

# Decentralized Health Planning: Lessons from Two Districts in India

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*The Government of India's experiments in decentralized health planning present special program planning challenges. This paper, through a case study of two districts, highlights the challenges and draws lessons for effective implementation of district health policy.*

*Key words: India; decentralized health planning; district health plans; antenatal care*

## **Introduction**

The *Panchayat Raj* Act passed in India in 1993 paved the way for devolution of power from the state to district *panchayats*. This Act entrusted the responsibility for preparing local development plans and monitoring implementation of those plans to the district *panchayats*. In 1994, the Central Council of Health and Family Welfare Ministers resolved that the states should take steps to develop district health plans; in response, the Government of India began to encourage experiments in district planning in different states to help develop a methodology that could be replicated nationwide. This paper discusses experiences from two such experiments, one that failed to take off and another that produced demonstrable results. The paper highlights the lessons for effective implementation of district planning policy.

## **Background**

Decentralized planning is seen as a way to cope with changing patterns of diseases and regional disparities in health (World Development Report 1993). In India, serious health inequities exist in different states and regions, caused by various social and economic factors. The centralized

planning and financing systems operating in the country have contributed to these inequities, since under these systems poor states get fewer resources to invest in health compared to richer states (Tulsidhar 1992). The Government of India has tried to correct these inequities by establishing national health norms and by funding several health programs centrally, but central funding does not help if the state lacks the capacity to implement these programs. As successive Five-Year plans have shown, poor states have reduced capacity to utilize allocated funds.

Therefore, in India, decentralized planning is needed not to modify resource allocation, but to achieve better efficiency in spending the available resources. The Planning Commission in 1984 made a case for decentralized planning on the grounds that it enables better perception of local needs, helps in making informed decisions, enables better exploitation of resources, and improves productivity (Planning Commission 1984). The *panchayat* system in Karnataka state in the mid 1980's demonstrated that health centers ran efficiently, doctor attendance improved, and building maintenance was better. These gains were achieved without much change in budgetary allocations (Aziz 1993).

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India has developed an extensive rural health infrastructure. It includes one community health volunteer and one trained

traditional birth attendant per thousand in population; one health sub-center, staffed by a male health worker and an auxiliary nurse midwife (ANM), per five thousand; and a primary health center (PHC), with one doctor and three to four paramedical personnel, for every 30,000 in population. Efficient utilization of this infrastructure is one of the goals the Government of India hopes to achieve through decentralization.

The progress of decentralization in India has been very slow. The obstacles often cited are lack of financial autonomy and delegation of powers at the district level. Since districts do not have their own sources of revenue, they depend almost entirely on grants received from the central and state governments. These grants are usually tied to various schemes and programs, leaving less than 15 percent of the outlay for district-specific schemes. As one district health officer said, "Each year we receive planning guidelines from the health directorate. The guidelines indicate the targets to be achieved and the size of the fund available. A large chunk of the fund is already committed to salaries and medicines. There is very little earmarked for district-specific schemes. Though we suggest many schemes, they are not approved, but low-priority schemes of the states are thrust upon us."

Districts also do not have authority over their budgets and staff because it is feared that their staff would spend too much time on transfers and postings or would get influenced by local elite in matters of recruitment and procurement (Satish Chandra 1993). Perhaps the most important obstacle in decentralization has been the target-based approach of the government in implementing its health and development programs. Government is always under pressure to achieve quick results. These pressures get translated into annual performance targets imposed upon program functionaries by the state or the central government, without taking into account local constraints. To these lower-level workers, local planning does not seem relevant, though it is practiced every year like a ritual.

If the concept of planning only means deciding local health priorities and allocating resources accordingly, district-level planning capacity is limited, because decisions in both areas are beyond the capacity of the districts at present. District

data bases are too limited and fragile to support robust estimates of disease burdens, and districts have no capacity to generate their own resources. But districts can attempt to deal with implementation problems.

