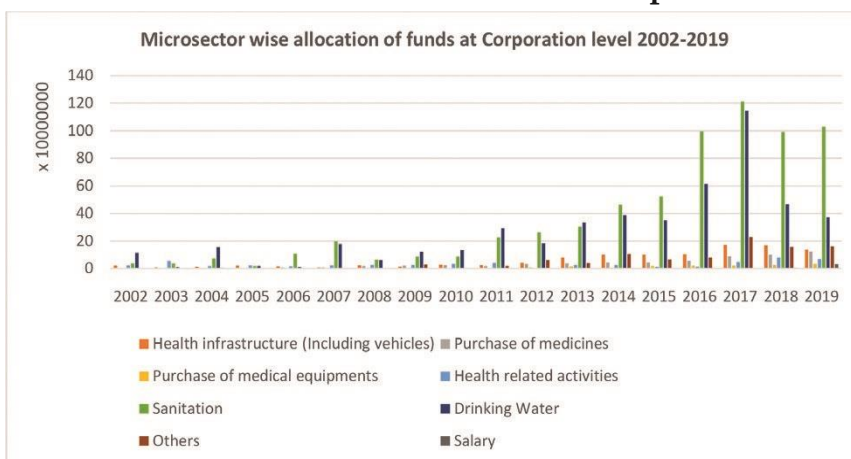
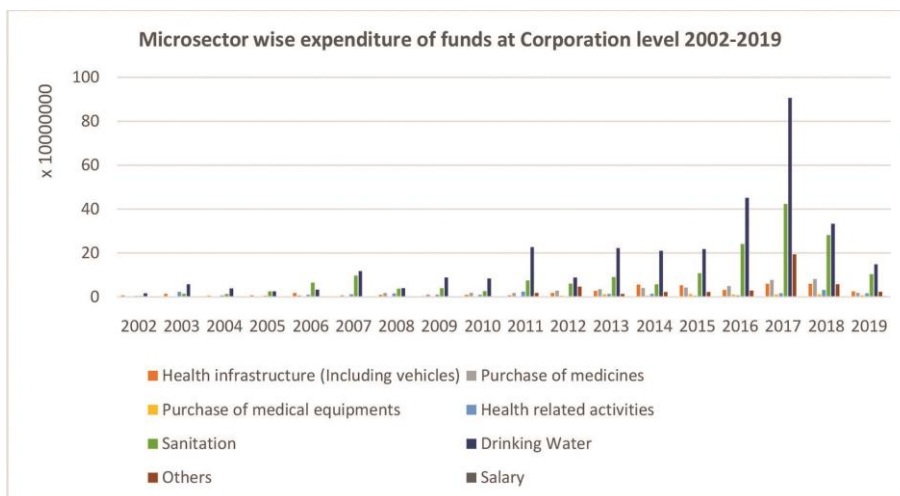




Figure: 13
Micro sector-wise expenditure in health at corporation levels



At the corporation level, drinking water and sanitation have received the lion's share of funding, while drinking water programmes have utilised more funds than sanitation (Figures 12 and 13).

Table 9

Total allocation and expenditure in the micro sectors in health across all levels of administration

