

marari health initiative project proposal for the development of a comprehensive health system

Dr. Joy Elamon and Dr. Vijayakumar

Background and context: Health Status of Kerala

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

Social intermediation process and health.

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

Population, environment, genome and social organization are now considered as the basic determinants of health. This model is in agreement with the view expressed by McKeon on the vital influence of socio-economic environment on health. Two different studies, one by Krishnan and Kabeer and the other by Kerala Sasthra Sahithya Parishad highlight this as one of the major facts responsible for the achievements of Kerala in health sector. The former points out that "it might be feasible to bring about 35 years if an appropriate mix of social policies in conjunction with the development of health infrastructure are implemented vigorously". Panicker and Soman are of the opinion that "... the initial breakthrough in mortality decline had occurred before the concept of development become articulated in government policies". They go on to add "The improvement of health status seem to be attributable more to the expansion of medicare facilities rather than to the effects of development policies".

Other researchers have considered both these views and conclude that there are many socio-economic factors unique to Kerala, which have made Kerala's health model possible. Kerala has higher level of literacy when compared to other Indian states. This is especially true of female

literacy. This factor is also reflected in its low infant mortality have shown an inverse relationships with female literacy.

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

Evolving challenges in the health sector in Kerala

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

Another interesting feature evolving is the phenomenon of low overall mortality co-existing with considerable morbidity, mostly caused by diseases linked to underdevelopment and poverty. This has been proved beyond doubt by the surveys conducted by Kerala Sasthra Sahithya Parishad and National Sample Survey Organization. The former points out that the Kerala situation is peculiar in that there is co-existence of infectious diseases like diarrhoea, hepatitis and tuberculosis with that of non-communicable diseases or life style diseases like cancer and heart diseases. A repeat survey conducted ten years after the first shows that there has been an improvement in basic facilities like latrines, drinking water etc. over the last ten years. This is reflected in the decrease in communicable diseases like diarrhoea. But, there is a growing menace of emerging and re-emerging infectious diseases like malaria, cholera, Japanese B encephalitis and leptospirosis. It is to be noted that they have emerged in certain localized regions and not the state as a whole. Apart from these are the impacts expected from Acquired Immuno Deficiency Syndrome (AIDS) and hepatitis.

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

It is true that public expenditure on health care in Kerala registered a significant and steady increase over the years. The state government expenditure on health also went up over the years. However, the percentage of outlay on health to total plan outlay from the Fifth-Five-Year Plan to Eighth Five-Year Plan ranged between 2.19 to 1.4. Revenue expenditure on health as percentage of total government expenditure, in fact, decreased from 10.41 in 1966 to 8.5 in 1985. In the primary level healthcare, almost 77% of the total revenue expenditure on curative services is being spent on salaries and this percentage is 96 at the secondary level, which includes the Taluk and District

hospitals. At the tertiary level, which consists of institutions like medical colleges, the spending on salaries is 83% of total revenue expenditure in health. This has prevented the introduction of any qualitative advancement in healthcare services. Even though the state was going through a period of fiscal crisis, share in expenditure on health had not gone down much. Yet, the growth of salary component has eaten up this share and has prevented any increase in capital expenditure and expenditure on medicines and other supplies. It is in this situation that the private sector has expanded to large extent in the health scenario of the state. The expansion of the private sector has led to an increase in out of pocket health care expenditure.

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

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

Emerging possibilities

The solutions to these challenges include improvement in quality of services with added emphasis on disease prevention and health promotion, improvement in infrastructure and facilities in public health system and locally specific interventions. The Panchayat Raj (local self-government system) now provides an opportunity for the people to demand the resources to operate a health service in which the people themselves will play the dominant role and of which they will be the chief beneficiaries. All the primary and secondary level health care institutions in the state have been transferred to the local bodies. In addition to this is the People's Campaign for Decentralised Planning, which has earmarked 35 of the State's developmental plan fund for local bodies. This has opened up a tremendous scope for facing the challenges to the Kerala model of health. The possibilities that were opened up are:

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

Approach and Objective

The approach envisaged in the proposed programme is based on the holistic definition of health, the components of which are based on the three broad "states" of injustice, poverty and health. These are being affected by a series of factors like status of women, empowerment, participation,

housing, agriculture, education, employment, water, malnutrition, literacy, sanitation and health care. The programmes being undertaken by the local self-governments of the project area are in tune with this approach. Thus environment is being created for an integrated approach to the development of health sector.