Interestingly, most district planning efforts undertaken since 1994 have focused on the implementation problems of national health programs. A district in Rajasthan, for example, tried to create community-based distribution centers for medicines and contraceptives because its population was dispersed over many villages (Pradhan 1996). A district plan in Karnataka included activities like removing administrative bottlenecks and improving quality of services (Appanavar and Murthy 1996). A district in Orissa attempted to improve efficiency in the health staff by reducing the frequency of staff meetings to allow more time for client visits (Herringshaw 1996).

These experiments have shown that the scope of a district plan depends on who develops the plan, what data are used, and how priorities get selected. The two district plans studied in this paper illustrate how these very same factors also determine the efficacy of those plans.

The two district plans selected for study belong to neighboring states. The districts are similar in many respects. Both have effective *Panchayat Raj* systems in place with similar administrative and financial systems. Both have similar size populations and areas. Both districts are rated average in terms of per capita income, education and health status in their respective states. The plans were both initiated in early 1994, when the *Panchayat Raj* Act had just come into effect. Both plans received technical support from one non-governmental organization (NGO).

#### **District A Plan**

The NGO which gave technical support to this district plan requested the state government to form a state-level committee to support and guide the plan. State health officers decided not to form such a committee because in their opinion, state involvement was not necessary in a district plan. In other respects, the state's response to the experiment was positive. The state health secretary issued letters to the Chief Executive Officer of the district to extend full support to the project. He examined the project to see if there was any financial liability for the state.

Since there was none, and the project was bringing in some funds, the project was approved promptly.

Other state health officers gave methodological suggestions. One suggestion was not to depend on the District Health Officer alone, but to involve other program officers in the planning exercise because District Health Officers were transferred too frequently in these districts. Another suggestion was to use caution in involving elected *panchayat* members. "Elected members vary in caliber and attitudes, so consult the District Health Officer before involving them," they said.

The first meeting of the planning team was attended by the District Health Officer and all his program officers. The planning team agreed that a household survey was needed to assess district achievements on the "Health for All" goals stipulated in the Health Policy document of the Government of India (Government of India 1986). The team decided that a few high priority goals would be selected for planning — the priority to be decided based on the gaps found between the goals and their achievement level in the district. The highest gap was to get the top priority. The question of inviting elected members to subsequent meetings was kept pending, to be decided later depending on how the experiment progressed.

The NGO carried out a survey of 4000 households to assess the district's achievements on the "Health for All" goals. On analyzing these data, the highest gaps were found in blindness reduction (90 percent), tuberculosis cure (64 percent), and in newborn delivery by trained person (46 percent). The health program officers discussed these findings and decided on increasing delivery by a trained person as the priority goal for planning, though its gap was not the highest.

The team selected this goal for three good reasons. Reproductive health was a national priority for which the district had received substantial resources from the Government of India. Female workers who were responsible for achieving this goal were considered more dependable than the male workers. And, the government centers provided antenatal services to over 70 percent pregnant women.

TB and blindness programs had none of these advantages. Male workers had stopped collecting sputum from suspected TB cases because they were not given risk allowance. The blindness program was very thin on the ground, as the primary health centers had no staff or budget for this program. Cataract camps were conducted by voluntary organizations like the District Blindness Committee, the Rotarians and the Lions. Hence, a majority of the TB and blindness cases went to private service providers (Murthy and Vasani 1995).

Since the goal selected for planning fell into the domain of the family welfare program, the District Family Welfare Officer was asked to initiate the planning process. He first identified the primary health centers showing below average performance on "newborn delivery by trained person" based on the service data reported by them. There were 33 such primary health centers, of which he selected 15 for planning; 18 were kept as control to see if district planning indeed worked.

Next he organized a series of workshops with the staff of the selected 15 primary health centers; the staff were to list reasons for their below-average performance on delivery by trained person. The staff listed problems like delayed payments of travel allowance, lack of vehicles, undisciplined staff, and inadequate medicines and supplies. If these problems could be resolved, the staff suggested, their performance would improve. Thus, the primary health center staff itself created an action plan for the district (Box 1).