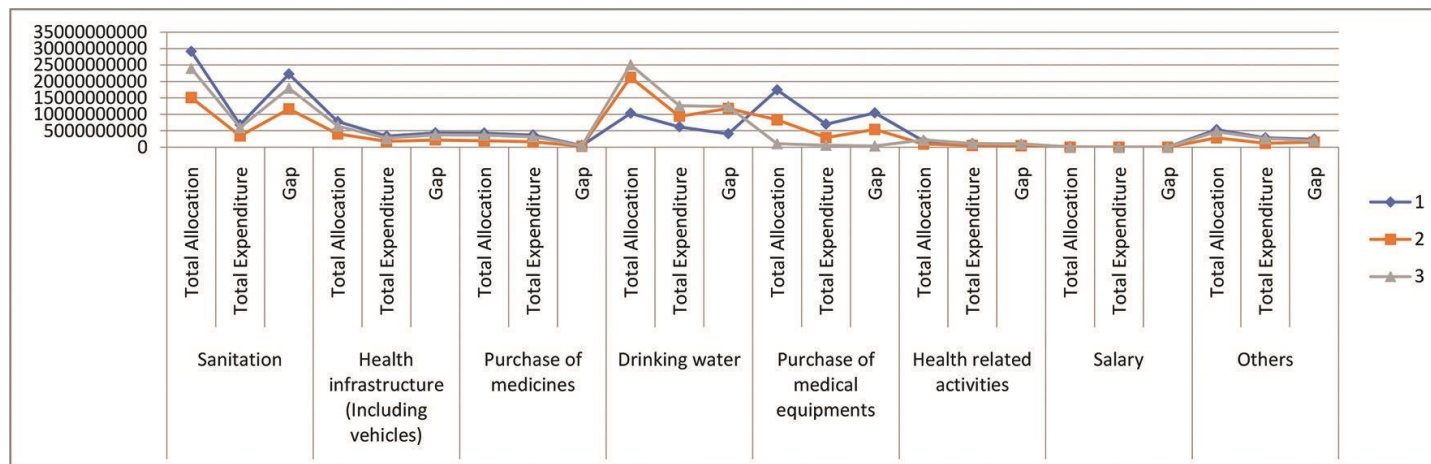
	Grama Panchayat		Block Panchayat		District Panchayat		Municipality		Corporation	
	Total Allocation	Total Expenditure	Total Allocation	Total Expenditure	Total Allocation	Total Expenditure	Total Allocation	Total Expenditure	Total Allocation	Total Expenditure
Health infrastructure	791794907879 1 cr	355249497735 5 cr	370619674837 0 cr	183760302118 3 cr	374450662937 4 cr	137480772013 7 cr	161382487716 1 cr	68021429768 cr	108109696110 8 cr	41098816741 cr
Purchase of medicines	651329486065 1 cr	576035496357 6 cr	72311965872 cr	59661622659 cr	123664770112 3 cr	102131963010 2 cr	93750719093 cr	78273892078 cr	61211025561 cr	44885996244 cr
Purchase of medical equipment	63866194763 cr	37168347237 cr	59584784559 cr	37922804437 cr	103788596610 3 cr	58635422358 cr	32662105732 cr	20789837220 cr	14621249414 cr	769133627 cr
Health related activities	318451862031 8 cr	178100348717 8 cr	65512164565 cr	38468021338 cr	110082985811 0 cr	57668175357 cr	62263229462 cr	31113275831 cr	55334149155 cr	22425755422 cr
Sanitation	396628941023 966 cr	926069385492 6 cr	523654833952 3 cr	172379489617 2 cr	419522273041 9 cr	115071353111 5 cr	124116445841 241 cr	246323276024 6 cr	672313518767 2 cr	176437723417 6 cr
Drinking water	415321652654 153 cr	189452971651 894 cr	114061597301 140 cr	517780949451 7 cr	147535260971 475 cr	624457495362 4 cr	749276031074 9 cr	326531202326 cr	494173885349 4 cr	330343107330 cr
Others	752099127975 2 cr	433132094343 3 cr	130109543113 0 cr	84152875284 cr	105641331510 5 cr	57470463857 cr	199470945419 9 cr	68683336168 cr	95854944095 cr	42916866042 cr
Salary	19099832719 cr	486442104 cr	11062339711 cr	462059404 cr	29260002 cr	121851112 lakhs	211140662 cr	531082553 L	370797823 cr	602794660 L
Total	107178723093 10,717 cr	458247994494 582 cr	23734712793 2373 cr	10987466586 1098 cr	27127958296 2712 cr	11530374959 1153 cr	25420813832 2542 cr	8402673317 840 cr	15053264463 1505 cr	6671398956 667 cr



In table: 9 we present a summary of the micro sector-wise allocation to health across the different levels of administration. We can see that Gram Panchayats lead in total allocation (Rs 10,717 crore) and total expenditure (Rs 4,582 crore) followed by district panchayats (allocation – Rs 2,712 crore, expenditure – Rs 1,153 crore) over the two-decade period. Drinking water and sanitation are the two sectors which have received the maximum allocation and witnessed maximum utilisation. This is followed by health infrastructure, purchase of medicines, purchase of medical equipment and health related activities. Gram Panchayats lead in both allocation and expenditure in all the micro sectors. At all levels of administration, a significant proportion has gone to the micro sector categorised as ‘others’, which involves dedicated funding to palliative care.

We classified the districts into three categories for selection of study settings for case studies (non-coastal non-tribal, predominantly tribal and predominantly coastal). In figure: 15, we have presented the findings of the total allocation, total expenditure and the gap between the two across the three categories. The predominantly coastal districts have allocated and spent more on sanitation, followed by the non-tribal, non-coastal districts. Total allocation and expenditure for sanitation, health infrastructure, purchase of medicines and health related activities are poorest in predominantly tribal districts compared to the other two categories. The gap between allocation and expenditure is high in sanitation in all three district categories. The non-coastal, non-tribal districts had the greatest share of allocation and utilisation in drinking water programmes. All three district categories allocated and spent considerably negligible proportion of funding on health-related activities.

Figure:14
Microsector-wise allocation of data across the three categories of districts selected for the case studies



- 1: Predominantly coastal—Thiruvananthapuram, Alappuzha, Malappuram, Kozhikode, Kannur
- 2: Predominantly tribal—Idukki, Palakkad, Kasaragod, Wayanad
- 3: Non-coastal, non-tribal—Ernakulam, Thrissur, Kollam, Pathanamthitta, Kottayam



Special Component Plan and Tribal Sub Plan in health across the district categories

The data on allocation and utilisation of Special Component Plan (SCP) and Tribal Sub Plan (TSP) are available only from 2012-13. Detailed tables regarding micro sector-wise allocation and expenditure are attached in Annexure III.