The overall concept is equity oriented as described in the 1978 Alma Ata conference. Equity is to be considered here as equal access to health care according to need and equal utilization of health care according to need, which can be termed as universal coverage of health care. Access in this case is defined in a broader way, which includes physical access to economic and social access. Utilization of health care has to address the issues of physical distance from the health facility, cost involved in using the health facility (fees, travel, medicines, lost income), perceptions of need and utility of health care, cultural constraints on the use of medical care and attitudes of health professionals. Together with equity the social and gender justice, quality improvement based on cost effective solutions, appropriate human resources development and desired lifestyle changes are also envisaged.

The programme will have a multi sectoral approach to health problems insuring the adoption and use of appropriate technology with an emphasis on health promotional activities. The community participation in decision-making is the key word especially in the context of decentralization and the emergence of micro level forms of democracy like self-help groups and the Neighbourhood groups. The programme plans to link all the developmental activities of the area to converge to the health sector.

The programme is to be owned by a group of partners, the partnership extends into participation in decision-making, resource mobilization, implementation of activities, monitoring and evaluation. Thus the possibilities of increasing the efficacy and effectiveness in dealing with the health problems and, of ensuring the acceptability of the approach both the target community and health service providers are addressed. It is expected that these will guarantee the sustainability of the approach and programme. Being implemented in an environment of overall development initiatives the health programme will have broader social and economic effects.

The overall objective of the project is to bring together all the players in the health sector, integrate all the developmental activities related to proximate determinants of health through Panchayat Raj institutions for improving the health status of the population by developing a sustainable model of health care system.

Project Partners

The project is to carry out its activities through building a partnership with various players in the health sector. They can be classified into two groups, namely the core partners and the supporting partners. Core partners include the local self-governments, Community Medicine Department of Medical College, network of self help groups, primary health centres and the district medical office. The supported partners include neighbouring government hospitals, charitable and mission hospital in the area, local NGOs, hospital development committees, private-for-profit allopathic sector, and the traditional practitioners.

Components

The project is to be organized into six components:

- 1. System planning and Strategy formulation**
- 2. System organization and development**
- 3. Curative Services**
- 4. Preventive and Rehabilitative Services**
- 5. Focus Areas Development**
- 6. Project Management**

System Planning and Strategy Formulation

a. Health Needs Assessment: A systematic situational analysis using participatory rural appraisal methodology will be the key activity of this sub-component. Facilitated discussions at the self-help groups and the neighbourhood groups will identify the felt needs and demands of the local community. This will also provide insights into the epidemiological and demographic characteristics of each area. Using structured questionnaire health status of the population is gauged. These are then consolidated at the panchayat level. Similarly the existing health care system is to prepare the status reports. The reports are combined to form a health status report to be presented and discussed in the seminars at the panchayat level. This seminar will prioritise the health needs using a problem matrix analysis.