#### Box 1 – Plan A

- 1) reduce the number of staff meetings and simplify record-keeping
- 2) supply essential medicines/equipment to sub-centers and vehicles to primary health centers
- 3) increase contingency amount at the primary health centers to undertake minor repairs
- 4) provide technical and management training to workers and doctors
- 5) reduce delays in payment of travel allowance
- 6) take administrative actions against undisciplined staff

District Family Welfare Officer did not agree with all the items listed in the action plan; for example, he did not agree that giving vehicles to the primary health centers or reducing the number of staff meetings would improve their performance. But he agreed that training and simplified records would help. So, from the action plan he implemented only those items with which he agreed. In the year that followed, he supplied printed registers to the primary health centers for record-keeping and gave the medical officers training in management.

Implementation was not initiated or not followed through for other items in the plan. For example, to expedite payments of travel bills the CEO delegated sanctioning authority to the *taluk* medical officers. Most of the *taluk* medical officer posts were vacant, and the action produced no result. An exercise to allocate available vehicles among primary health centers was done, such that each primary health center would have a vehicle for one week per month, but the plan was not implemented because many of the vehicles needed repair. Though the project had funds for repairs, administrative procedures prevented them from taking place. The CEO also issued orders to increase the contingency amount at the primary health centers, but the amount was not released by the treasury. Soon the CEO was transferred and the matter was forgotten. For inexplicable reasons, the District Family Welfare Officer was not even able to send the equipment and supplies which he claimed were available in the district warehouse to the sub-centers.

Out of the six items listed in the plan, only two were implemented. As a result, the District Family Welfare Officer could not raise performance issues with the primary health center staff. Each review meeting ended with the staff asking, "What happened to the items listed in the district plan?"

Shortage of funds was not the reason for non-implementation of the plan; in fact, the project had sufficient funds that were not used. The CEO insisted on using district funds because, she said, every year the district re-funded ten percent of its health budget as unused.

Midway through this project, the District Family Welfare Officer lost interest in implementing the plan, as he faced hostility from other program officers and failed to get support from the District Health Officer or from state-level officers.

Between 1994 and 1996, five District Health Officers had come and gone. They had no time to understand the project or to participate in it. Without their involvement, the actions requiring administrative sanction could not be taken.

Other program officers began to complain about some primary health centers getting special attention. They also resented the little autonomy and visibility the District Family Welfare Officer received because of the experiment. As no state officer was associated with this project, each new District Health Officer began by questioning its legitimacy and the District Family Welfare Officer's role in it. Implementation of the plan came to a grinding halt.

According to a very senior state officer, the plan failed because the district officers did not know what they could do and could not do at their level. According to him, they could not delegate powers or increase contingency amounts at the primary health centers without state sanction. "They should have consulted the state officers before making such plans." In hindsight, he also felt that the community should have been involved. "The NGO should have worked directly with the community instead of working with the district machinery," he concluded.

### **District B Plan**

In our second case, the state and the district played complementary roles. At the outset, the state Directorate of Health Service appointed a Steering Committee to oversee the project. This committee was chaired by the health director and included several senior officers from the directorate, two representatives of the NGO, and three prominent researchers from the state. This committee selected a district for the experiment that was neither too developed nor too backward.

At the district level, an Implementation Committee was appointed including the CEO, the District Health Officer, the Assistant District Health Officer who served as project coordinator, a co-coordinator from the NGO side, and one member of the state Steering Committee. The role of this committee was to plan field activities, supervise implementation, and keep the Steering Committee informed. The plan was to be implemented first in one block — on a pilot basis — and then in the rest of the district.

At the time of initiating this project, the state government was concerned that its population growth rate had remained static over 10 years with no significant change in birth and contraceptive prevalence rates, in spite of economic growth and adequate health infrastructure. An expert group appointed by the government had suggested measures like improving quality of services, increasing access to government services in rural areas, and reducing emphasis on sterilization operations. The Steering Committee decided to select these issues as the priority problems for district planning.