Among the five non-tribal non-coastal districts, Thrissur leads in the total allocation of SCP to the health sector. There is also an increasing trend of allocation to health sector from SCP in Thrissur. It is followed by Kollam, Ernakulam, Kottayam and Pathanamthitta. However, none of the other districts shows a significant upward trend in allocation to health from SCP (Figure:15). However, all the districts have shown a downward slope in allocation since 2017. Kollam led in SCP spending in health until 2015-16, after which it witnessed a dip. Since 2016-17, Thrissur witnessed a significant surge in SCP spending for health. All the districts showed a surge in allocation since 2015-16 a downward slope in both allocation and spending since 2017¹⁸ (Figure :16). Among the predominantly coastal districts, Malappuram leads in SCP fund allocation and utilisation in health. Kannur allocated and utilised SCP funds the least (Figures 17 and 18). All the districts in this category showed a surge in allocation between 2014 and 2016 and showed a downward slope in allocation and spending between 2017 and 2019.

Among the predominantly tribal districts, Palakkad allocated and spent the highest share of TSP for health, closely followed by Wayanad. All the districts show a surge in allocation and utilisation since 2015-16 and a decline during and after 2017 (Figures 19 & 20). The gap between allocation and utilisation is particularly stark in the case of TSP funds in these districts. Of the Rs 3.91 crore allocated for health infrastructure in Wayanad from



tribal plan fund, only Rs 93.5 lakh has been earmarked as expenditure. Kasargode, has utilised 40 per cent of the allocated funds, Palakkad 50 per cent and Idukki 56 per cent from tribal plan fund for health infrastructure. Wayanad district, holds the highest position in utilising tribal plan fund for the purchase of medicine since 2012-13.

Figure 15
shows the Special Component Plan and its allocation to health sector in non-tribal, non-coastal districts

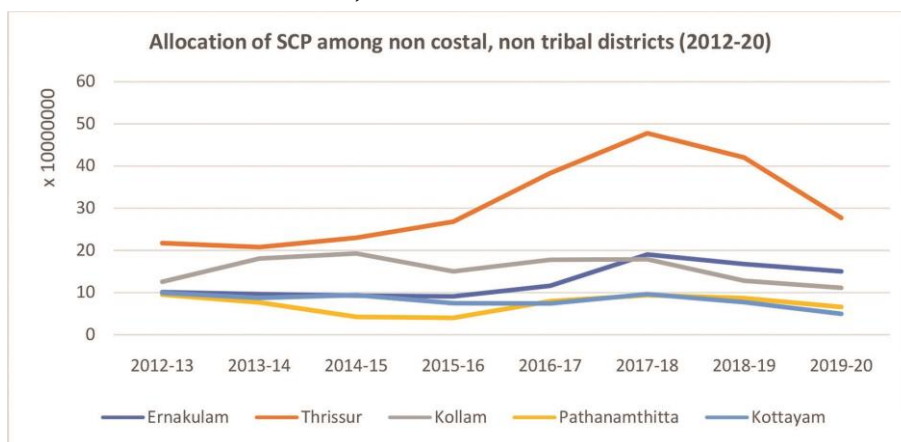


Figure 16
Special Component Plan and its contribution (utilisation) to health sector in non-tribal, non-coastal districts

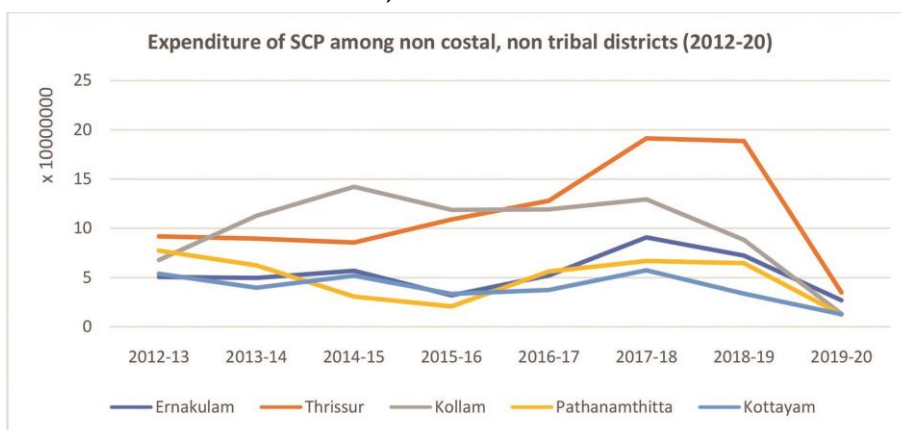




Figure 17
Special Component Plan and its allocation to health sector in predominantly coastal districts