The health need assessment will take into consideration all the determinants of health including the public and private health care system. It will also consider all the systems of medicine.

b. Resources Identification: The methodology used in the case of health needs assessment is again used in the identification resources. The exercise is to focus on community financing and health care, which shall take into consideration equity as the major factor. This resource identification is based on the larger programmes of development and empowerment and self-reliance being organized and supported by the local self-government through self help groups. This community financing is in addition to the resources being mobilized from other sources, resources like the central and state governments, NGOs and donors. It will also try to identify resources other than money like materials, facilities, human resource and the like.

c. Strategy Formulation: Based on the health status report and resource identification process strategy is to be evolved at the panchayat level and at the project area level. Apart from the panchayat level workshops, consultative meetings with various actors in the health sector and a project area workshop will be held. These will be platforms where experts, electoral representatives and all the stakeholders discuss and finalise the strategy. The Strategy is to focus on the long-term objectives and sustainability of the health system being developed.

d. Detailed planning and project development: Component wise detailed planning of the programme will also include the preparation of various projects, which together form the plan. It is here that the question of integration of projects and programmes directly and indirectly influencing the health status of the population. There shall be a three-year plan with the time activity schedule clearly specified. It will also have inbuilt monitoring mechanism at every level.

System Organisation and development

a) Health Management Committees: A people's initiative with creative partnership between the people, local self-governments, officials, governments, private sector and the NGOs is to be established. This will not only concentrate on hospitals and institutions, but also shall consider health in its holistic perspective as defined by the WHO definition of health. This partnership will have to be institutionalised to become a model for other parts of the state and further nationally and internationally. Professional managerial skills have to be developed among the partners of this initiative and the Health Management Committees which function in each grama panchayat with a federal structure at the project area level.

b) Health information and monitoring system: A simple and effective health information system is to be developed. An IT interfaced HIS is being envisaged. This is to link all the primary health centres and community health centres to each other and to district medical office. A network of self-help groups, private health care providers and public health care providers will be developed. A two-way information flow will be ensured.

The health information system, apart from being an information base for planning will also be a major tool for monitoring. Monitoring is to include project monitoring and the health system monitoring. Network of self-help groups, health management committees and local self-governments are the agencies in their own levels to monitor the health system being developed.

c. Human Resource Development: Human resource development is to be addressed at two levels. In the first level the functions; distribution and skills of the already existing health care professionals and staff are to be re-looked. This is to be based on the health needs assessment. Thus the functions and distribution of the human resources will have to be remodelled to suit the demographic and epidemiological status in each locality. In order to achieve this and to ensure a quality based health care system their skills have to be upgraded.

In the second level on the basis of the health needs assessment additional human resources have to be organized at every level from community health to sub-centres as the case may be. This may include recruiting doctors and field workers, getting assistance from private health care providers, extending health services to more areas and time.

d. Capacity Development: In order to maintain the quality of services, to make it sustainable and to upscale them, provision is made for capacity development programmes. These include continuing training programmes for professionals, health staff and local health volunteers. In addition to training programmes, field studies, feedback systems, good practices dissemination etc. will also be undertaken.

e. Policy Formulation: As part of a sustainable system development the project envisages the empowerment of the local communities and the local self-governments to formulate their own policies in the health care system. This includes the development of laboratory policy, technology policy, drug policy and various protocols and good practices development.

f. Research: In conformity with the objectives of the various developmental programmes and health care system development being under taken in the area provision is also made to undertake research programmes, which shall compliment other activities.

Curative Services

a. Minimum Quality Programme: The project visualizes the development of health care system which shall provide certain basic health care services, the quality of which will be pre-defined and ensured. The approach is to provide universal coverage for these basic services.

1. Village health education unit: Every sub-centre to community health centre will have a village health education unit. According to the levels minimum facilities and communication aids will be provided. The skills and tools will be upgraded and made up to date. The department of community medicine of medical college Alleppey is to link wit all the units. Local health volunteers one from each self-help group with ward level health animators will form a network with the sub centres, PHCs, CHCs and the department of community medicine.

2. Rural outreach services: A total revamping of the sub centres is on the anvil. Apart from identifying the geographical need of sub-centres, the structure facilities and functions of these will have to be remodelled. Based on the health needs assessment planning for revamping of sub centres will be done. This may take away some of the extra load that the primary health centres have been taking now. Upgrading the skills of the field level health workers together with up scaling their functions will be considered according to the need.

