

OP-24 **PUBLIC HEALTH INTERVENTIONS BY LOCAL GOVERNMENTS IN KERALA: AN EFFECTIVENESS ANALYSIS**

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Background Consequent upon the 73rd and 74th amendment of the Indian Constitution, the state of Kerala adopted decentralisation with a big-bang approach, devolving funds, functions and functionaries to the lower tiers of government. Health care was viewed as one service that has local public good characteristic and was decentralised to achieve the potential gains of possible improvement in service delivery and access. Kerala has now gone through the fourth election to its local bodies and the elected representatives are in office. An understanding of the effectiveness of the decentralised health-care system is necessary in this context to evolve and fine-tune policies.

Methods Three *Panchayats* were selected on the basis of stratified random sampling, based on the per cent of health expenditure to total expenditure incurred by the *Panchayat*. Data were collected at three levels, i.e. as circulated to the public health cadre, to the *Panchayat Raj* Institution and to the beneficiaries. Two detailed case studies were done in Attappady and Kadamakkudy since these *Panchayats* have attracted international attention because of malnutrition-related deaths and environmental health hazards respectively. Aspects including institutional arrangement and response to community needs were analysed. The Knowledge Attitude Practice (KAP) model was used to understand community's involvement.

Findings & discussion Interventions of *Panchayat Raj* Institutions (PRI) were successful to some extent for making the health personnel accountable to the public. Wherever medical officers were ready to respond to local situations and requirements, the results were positive. Many local leaders took interest to ensure the availability of doctors and auxiliary nurse midwives (ANMs) in their area; however indifference on the part of the local leaders is also seen. The mere existence of a health facility does not ensure its satisfactory functioning and utility to the common man. Many facilities lack basic facilities like water, vehicle and staff quarters. Some *Panchayats* took initiative in improving the health infrastructure by earmarking funds for direct and proximate determinants and by mobilising funds locally, whereas some did not. Any meaningful involvement of grassroots leaders can only be possible by creating health awareness and by imparting training about their duties and responsibilities in the provision of primary health care of the communities. Given the relatively lower educational attainment of most *Panchayat* members, lack of exposure to any kind of governance outside and political inexperience, their participation in the PRI system and ability to discharge their responsibilities is often not very effective. However, those

elected in the *Panchayat* who had good awareness of these scenarios actively involved in improving the health status of the community.

In general, health planning has become routinized, focusing on specific infrastructure and mandatory allocations. Some *Panchayats* have nevertheless undertaken innovative initiatives with professional support and guidance, and the results are encouraging. Unfortunately, there is no clear-cut idea about the division of powers and responsibilities between the PRI officials and the public health functionaries. Cases of conflict between those two stakeholders were reported. Nevertheless, wherever knowledge, attitude and practice of the people were high, *Panchayat* officials and public health functionaries responded positively with the aim to improve healthcare provision.

Conclusion & recommendations The decentralisation experience in Kerala's health sector provides examples of success and signs of potentials. More often than not, those potentials did not yet fully develop.

Accountability to the public can be fostered if the Health and Local Self Government (LSG) departments would focus more on providing training both to professionals and elected representatives. Induction training of professionals including the medical officers and their staff need to be reoriented within the context of health management in a decentralised setting. Local government's mandate to respond to local health needs being curbed by grassroots leaders' lack of skills and exposure, steps should be taken by the LSG department to improve the capacity of the latter. The LSG department's allocation for the health sector should be fixed at a uniform minimum level, with freedom to allocate more for new programmes. This would contribute to improved basic facilities in health facilities (water, vehicle and staff quarters among others) and would allow addressing proximate health determinants too. Exemplary *Panchayats* have already evolved innovative initiatives. Their best practices should to be popularized across the state, adopted according to local suitability.

To make this possible, better co-ordination is needed between the Directorate of Health Service through its district machinery and local government. For dual control to become effective, the roles, activities and responsibilities of PRI officials and public health functionaries should be better defined. The Kerala *Panchayat* Act can serve as a basis for developing a manual that enlists the complementary activities of all actors and guides day-to-day management of the local health system. In this way, the still patchy effectiveness of Kerala's decentralisation in health can become a more widespread success story.

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