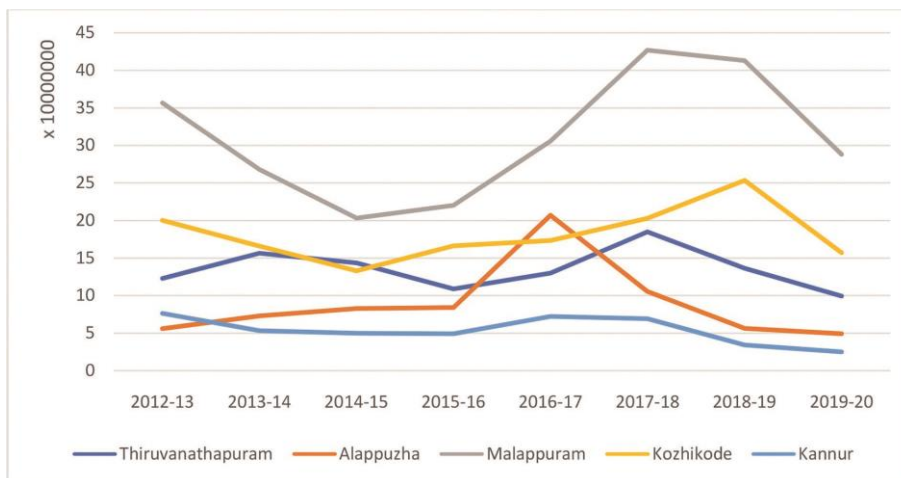


Figure 18
Special Component Plan and its contribution (utilisation) to health sector in predominantly coastal districts

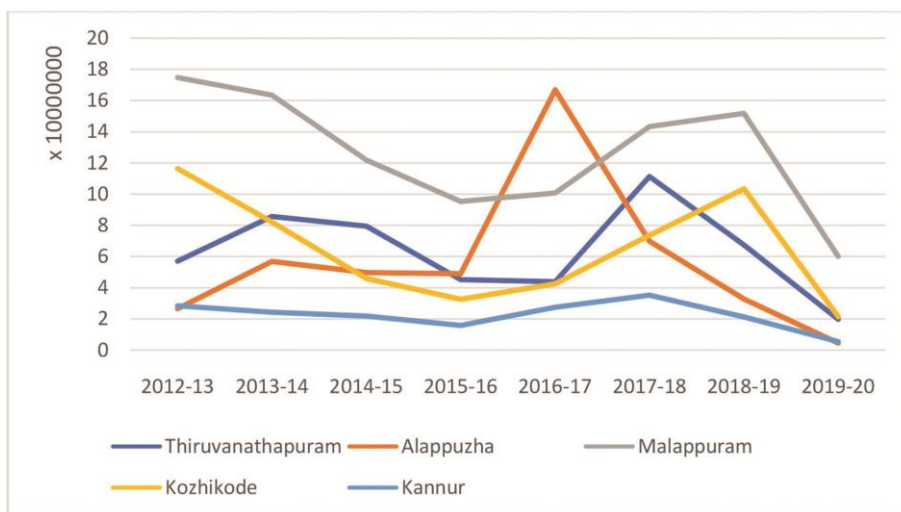




Figure 19
Tribal Sub Plan and its allocation to health sector in predominantly tribal districts

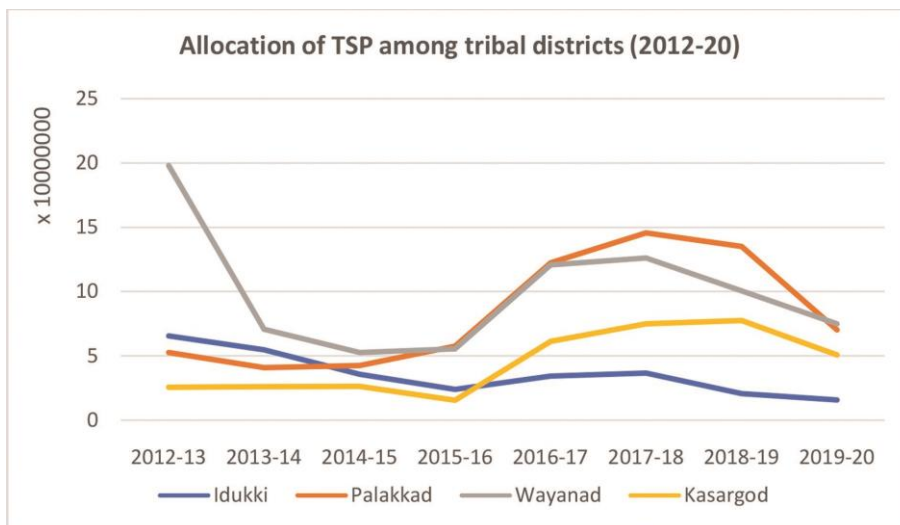
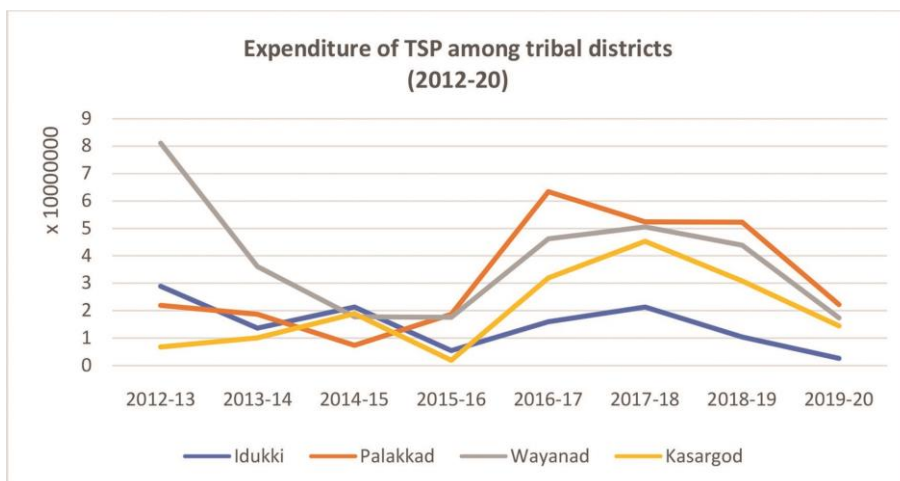