3. Village epidemiological unit: A network consisting of self-help groups, sub-centres, PHCs/CHCs, private health care providers and the department of community medicine will function as a village epidemiological unit. This will also cater to the organisation of a disease surveillance system.

4. Out patient services for all the basic ailments: Out patient services will be provided for all the basic ailments. The listing of these ailments will be made based on the status reports to be prepared. Facilities will have to be made to meet these requirements in each PHC. As mentioned earlier sub-centres will also be provided with certain out patient services apart from the various clinics to be organized at the sub centres. Time schedules at the PHCs and CHCs may need a relook. As the demand increases expanding the human resources base will also become a priority.

5. Speciality Clinic Services: As has been observed in the Kerala health scenario regarding the epidemiological transition, there would be need for a few speciality clinic services. Collaboration with the nearby medical college and a few private health care providers is envisaged to undertake this activity.

6. Maternity Services: More specialized antenatal, natal and postnatal facilities and skills have to be provided at the sub centres and the primary health centres. The CHCs will have to be fully equipped to cover all the maternity services for people in the area. Addressing the problems of infant mortality rate, maternal morbidity etc. are a few objectives in this area.

7. Pharmacy Services: Sub-centres will be developed into a basic pharmacy for very common ailments. But the project focuses a lot in ensuring continuous and free supply of medicines to all those who are registered under the social security scheme. The system is to function on the basis of panchayat level essential drug formulary. The health management committee may also run paying counters from where those registered under the social security scheme will get their supply of drugs free of cost.

8. In Patient Services: In patient services for basic specialities will be provided in selected centres as per the health needs assessment. In the case those registered in the social security scheme, in patient services for defined basic specialities will be provided through linkage with medical collage and few private health care providers.

b Basic Facilities and Standards: Each health care institution will be re-modelled to have certain basic facilities. Standards in facilities and services will be defined and made known to public. A social audit mechanism is to be brought in to monitor and to ensure sustainability.

1. Laboratory Facilities: Each level of health care system from sub centre to CHCs will have functioning laboratories, the standards of which will be defined for each level. The regular supplies will be ensured. A larger laboratory is to be set up as a joint venture to cater to the needs of the population in the area.

2. Referral Services: For the members of the social security system referral services will be provided. The components of these services will be finalized based on the health needs assessment. For the purpose of referral services, linkages will be established with the private health care providers, secondary centres of health and medical college.

3. Infrastructure: Additional infrastructure needed in all the levels of health care system in the area will be provided. It will also look into the feasibility and viability of such infrastructure on a long-term perspective.

Preventive and Rehabilitative Services

a. Proximate Determinants Development: As mentioned earlier, the project will focus also on the development of proximate determinants of health. This is all the more possible in the context of the larger canvass of activities being undertaken in the area. These have been explained in the introductory section, where mention is made about the productive sector, employment, and other income generation activities. Drinking water, sanitation, housing, environment are a few of such areas where the local self-governments in the project area are already in the fray. The present proposal will try to link these activities to further advances in the health sector through facilitation

and advisory activities. The finances required for other interventions in this area are being mobilized separately by the local self-governments.

b. Health Education and Lifestyle Modification: The epidemiological and demographic transitions have placed the population into a more vulnerable status with in addition to the communicable diseases, both old and the emerging, the degenerative and lifestyle diseases are also on the rise. This points to the importance of modifying the health initiatives to cater to the life style diseases. Thus, the project will be focussing on health education and life style modification. Instead of making it a mundane programme by the health officials, a people's initiative will be developed with the support of all players including the private sector and the traditional sector. Potentials of these sectors till now underestimated and unutilised will be totally made used for the health of the population. The effort will be to formulate a model of partnership between these groups for the health of the people. Self help groups and the neighbourhood groups shall eventually take up the ownership of the activities thus making it a sustainable model.

