International Journal of Community Medicine and Public Health
Sujatha C et al. Int J Community Med Public Health. 2024 Oct;11(10):4043-4049
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20242659

Protocol

Decentralized planning for non-communicable diseases: protocol for an explanatory study of local self-government projects in Kerala, India

Chintha Sujatha*, Srinivasan Kannan

Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala, India

Received: 17 August 2024
Revised: 30 August 2024
Accepted: 03 September 2024

***Correspondence:**
Dr. Chintha Sujatha,
E-mail: sujathachintha@gmail.com

ABSTRACT

Background: Priority setting and resource allocation in decentralised planning is often not in line with the social and economic burden associated with non-communicable diseases (NCD). This is a protocol developed for the purpose of analysing the pattern of budgetary allocation and utilisation of funds for health sector projects on non-communicable diseases by the local self-government (LSG) institutions in Kerala. It is also proposed to document the processes along with the stakeholders' role in planning.
Methods: Following explanatory design, first we will do secondary data analysis of health sector projects on NCD fund allocation and utilisation, followed by document analysis and key informant interviews in LSGs at selected districts of Kerala. Following policy framework used in public health related policy processes, will perform descriptive analysis, based on stages heuristic in decentralised planning. Multiple dimensions of priority setting and allocation process will be studied. Explanatory analysis for resource allocation process will be studied using Kingdon's multiple streams framework.
Conclusions: The study will help in understanding the decision-making process for fund allocation with the specific focus on NCD. It will also help in building an evidenced based framework for decentralized health planning.
Trial Registration: No: SCT/IEC/1849/FEBRUARY/2022.

Keywords: Non-communicable diseases, Decentralised health planning, Resource allocation, Local self-government, Kerala

INTRODUCTION

Non-communicable diseases have become a major contributor to morbidity and mortality across the globe.[1] India has been experiencing the epidemiological transition with two-thirds of disease burden attributed to non-communicable diseases (NCDs) and injuries.[2] Among all states of India, Kerala is experiencing the highest epidemiological transition level with an epidemiological transition ratio of 0.16. Over 90% of Kerala's premature mortality is contributed by NCDs.[3] The national program for prevention and control of cancer, diabetes, cardiovascular diseases, and stroke (NPCDCS) was launched nationwide and subsequently in the state of Kerala in a phased manner starting from 2008. In spite of the efforts made by the programme, most adults (82.4%) in Kerala had at least one of the NCD risk factors. Only 12.4% of individuals with hypertension and 15.3% of individuals with diabetes were found to have these conditions under control.[4] But the global policy response is not in line with the enormous health, economic and social burden of NCDs.[5] This necessitates an urgency in realigning the priorities to address the economic implications due to high morbidity and mortality caused by NCD.

There is wide acceptance among all levels of stake holders that the problem of non- communicable diseases can be

controlled by strategies focussing on prevention, applying principles of primary health care with emphasis on community participation and intersectoral co-ordination.[6] NCD responses need to be adapted to local contexts and should have stronger governance structure.[5] Evidence suggests that interventions for NCD control should extend beyond the health sector and be targeted within the natural settings at various stages of lives of those in need.[7] Many at times it is assumed that it is the responsibility of the health system to address this problem. But, in reality the conducive behavioural and environmental conditions will control the risk factors associated with NCD.[8-10] This leads us to adapt health promotion approaches. Health promotion, is the process of enabling people to increase control over one's own health, and to improve health needs.[11] This necessitates the provision of optimal architecture for healthy choices ("nudges") with necessary physical spaces for exercises, sufficient resources and information related to healthy diet and so on.[12]

Kerala has strong local bodies engaged in decentralised planning for development projects including health. These bodies are officially known as local self-government (LSG). These LSG institutions play a crucial role in integrating community health interventions with health services of Kerala.[13] Though initiatives of LSGs engaging with the NCD control program for screening and treatment is successful, but were not helpful in achieving complete NCD prevention.[8-10,14,15] For achieving greater success, the LSG institutions need to focus on prioritising NCD control interventions at the grassroot level. Published literature shows at the local level, there is a little fund allocation for NCD, which causes high morbidity and mortality.[10,16] This clearly shows how the planning has gone wrong while setting priority that lead to suboptimal use of resources.[17] Many at times the LSG institutions set priorities without considering the disease burden. The general practice in such instances are creating new infrastructure, purchase of drugs and equipment, organising medical camps and health education programme.[10,16] All LSG institutions do not default as mentioned. There are some LSG institutions engaged in initiatives associated with healthy living and primary prevention.[18] The success of LSG participation was due to increase in fund allocation.[19] Intersectoral co-ordination and community participation will improve preventive strategies such as, lifestyle modification for healthy diet, physical activity, tobacco cessation, early screening for NCD and providing healthy choices at the neighbourhood.[11,20] There is paucity of evidence on community-based health interventional studies from developing countries and this necessitates a study on community-based health interventions and its dynamics.[21] This will help in understanding the role of LSG institutions in implementing community-based interventions and will generate evidences.