Figure 20
Tribal Sub Plan and its contribution (utilisation) to health sector in predominantly tribal districts





6

DISCUSSION

This evaluation aimed to explore the perceived impact of multilevel planning and decentralised governance on the health sector of Kerala. The three outcomes we had envisaged were accountability, responsiveness and inclusiveness of the health sector. We had explored these outcomes from the perspectives of five major stakeholders – the LSGs, public healthcare facilities, the community, political parties and other interest groups like the Kudumbashree. The perceived impact was assessed through key informant interviews from the champions and advocates of People’s Planning Campaign and in-depth interviews with stakeholders from 25 selected case study settings. We had also analysed general planning related documents i.e. policy guidelines and specific documents from all the case study settings. In order to understand the community’s perspectives regarding the impact that decentralisation had exerted in their lives, we conducted exit interviews from local public healthcare facilities, surveyed and interviewed community members from the most marginalised and vulnerable households purposively selected from eleven Gram Panchayats. Another major objective was to explore the pathways or mechanisms through which decentralised governance mediated these outcomes.

The findings clearly suggest that the shift to decentralised governance has made a significant impact on the health sector of the state as perceived by the stakeholders. This was especially professed by the relatively senior participants who have witnessed the situation that existed in the health sector of the state before the shift and the transformation which occurred in



the sector consequent to the shift. The public health sector of the state was marred by issues of poor infrastructure, manpower shortage and poor accountability, before being transferred to LSGs and this was highlighted by the early champions of PPC. A historical analysis of the development of healthcare facilities of Kerala, published in the year 2000, reports that by mid-1980, there was a significant slowdown in the growth of government healthcare facilities in Kerala, primarily due to the fiscal crisis that affected the state from the 1970s. This slowdown reflected as a reduction in growth in infrastructure and also in the quality of services provided.²² This was also the period which witnessed a huge rise in the demand for healthcare in the state leading to the creation of a conducive environment for the growth of the private sector. The poor accountability of the state health system and that of health professionals during this period was highlighted by our key informants.

Accountability

The shift to decentralisation and transfer of health institutions enhanced the accountability of the health sector. Although medical professionals were initially reluctant to accept the change, gradually, over a period of time, the public health sector of the state witnessed a positive transformation. In the Gram Panchayats, the geographic proximity of governance structures to the healthcare facilities ensured that they were more closely monitored. Although this supervision of the LSGs was initially perceived as interference in their functioning by healthcare professionals in the government sector, in effect, it greatly enhanced the performance of the sector.

Community mobilisation brought about by the People's Planning Campaign was a key event in shaping the way decentralised governance was received in the state. The campaign greatly emphasised on building



social solidarity and inter-sectoral coordination. It also conceived health as a resource for development and emphasised the need for action on broader determinants to improve the health of any community. The community started recognising LSGs as the structures which are accountable for their health and well-being. The enhanced political visibility of health, thus, propelled the LSGs to take charge of the health sector.

We defined democratic/political accountability as the state where institutions, procedures, and mechanisms ensured that the health sector represented the felt needs of the community. Performance accountability was defined as the state where the accessibility, availability, affordability, acceptability and quality of public healthcare facilities met the expectations of stakeholders and community members. This conceptualisation posed a problem, since it naturally assumed that the expectations of the stakeholders and the felt needs of the community were in alignment. However, we realised from the field that the community's needs were predominantly curative and they expected advanced curative services to be available in the local health facility of their community. This was not in alignment with the concept of primary healthcare and the stakeholders from the health sector emphasised this contradiction. For instance, the need for inpatient care in the Primary Health Centre was raised as a major health need which even appeared in the development reports of many Gram Panchayats, but was considered entirely unnecessary by the stakeholders from health. However, the LSGs in many settings chose to prioritise the community's vision and understanding of health over the concept of primary healthcare. The political visibility of health meant that their achievements in the health sector during the governance had a role to play in determining their electoral chances and this meant that they had to deliver according to the expectations of the majority. This conundrum could



be solved only by developing a discourse around health by engaging with the community and developing a shared vision.