c. Nutrition: Nutrition is a major area of focus in the programme being developed at the project area. It is an integrated programme, the components of which include development in agriculture, vegetable cultivation, animal husbandry, integrated child development programme and the various vertical health programmes. Children, women and the aged are the groups, which are to be given attention. Anaemia among the women of reproductive age group and the low birth weight phenomenon will be given attention to. Proper monitoring of nutritional status through Anganawadis and supervision by the self-help groups are envisaged in the programme.

d. Early Diagnosis and Treatment: Early diagnosis of health problems like hypertension, diabetes mellitus, cardiac disorders and cancers are expected to improve the prognosis of these conditions. Moreover, quality of life can be improved through initiating proper treatment at the right time. The project plans to bring together various agencies and programmes involved with these specific conditions. Screening for diseases and follow up are envisaged through the network of partners. The members of the social security scheme will be supported for curative services at a higher level also as the case warrants.

e. Disability Limitation and Rehabilitation: Disability limitation and rehabilitation are the two areas where the governments in the developing countries do not have a sustainable model. At Mararikulam, the health management committees will make ties with the mission/charitable agencies and the self-help groups in this regard.

f. Palliative Care: Another important area being evolved is the palliative care. With the onset of degenerative diseases, palliative care needs to be given more thrust. Institutional, community and household level palliative care services have to be developed. Network of palliative care clinics with professionals, volunteers and the self help groups representatives trained in the area will make them self sustainable in the long run. Along with this will be the training of home nurses for providing health care in the households, especially for the aged.

focus Areas Development

The project identifies a few focus areas acknowledging the emerging health needs of the population. Detailed situational analysis and programmes planning will be undertaken. Comprehensive programmes are being developed in the following areas:

- a. Child and Adolescent Health,
- b. Women's Health
- c. Geriatric Care,
- d. Mental Health

Project Organisation

Project will have a four-tier structure. This comprises of health development committees at the panchayat level, project monitoring committee, core committee and the joint project committee.

Joint Project Committee

Joint project committee consists of the precedence of the local self-governments, DMO, two representatives from the network of self-help group, representative from among the various partners of the project. Joint project committee is the policy making body of the project which meets twice in a year, approves the budget and half yearly and yearly progress reports.

Project management committee

PMC consists of two representatives each from the health development committee of which one shall be the medical officer of the respective primary health centres. Project management committee meets once in month and looks after the integration of various activities and components of the projects.

Health development committee

Health development committees are formed at the level of the grama panchayat with their head quarters at the primary health centres. Apart from the members of the hospital development committee representatives from the network of self-help groups are also to be included in this committee. Each self-help group will have a health volunteer, who will have the ward level and panchayat level committees.

Core Committee

Core committee is the management agency, which deals with the day-to-day activities of the project. A lean secretarial office will support the core committee.

Role of KHSRC: KHSRC will function as the facilitator for the initial three years of the programme. The core committee will be organized by KHSRC. It will be the responsibility of KHSRC to create the environment, bring together various partners and actors, provide professional support, facilitate planning for health sector development, capacity development, implementation and monitoring of the activities. It is planned to have a gradual exit of KHSRC from the proposed project area once the capacities are developed at the local level and made sure that the system developed is sustainable by it.

Financial Organisation

Fiscal crisis in the state has definitely affected the growth of health sector in Kerala. On the other hand increased health awareness among the people has led to rising expectations from the health system. The demographic and epidemiological changes together with the escalation in the cost of health care had made the issues more trivial. The programme shall try to overcome these through improving efficiency, reallocation of resources within the health sector, reallocation of resources to the health sector from other sectors and community financing

Resources are being pooled from various agencies like the state and central governments, local self-governments, community groups including self-help groups and Neighbourhood groups, NGOs, charitable institutions and the donor agencies. The resources include money, materials, human resources, facilities and services. The resources are to be pooled and managed through health development committees to be formed in each of the grama panchayats.