Before selecting specific actions at the district level, the NGO conducted a household survey, covering about 1000 households from 40 villages. This data showed that over 80 percent of pregnant women were registered for antenatal care (53 percent in government centers), 81 percent of children were fully immunized, and 59 percent of couples were using contraception (Foundation for Research in Health Systems 1994). But the data also showed that less than 50 percent of the registered pregnant women were receiving "full antenatal care", meaning two Tetanus Toxoid injections, 100 iron tablets, and three health check-ups during pregnancy. Service coverage was much lower in villages without health centers (69 percent) than those with health centers (85 percent).

These findings were presented to the primary health center staff to get their views on how to improve the situation. The staff fully endorsed the findings and added that women were not receiving "full antenatal care" because most auxiliary nurse midwives did not have the needed equipment and supplies; many auxiliary nurse midwives lacked practical skills and PHC doctors did not examine high-risk women referred to them. These observations were confirmed by a facility survey in the district.

Antenatal services in this district were delivered through Mother and Child Protection camps held in each village, once a month. A typical camp was attended by 25 to 30 children, five to six pregnant women, and one or two women who came for contraceptive supplies. At these camps, auxiliary nurse midwives alone provided all the services. Male workers did not attend the camps. Supervisors brought vaccines to the camps but did not stay, as they had vaccines to be delivered to two or three other camps. Midwives were overwhelmed by immunization work and

had little time for the pregnant women. Some camps were held in public places like school compounds or temple verandahs, where pregnant women had no privacy.

Based on these findings, the Implementation Committee members decided to use the Mother and Child Protection camps to provide "full antenatal care", because that mechanism had worked well for immunization. But, they also realized that the existing camps were not appropriate for this purpose. They planned to modify the camps to deliver full auxiliary midwife care at the village level.

The District Health Officer first thought of holding separate camps only for pregnant women. He asked the midwives to organize such camps, but those who did soon began to report problems. Women complained about having to come twice; midwives complained about increased work-load and about not having time for household visits. After receiving many such complaints, the District Health Officer agreed to withdraw the additional camps and instead decided to strengthen the existing camps.

Taking into account the problems observed at the Mother and Child Protection camps, the Implementation Committee listed a set of actions needed to strengthen the camps (Box 2). Since the equipment and supplies they needed to provide "full antenatal care" were already approved by the Government of India under its new Safe Motherhood Program, the District Health Officer saw no difficulty in supplying the items using the project funds, but he ensured that all actions were within the guidelines approved by the Government of India.

**Box 2 – Plan B**

- 1) improve availability of equipment and supplies with midwives
- 2) upgrade midwives' knowledge and skills
- 3) provide additional staff at the camps to share midwives' workload
- 4) fix timings and ensure sufficient duration for the camps
- 5) find proper locations for the camps
- 6) ensure medical attention to at-risk pregnant women

Within six months, most actions listed in the plan were implemented.

1. A portable antenatal care kit weighing 4 kilograms was supplied to each midwife to carry to the camp sites. The kit contained a *dari* (a mat to spread on the floor), a curtain, weighing machines (adult and infant), tape to measure height, blood pressure apparatus, stethoscope, fetoscope, Uristix and antenatal cards.
2. All auxiliary nurse midwives were given two days training in using these items, focusing on the blood pressure apparatus, fetoscope and weighing scale.
3. All camps were rescheduled such that at each camp, the entire health team (the female and male supervisor, and male worker) could remain present to share the midwives' workload.
4. Camp timings were fixed from 10 am to 4 pm. In each village, the timings, days and names of the camp workers were prominently displayed.
5. The staff found proper accommodation for all camps, usually in the *panchayat* buildings. Staff used curtains to ensure privacy for women.
6. All medical officer positions in the pilot block were filled. A vehicle was assigned between two primary health centers to enable the doctors to make sub-center visits.

These actions had the most visible effect on attendance of pregnant women at the camps. The number increased from three or four to over fifteen (Table 1). All camps were held as per the schedule. Pregnant women received full antenatal check-ups. Equipment and supplies were available in all the camps. The presence of the entire health team at the camp generated enthusiasm; other functionaries like the community health volunteers, traditional birth attendants, and *Balwadi* nursery school teachers came forward to help (Murthy and Barua 1998: 291-309)

One thing that did not improve was the communication between the midwives and the primary health center/district officers. Midwives would not even tell their bosses about broken equipment and exhausted supplies because, as one of them said, "If we tell our problems we get blamed for them."