One of the most important achievements of the integration of local governance in health would be the emphasis placed on health determinants like drinking water and sanitation, consequent to the shift. The secondary data analysis clearly reveals that the two major micro sectors tremendously gained from the shift. However, even after two decades, the lion's share of the funds earmarked for health is still largely allocated to these two sectors. The almost negligible allocation to health-related activities for prevention and promotion, especially in the recent years, reiterate that the concept of primary healthcare has not yet come to forefront of the planning agenda in the local communities. The reasons for this could again be related to the need to prioritise programmes which gain the attention of the community, over programmes which attempt to realise a long-term plan. Dedicated funding and focus given to palliative care programmes is another example of how LSGs prioritise programmes in accordance with the need and demand of the community.

The overall gap between funds allocated and utilised was considerably significant in all micro sectors and this pattern has continued for the twodecade period. The lack of vision and in authenticity of the planning process, the delay in release of funds by the state and poor transparency in actual implementation have been cited by the key informants for this underutilisation of allocated funds.

The less than satisfactory collaboration between local health systems and local governments in many settings was perceived as a major barrier to democratic accountability by the stakeholders. The members of the LSG-local health system dyads, in settings which brought about positive



transformation in the health sector, emphasised on the need for change in attitudes of those involved and the willingness and ability to engage in teamwork. The medical officers in most settings were neither keen nor prepared to being implementing officers of health, the roots of which lay in the poor emphasis given to public health in the medical curriculum. Another major gap in the road to democratic accountability was the poor inter-sectoral coordination witnessed in the actual process of health planning.

The surveyed households reported high morbidity needing regular healthcare. Their dependence on local government health facilities for routine healthcare is reflective of performance accountability. However, a majority of the participants reported out-of-pocket expenditure over Rs 50 for a single healthcare visit to government facilities. This included transportation, cost of medicines which had to be purchased from external agencies and the cost of investigations which needed to be conducted from external facilities. Half of the participants did not have access to insurance schemes and/or other social support schemes and were not aware of the presence of grievance redressal mechanisms to discuss concerns about the functioning of local healthcare facilities. These two aspects reflect gaps in performance accountability which need to be addressed.

Responsiveness

Responsiveness of the health sector was predominantly conceptualised in terms of the healthcare experience of beneficiaries. The attitude and involvement of health professionals had a major role to play in determining this. The poor quality of healthcare services, including poor answerability and indifference of health professionals before the shift was highlighted by the key informants. All the stakeholders including community members agreed that the quality of healthcare experience in government facilities has



improved considerably over the past decades. Although accessibility, affordability and availability of services were still raised as issues in many settings, the shift to decentralised governance and the subsequent increase in accountability definitely made a huge difference to the way government hospitals functioned in the state. We found that the socio-economic profile of beneficiaries of the public health sector in each setting had a role to play in determining the extent of responsiveness. In settings where a diverse and significant proportion of the population used local government health facilities, the responsiveness was perceived to be generally higher.

The perceptions of community members reflected in the household surveys, in-depth interviews and exit interviews revealed that there were gaps in the experience of responsiveness perceived by the beneficiaries at the local healthcare facilities. This gap reflected in receiving of prompt treatment, adequacy and promptness of the staff, ease of physical access to facilities, provision of medicines and lab investigations at the facilities, experiences of disrespect, time taken by the clinical team in providing care, the extent to which they took time to explain the condition to the patients and the ease of access to advanced care in government facilities.

A significant observation was the fact that the community's expectations of the nature of healthcare experience from the government sector were much lower than that from the private sector. Public healthcare facilities were trusted and considered dependable as the first resort for low grade illnesses for the socially and financially backward sections. The narratives reflected the dissatisfaction of beneficiaries with the healthcare experience at these facilities with many reporting instances of disrespect and inadequate attention. However, there was poor willingness to complain as reflected in the narratives of the community members. They considered this behaviour of health professionals from public healthcare facilities as normative and



related this to their own powerlessness. They did not feel entitled to better healthcare experiences from the government facilities due to their poor financial status and vulnerable position.

The secondary data analysis indicates that the proportion of fund allocated for health infrastructure, provision of medicines and lab equipment was relatively much lower than the micro sectors of drinking water and sanitation. It is also significant to note that this pattern continues even after two decades of planning.

The huge role played by the clinical team and public health professionals associated with the local health facilities in determining the responsiveness of any facility is a major theme raised by all the stakeholders and the key informants. For a local governance to ensure that a health facility is adequately responsive, it should have a say in the working of the facility on a day-to-day basis. For this, health professionals should be receptive and motivated. Salary became a component of plan funds only from 2018. Even then, only a small proportion of salaries of health staff came from the plan funds. Under these circumstances, there is little incentive for an unmotivated team of health professionals to engage with the LSGs or accept their inputs in deciding how the facilities function. A change in attitude requires intensive and repeated engagement, training and motivation. The training of doctors and other health professionals is still handled by the state Department of Health and there is hardly any funding allocated to the training of health professionals at the LSG levels.