Social Security Scheme being developed at Mararikulam will contribute substantially to the community financing component of the project. Every household of the self-help groups will set apart a portion of their savings for health care contribution. There will be graded system where the people above poverty line will have a higher slab of contribution. This will guarantee them certain defined additional services from the health care system. Those outside the self-help groups will also have the benefits of the social security system, provided they have their membership in the scheme.

BUDGET SUMMARY (in Rs. Lakhs)

Co-mp. Component Name	2002-04	2004-05	2005-06
1 System Planning and Strategy Formulation			
A Health Needs Assessment	10		
B Resources Identification	2		
C Strategy Formulation	5		
D Detailed Planning and project development	2		
2 System Organisation and Development			
A Health Management Committee	1	1	1
B Health Information and Monitoring System	10	5	5
C Human Resource Development	20	10	10
D Capacity Development	2	1	1
E Policy Formulation	1	1	1
F Research	6	3	1
3 Curative Services			
A Minimum Quality Programme			
1 Village Health Education Unit	4	4	4
2 Rural Outreach services	10	10	10
3 Rural Epidemiological Unit	2	1	1
4 Outpatient services	16	2	2
5 Speciality Clinic Services	3	2	2
6 Maternity Services	15	10	
7 Pharmacy services	80	100	100
8 In-patient services	10	8	8
B Basic facilities and standards	20	8	8
C Laboratory Facilities	20	4	4
D Referral Services	10	12	15
Infrastructure	50	10	10
4 Preventive and Rehabilitative Services			
A Proximate Determinants			
B Health Education and Lifestyle modification	5	5	5
C Nutrition	2	2	2
D Early Diagnosis and Treatment	10	12	15
E Disability limitation and rehabilitation	5	5	5
F Palliative Care	5	2	2
5 Focus Areas Development			
A Child and Adolescent Health	5	5	5

B	Women's Health	7	5	4
C	Geriatric Care	5	5	5
D	Mental health	5	4	4
6	Project management	20	15	12
	TOTAL	368	252	242

The first year will be 18 months year (2002 September to 2004 March)

Expected Resources

	Agency	2002-4	2004-05	2005-06
1	Local Bodies	25	25	25
2	Self-Help Groups	35	35	35
3	Other memberships	10	15	20
4	Government	50	40	30
5	Health Management Committees	10	15	20
6	Other agencies	50	40	40
7	MP Fund (Member of Parliament)	10	5	5
8	Donor Agencies	188	77	67
	Total	368	252	242

The total amount needed from donor agency is Rs. 332 lakhs.

Appraisal and Dissemination

Yearly appraisal of the activities will be undertaken. It will have two components. One will be a series of self-appraisal by the partners and stakeholders. An external expert team will do the second level of appraisal. These appraisal reports will be presented in the annual workshops, which will be attended by people from inside and outside the project area. National and international participants at the third annual workshop will help in the dissemination of the experiences. An annual report to be made available to the planners and academicians across the globe will also facilitate this process dissemination.

Risks

The project is not without its own risks. Resistance to Change by various sections of officials and professionals in the concerned sectors will be a major factor. This is expected to be overcome by creating an environment where everybody owns the programme. The partnership with local self-governments, NGOs, self help groups and professional organizations are expected to yield results in this regard.

Another possible risk would be the over expectation of the stakeholders on the services to be rendered. This will be tackled through clearly defining the project and its components. As in the case of many similar programmes, there is a possibility of ending up with selective strategies, which will not yield results as envisaged in the project. Proper monitoring is a necessity in this regard to avoid selective strategies, which will take away the essence of the programme.

Political compulsions and changes may also affect the programmes. In this case, the term of office of the presently elected local self governments have almost three and a half years to go and so this is the ideal time to start implement the programme. Once it becomes successful, institutionalising the programmes will be possible despite political changes and compulsions.

Mention also have to be made of the potential risks involved with the external factors like policy changes by the state and central governments, rise in drug prices etc.