Evidence suggests that active facilitation of decentralized health planning and influencing the health system to expand participation, are essential to ensure changes in planning.[22] To generate political priority, advocates will need to address several challenges, including the creation of effective institutions to guide the initiative and the development of a public positioning of the issue to convince political leaders to act on it.[23]

The present endeavour is an effort to answer the following questions; Why certain health issues are only included in the existing LSG projects? And how? What are the factors that determine the priority setting process and decisions on resource allocation with respect to NCD control? What is the pattern of budget allocation and decision-making process followed at present?

Based on the above research questions, the present study aims at analysing the pattern of budgetary allocation and utilisation of health sector projects with specific reference to non-communicable diseases at different levels of LSG institutions in Kerala during 2018 to 2022. The study will also document the allocation processes and the role of stakeholders in health sector planning at LSG institutions in Kerala.

METHODS

The present study follows an explanatory design. The study will be conducted in two phases. In the first phase, the researcher retrieves the data from the public database and collect data on the details on fund allocation by different local bodies in the study districts for the purpose of analysing the pattern of utilisation for health projects with specific reference to NCDs. In the second phase, key informant interviews and analysis of relevant documents will be done at the randomly selected local bodies from the study districts.

Study setting

Kerala state, located in the southern part of India has a population of about 3.5 crores. It has 14 districts. We are selecting three districts of Kerala based on their geographical location. The districts included in the study are, Thiruvananthapuram representing the south, Kozhikode representing North and Kottayam for the centre of the state of Kerala. We will do secondary analysis of data from both urban and rural LSG institutions from these three districts. Urban local bodies include municipalities for towns and corporations for cities. Rural local bodies at three levels of decentralised governance include district, block and grama panchayaths.

Data sources

Secondary data are accessed from the digital datasets that are available in the report format on different health sector projects from the Information Kerala Mission, a Government of Kerala organisation. Documents that were part of the planning and resource allocation processes at the LSG institutions at different levels will also be accessed.

Study participants

For the key informant interviews, the elected representative of local bodies (both former and present), members of different committees at the local levels and the staffs at the selected LSG institutions will be included. As per inclusion criteria only members of the working group for health sector planning in the Grama panchayats will be interviewed. Those members with less than one-year experience in local level planning and those not willing to participate will be excluded.

Framework

The present study adopts a policy framework that was applied in public health-related policy processes.[24] The framework follows a descriptive analysis based on stages heuristic. That is, the actors, contexts and institutions will be analysed in stages. The stages followed are, agenda setting; how problems have been recognized and how they have been framed, project formulation; how options are considered and decided upon and communicated, project adoption; what decisions are made, project implementation; what rules and procedures are established and to what extent are they aligned with initial intentions, and finally project assessment; what has been the impact of the project; how is it monitored; has it achieved its objectives; are there unintended consequences. All stages will be assigned values for different categories of options and a process map will be created based on that. Using this approach, the multiple dimensions of priority setting and allocation process will be examined. Explanatory analysis for understanding the why and how of resource allocation will be following the adopted Kingdon's multiple streams framework (Figure 1).