**Table 1** Impact of Mother-Child Protection Camps on Antenatal Services in District B

Indicators	Baseline	1996-1997
% antenatal care cases registered, of all expected pregnancies	53%	74%
% registered before 16 weeks	not available	30%
antenatal care patient attendance at camps	4 to 5	15 to 20
<b>Services delivered</b>		
physical examination	53%	99%
blood pressure	50%	92%
urine test	46%	90%
TT IFA tablets	70%	92%
high-risk cases receiving medical attention at primary health center	28%	75%

This lack of communication partly reflected the prevailing administrative culture and partly the worker's way of avoiding work. In spite of this constraint, supply lines were maintained with the assistance of the NGO staff who visited the camps frequently, noted the deficiencies and informed the assistant district health officer, who usually took prompt actions.

After improving the Mother and Child Protection camps in one block, the district officers decided to extend this concept to other blocks. They also selected new problems to work on, like increasing postnatal contacts with the women, getting women to come early in their pregnancy, and providing services for gynecological problems which were not covered earlier.

### Analysis

Though these district plans both sought to improve mother care, they were different in many respects: in their content, in the roles played by the states, how they used data, and the attention given to implementation.

Most items in the District A plan did not directly relate to the problem selected for planning. It contained many unrelated items with no clear focus on service delivery. Some items were within the district's control; some needed state's approval or action; other items, like vehicles for each primary health center and disciplinary action against erring workers, could be regarded as non-feasible. Putting such a

variety of items in one district plan only helped to make the plan impractical.

District B's plan was more focused in its attempt to improve service delivery. Only a few actions were selected for implementation, all within the district's control. When those actions began to show impact, the scope of the district plan was expanded to include other blocks and other problems. District B, thus, took a modular approach to planning — select one action at a time, implement it and build on its success. But, District B did not attempt to modify the Mother and Child Protection camps through Government Orders or by introducing any systemic changes. This could be seen as a weakness of this plan because a new District Health Officer could have discontinued the innovation.

In State A, decentralized planning was interpreted to mean that functionaries at each level were free to decide their own plans. The state relegated responsibility for planning to the district, and the District Health Officer left it to the Family Welfare Officer, who in turn asked the primary health center staff to develop their own plans. Interestingly, though, functionaries at each level aligned their plans with the expectations of their higher-ups. The district planning team chose to address the maternity care because it was a national priority. Auxiliary midwives decided to increase household visits and primary health center doctors agreed to intensify supervision because the District Family Welfare Officer used to complain about workers not going to the field and doctors not supervising them.

Only the state had no expectations from this exercise. State officers decided not to take part in it because they wanted the district staff to develop their own plan. But, this decision by the state seemed to actually hurt the district planning process. Sensing lack of interest from the state, the district staff became less involved and the District Health Officer less supportive to the plan.

In District B, on the other hand, the state took an active role. The Steering Committee provided policy directions to the plan. The director periodically asked for reports on implementation progress. He visited the district, met with the staff, and appreciated their efforts. As a result the district staff felt secure and encouraged about what they were doing.

Both districts used data from household surveys to decide priorities. Planners in District A used data to assess the district's performance on "Health For All" goals, but not to identify reasons for low performance. They thought the reasons were well known: poverty, low education, and lack of access to services. Instead of using data, they asked the primary health center staff to explain why their performance was low. The staff naturally identified supply-side problems like inadequate facilities, poor technical skills, and administrative bottlenecks, instead of demand-side (client) problems. In fact, survey data had shown that poverty and access to government health centers were not the major problems, but that women's education, especially their health-related knowledge, was one (Table 2).