Inclusiveness

The third and final outcome that we explored was inclusiveness and we had explored this predominantly from the perspectives of community members. The analysis of secondary data analysis indicates little differences in



allocation and utilisation of funds across the three district categories. The general pattern of focus on the two sectors of drinking water and sanitation, especially in recent years, with relatively limited focus on development of healthcare infrastructure, purchase of medicines and equipment is also applicable for all districts. The poor allocation and utilisation of funds for health-related activities was also uniform among all the three district categories.

We also explored the trends in use of SCP funds in non-tribal, non-coastal and predominantly coastal categories and those of TSP funds in predominantly tribal districts. There was a surge in allocation of funds under both these categories during 2015-16 and a decline after 2017. The stakeholders attributed the launch of the Aardram Mission for the surge because it triggered a greater optimisation of resources towards health. The economic impact of the 2018 floods which affected the state was one of the cited reasons for decline in allocation and spending after 2017. Most of the funds were utilised for drinking water and sanitation programmes targeting the Scheduled Caste and Tribe populations and the pattern continues. However, considering the high morbidity reported among household survey participants, a significant proportion belonging to these two groups, there is a clear need for better healthcare, preventive and promotive activities in health. The relatively lesser allocation to micro sectors like health infrastructure and health-related activities could have more severe consequences to the vulnerable groups, necessitating the allocation of SCP and TSP funds to more specific programmes targeting the health of these groups. The gap between allocation and utilisation in predominantly tribal districts is quite stark especially in the micro sector of health infrastructure.



Inclusiveness was one of the original expectations of the key informants from the shift. They expected that the democratic nature of the planning process would ensure that the voices of the poorest of the poor would reach decision makers. However, our findings indicated that inclusiveness was the weakest of the three outcomes. One of the reasons for this could be because we chose the most marginalised and vulnerable sections to examine inclusiveness. The themes from the community interviews reflected alienation, exclusion, differential treatment, invisibility and lack of adequate representation. This was reflected in the local health plan, healthcare experience of this group, their access to healthcare and broader determinants of health. The themes also revealed that the processes and platforms placed to ensure the participation of all sections of the community were largely ritualised. The decline in the participatory element of planning and democratic deficit in the process was reported by many of the key informants and stakeholders. This was also evident from the document analysis. However, the community interviews revealed that this deficit made a far more powerful impact on the health and well-being of the most vulnerable.

Decentralisation is expected to enhance inclusiveness and lead to better equity outcomes. However, the evidence regarding the impact of decentralisation suggests that its effects on equity in healthcare could be negative or ambiguous.²³ Some authors are of the opinion that decentralised governance inclines the settings to inequity in healthcare, since different autonomous units could have different approaches to healthcare leading to differential equity outcomes. Another argument favouring this assumption is that, decentralisation, if not mindful of existing social relations and power dynamics, could end up reinforcing the status quo in terms of social inequalities.²⁴



Lessons from the Kerala Experience

Globally, reforms in governance are striving to create new democratic spaces within local communities and institutions, which are aimed to encourage deeper democratic engagements between the state and the governed.²⁶ The shift in governance to a multilevel planning and decentralised governance in Kerala has also managed to create new spaces for democratic accountability and citizens' engagement. Gram sabhas, working groups, Kudumbashree, standing committees and development seminars are all examples of new democratic spaces located at the inter-phase between state and community meant for exchange of information, negotiation and participation. However, mere creation of such participatory spheres would not result in effective and meaningful participation leading to actual shift in policies and practices. For that to happen, participation should be conscientious and driven. Participants should engage as citizens and not merely as beneficiaries. This means that the institutions of governance should also strive to actively create citizenship as they engage in the democratic processes of planning and governance. This involves suitable institutional designs and steps in the planning process, which will encourage the stakeholders to develop ownership and be active participants. This also necessitates constant discussion, motivation and social mobilisation of the participants ranging from doctors and bureaucrats to the most marginalised sections of the community regarding their role in governance.²⁶

To sum up the Kerala experience, we used the five principles of governance by the United Nations Development Programme (Table: 10).²⁷



Table:10

Five principles of governance and the themes which constitute them

Principle	Themes
Direction	Consensus orientation Strategic vision
Legitimacy and voice	Participation
Accountability	Effectiveness and efficiency Accountability in decision-making Transparency
Performance	Responsiveness
Fairness	Equity and inclusiveness Rule of law

The last three principles and /or themes are the conceptualised outcomes of the study. However, the first two have emerged as part of the exploration of the process of governance.

Direction: –This evaluation suggests that the process of consensus building which occurs routinely as part of planning is not completely authentic. The natural consequence of this is that there is still the absence of a long-term strategic vision in health sector. The community’s felt needs and demands and the health system’s perceptions of health action are not in alignment in many situations, hampering the overall direction of the process. Another important aspect which reflects the lack of sense of direction and vision is the poor horizontal integration in health planning. This also emerged from the secondary data analysis. Except for one project that mentions electrification, drinking water supply and sanitation together, there was no other project that reflected horizontal integration among different programmes and sectors for a common health-related cause.