**Table 2** Influence of Selected Factors on Rate of Delivery by Trained Person

Indicator	With	Without
health-related knowledge	69%	47%
economic well-being	62%	54%
access to government health center	59%	57%

District B, on the other hand, used data to identify factors associated with access and quality of services. The idea of strengthening Mother and Child Protection camps, for example, came from the finding that the presence of a government health facility in a village was strongly associated with antenatal care coverage. This idea was accepted unanimously at all levels, because it was backed by data obtained from an independent and reliable source.

In district A, implementation was given minimal attention. Except for issuing administrative orders to implement the various items in the plan, there was little follow-up on the actual implementation status. For example, the CEO issued orders to increase the contingency amount for primary health center workers, but the order was not implemented, and no one knew why. Was this action beyond the CEO's powers? Was there a shortage of funds? How else could this problem have been solved? No attempt was made to find answers to these questions.

Similarly, district engineers insisted that the vehicles mentioned in the plan be brought to district headquarters for repair. The vehicles were not in a condition to move, the engineers would not go to where the vehicles were,

and the District Family Welfare Officer made no effort to resolve the stalemate. Buying a new vehicle would be faster than working out these administrative procedures for repairs, he argued (Murthy 1996).

In District B, though the plan required action at the primary health center and village levels, district officers were actively involved in removing all implementation constraints. For example, they contracted *panchayat* presidents to get *panchayat* rooms for the camps, got vehicles repaired, filled vacant staff positions in the pilot block, re-scheduled the camps, and re-allocated villages among workers and supervisors to ensure proper functioning of the camps. In doing so, they took into account the smallest of details, like matching bus schedules with clinic timings for each worker, arranging patient privacy areas, and distributing the workload fairly.

By and large their attention remained on solving implementation problems related to staff, facilities and supplies. The NGO was encouraged to play the supportive role of monitoring camps and providing funds to alleviate immediate supply problems. District A did not want the NGO to play such a role.

## **Discussion**

The contrasting experiences of these two plans show that the success of decentralized planning depends on the extent of administrative and implementation support provided. The chances of getting administrative support are better if there is a clear understanding at the level of program planners about what can be and cannot be done at various levels, and if there is confidence that plans have been developed based on rational analysis of local needs. The chances of getting implementation support are high if the plans are decided by consensus among the implementers, and if they are linked directly with service delivery.

Decentralized planning cannot be the exclusive responsibility of the district. It needs the state's technical and moral support and community backing in the implementation. While community support needs to be negotiated, state support must be built into the process.

It must be recognized that district officers — used to guidance from above — do look up to state officers for approval of

their actions. If the state remains uninvolved or indifferent to their actions, district officers are less enthusiastic and less confident about what they do. State level officers can participate in the district planning process — without controlling it — if they provide policy directions to the plans, help overcome administrative bottlenecks, and share with district planners their technical knowledge and experience. At the community level, *panchayats* and NGOs can provide useful support if the district staff allows their involvement and finds appropriate roles for them. This support, however, cannot be mandated; it has to be negotiated at the local level (Murthy "Management" 1996).

District Health Officers need reasonably long tenures in the district if they are to shoulder planning responsibility. Otherwise, planning gets pushed down to program officers who have limited control and influence in the district. As both cases showed, implementation requires changes in established procedures and practices, for which District Health Officers' involvement is essential. Even the simple exercise of re-scheduling the Mother and Child Protection camps demanded re-allocation of villages among the workers and supervisors. A primary health center doctor could not have made the necessary changes without the approval of the District Health Officer.

Implementation of a district plan inevitably requires involvement of the state and district level officers — a finding that may be considered counter-intuitive. In the government system, lower-level functionaries can take action only when approved by their superiors. The staff at lower levels are either unaware of their administrative powers, or are afraid of using them (Murthy "Proceedings" 1996). This situation will change only when the administrative powers get decentralized and the staff at lower levels learn to use those powers.

Decentralized planning requires consultation with the stakeholders to ensure that the plans are locally relevant and well-supported. The Government of India's manual on participatory planning specifies that all health workers, local NGOs, school teachers, *panchayat pradhans* and members, private practitioners of medicine, and others be involved in the formulation of local plans. There is sufficient evidence in the literature to show that people's priorities are influenced

by their own immediate health problems and not by the community's health needs (Bowling 1993:851-857). How feasible is it then to involve them and expect them to develop a consensus on district priorities and plans?

Outside facilitators, like reputed NGOs, can facilitate consensus building. An external facilitator is especially useful in a government system where subordinate staff do not speak their minds in front of their superiors and do not challenge their superior's views even when necessary (Bowling 1993: 851-857). This facilitator can also be the link between the client and the program managers, monitoring services and taking client feedback to the managers.

Both districts consulted primary health center staff before deciding the action plan. In District A, this process caused confrontation between the primary health center and the district staff because they did not agree with each others' priorities. In District B, these consultations resulted in a consensus on the actions to be taken, possibly because of the way these consultations were conducted. There was all-round agreement on the problems identified, based on survey data. There was no apportioning of blame for past performance; the focus was on the tasks ahead. State and district officers did not pretend to know all the answers but sought information or consulted the health staff.

It is easier to build consensus around solutions that are backed by data rather than opinions. Though opinions of superior officers often get imposed, they may not get support from the implementers. It may be easier to build consensus around actions which directly benefit the people.

### **Conclusions and Policy Recommendations**

These two experiences show that (1) responsibility for district planning should not be pushed too far down the administrative hierarchy; (2) even within the existing administrative structures, district planning can be made meaningful by focusing on the implementation constraints of service delivery; and (3) it may be better to look upon district planning as a continuous process of successfully taking small corrective actions, than as a one-time exercise. On the contrary, it is important to ensure that all levels, from the state to the community, are allowed and encouraged to play their roles in this process (Box 3).

#### **Box 3**

##### **How to Promote District Planning**

- 1) ensure administrative support for the plan at the state level
- 2) consider implementation details to be an integral part of district plans
- 3) encourage planner to begin with a small and feasible plan; expand its scope after experiencing success
- 4) make client needs the focus of the district plan
- 5) periodically undertake surveys in the district to assess client needs

*Define state's role as facilitator of the decentralization process:* If district planning is to be attempted within the existing administrative and financial arrangements, the state's role in it cannot be minimized. State officers must support this process by facilitating the structural and procedural changes needed to implement the plan as well as by sharing their knowledge and expertise with the district planners. If the state does not accept or is not able to play this role, district plans will remain on paper.

*Make implementation the focus of district plan:* The main purpose of district planning, as the two case studies showed, should be not merely to set goals or targets but to find ways to achieve them, whether the goals are set locally or from outside. Therefore, each district plan needs to have an implementation plan as a road-map that assesses the feasibility of each action and finds detours to all road blocks. No district plan is complete without such a road-map. To be sure that the need for this road-map is not lost, decentralized planning may be called the District Implementation Plan.

*Make the plan selective, not comprehensive:* A district plan should contain only a few items and not try to be comprehensive, so that its chances of being implemented remain high. The temptation to prepare a comprehensive district plan is felt because it is viewed as a one-time opportunity to list all needs. This temptation can be countered by viewing a plan as a continuous process: identifying a problem, finding a solution, implementing the solution and evaluating its impact. Successful repetition of

this cycle is a key to achieving significant improvement in service delivery.

*The plan should focus on meeting the client needs:* A district plan will be effective if it focuses on meeting client needs. It has been found that health functionaries and clients view "needs" differently. Health functionaries consider lower service coverage as unmet needs, while clients usually express needs such as access to services, information about services, and effective treatment. By addressing those client needs which have significant bearing on performance, the plan becomes meaningful to both health functionaries and clients.

*Use objective data to identify client needs:* Health functionaries at all levels, especially at the state and district levels, believe that they know client needs because they have been in the field for so long. By experience they know the general patterns of client needs, but may not know the specific needs in that district. For instance, access to government health centers was a problem in District B, but not in District A. Therefore, it is important to rely on local data to identify client needs. This will also help the planners to develop distinct and locally relevant plans.

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