Drinking water and sanitation are critical determinants of health of the community and there is no doubt that the shift in governance has tremendously benefited the community in terms of access to these basic needs. However, the relatively negligible proportion of allocation and spending towards community-based, health-related activities indicate a set pattern which is being replicated year after year. This presents the need for local governance to reassess the priorities against a vision developed for the future.

Legitimacy and voice:– As discussed above, mere creation of platforms and institutions will not ensure meaningful participation. Inadequate motivation for active participation is reflected from the overall process and is applicable for all stakeholders.

Accountability: This was one of the major outcomes of this evaluation and has been discussed in the previous section. The very design of decentralised governance in the state places accountability at its core and this has created a positive impact over the two-decade period. However, the path to effectiveness, efficiency, accountability in decision-making and transparency is through the two above mentioned principles of direction and participation. Lack of authenticity in the planning process, lack of a shared strategic vision in health and inadequate motivation for active participation among the stakeholders create barriers to accountability.

Performance: We assessed the responsiveness of public healthcare facilities from the experiences of beneficiaries and found that, although the local communities are highly dependent on these facilities for healthcare, more often than not, this is because of lack of other viable options to access healthcare. Although stakeholders and key informants agree that the situation has changed considerably from what existed before the shift, there



is still a long way to go before ensuring responsive healthcare. There has been relatively poor allocation to health infrastructure, purchase of medicines and equipment as compared to other sectors, which could have a definite bearing on the healthcare experience of the community.

Fairness: One of the themes which constituted this domain namely inclusiveness was one of the outcomes of this evaluation. We identified it as one of the weakest outcomes since participants from the marginalised sections of the society did not experience belonging, dignity, and entitlement when they negotiated with the health sector, warranting greater focus in this aspect.



7

POLICY RECOMMENDATIONS

- i. The basic requisite for enhancing democratic accountability in the health sector is the conduct of bottom-up, participatory, integrated health planning actively engaging the community. To successfully and continually engage in this complex process, the members involved need regular, in-depth training and motivation. Separate training modules need to be developed for this purpose and training needs to be supervised and conducted by a diverse resource team of experts, which include actual champions from the field, academicians, activists and researchers well versed in participatory methods and social research.
- ii. In order to understand and replicate the success stories of positive transformation from selected local health settings, the standard of documentation of the process of health planning needs to be drastically improved. Prepared forms including the minimum information expected from each of the planning related documents could be developed for documenting the planning process.
- iii. The level of professional capacities and responsibilities expected from health professionals at each level of the health system (from Primary Health Centres to District Hospitals and District Medical Offices), to appropriate the requirements of the level of local administration need to be specified in separate manuals. Regular, systematic and mandatory in-service training should be instituted to constantly upgrade the performance accountability of health professionals.
- iv. Severe manpower shortage and excessive work have practically disempowered health professionals engaged in public health work.



Manpower shortage existing in four positions – Lady Health Inspector, Health Inspector, Junior Public Health Nurse and Junior Health Inspector – needs to be immediately addressed. The existing policy is to engage these professionals for all the current and future public health programmes, documentation and evaluations, which is affecting their morale and severely limiting the time available for actual community health activities. This policy needs to be reconsidered and the duties and responsibilities of these professionals need to be clearly laid down.

- v. A major lacuna with the existing platforms for community engagement is that none of them provides opportunities for actual two-way communication between the community and the governments. Although situation analysis is considered the first step in a planning process, repetitiveness and lack of originality in the documentation of this step raises questions about its authenticity. An effective way to check the democratic accountability of plans and programmes developed for the health of any community is to conduct periodic social audits as part of Gram sabhas.
- vi. Community mobilisation which occurred during the People's Planning Campaign has greatly facilitated the roll out of decentralised governance and in redefining health in Kerala. The poor inclusiveness perceived by the weaker and marginalised sections and the general decline in collective thinking and the participatory element, underscore the need for another campaign to build social solidarity. This could especially benefit the public health sector in the current scenario, as the state has rolled out Aardram, as a major primary healthcare intervention. Such a campaign, however, must also attempt to subvert the existing social statuesque and power dynamics to ensure better inclusiveness.



8

CONCLUSION

Health sector under decentralised governance has been positively transformed with greater accountability and responsiveness in the state of Kerala. The commendable changes which have occurred in a few settings could be replicated throughout the state to produce excellent health outcomes. However, it is a matter of concern that these achievements have not fully reached the most vulnerable and marginalised sections of the community. The alienation and differential treatment perceived by them in accessing health has stopped us from going the distance. To achieve intangible inclusiveness, we need to specifically target those socially and economically backward sections that are hounded by multiple vulnerabilities and bring them at par with the rest. Since the ultimate outcome of democratic decentralisation is to bring power to the hands of the people and to make them partners in governance, complete authenticity in the planning process is of utmost importance.



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