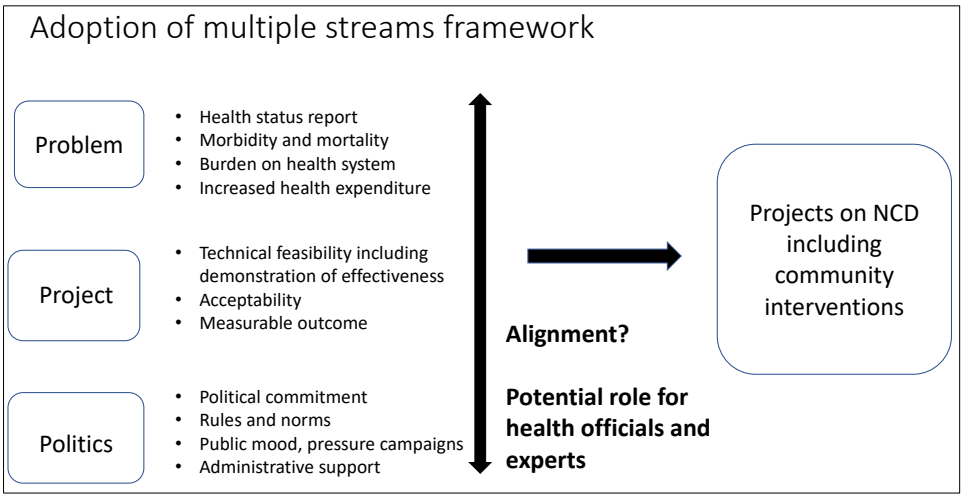

Figure 1: Framework adopted from Kingdon's multiple streams framework

Sample frame

Sample size

Sample size was calculated using the formula for estimation of proportion. With the assumption that the proportion of local bodies with at least a single NCD related project is 60% as per data from Information Kerala Mission (IKM) for the last available year 2019-20, and at a confidence level of 95% and absolute precision of 15%, sample size required was 40 local self-government institutions. Rounding to nearest multiple of three, 42 LSGIs was included in the study. To study the processes and stakeholders in resource allocation the researcher will conduct key informant interviews from at least one respondent to a maximum of three respondents for each of the selected local body institution.

Sampling design

Out of the total 14 districts of Kerala, we are selecting three districts based on geographic location for ensuring representativeness. We will analyse secondary data from all the rural and urban local bodies from the selected three districts. For the phase two primary data collection, which includes document analysis and key Informant interviews, we will be randomly selecting local bodies from the selected three districts.

We will include one urban local body each from all the three districts. Among rural local bodies, three of the district panchayaths will be included. Four block panchayaths will be selected from each district and two grama panchayaths from each block. Thus, the sample will include three urban local bodies, three district panchayaths, 12 block panchayaths and 24 Grama panchayaths, a total of 42 local bodies.

List of local bodies will be the sampling frame. Simple random sampling using computer generated random numbers will be the method employed for random selection of local bodies. Sampling design is shown in Figure 2.

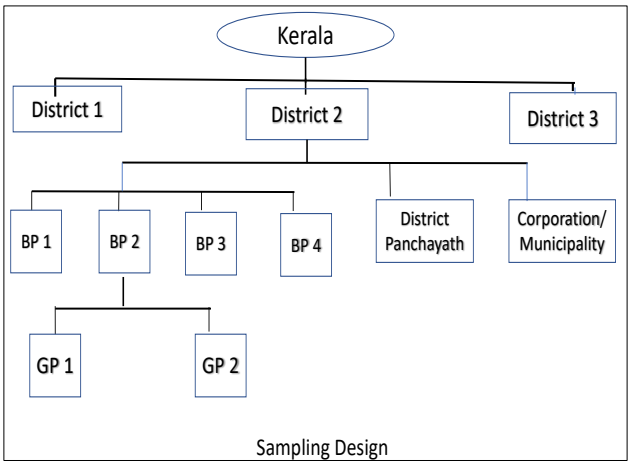

Figure 2: Sampling design.
GP: grama panchayath, BP: block panchayath.

Study tool and procedures

We have obtained permissions for conducting this research work from the LSG department, Government of Kerala. We have developed and validated the data collection tools based on literature review and consulting the experts and a pilot study was conducted. A data extraction form has been developed for secondary data analysis of data on health sector projects. The form extracts project particulars for each year, which includes total budget allocation, number and amount of projects in each category. Document analysis will be done using a checklist for capturing the timeliness, and completeness of documentation of planning meetings, participation and concerns and topics emerging. Interview guides are developed for key informant interviews. Interview will cover questions on conduct, participation and topics emerging in Grama sabha and working group meetings, details of health status and development report, project approval process, trainings, mechanisms for data management and perceptions regarding allocation process. Project documents for health sector will be reviewed for extracting data for detailed analysis of pattern of allocation. Analysis of documents on health sector planning and interviews will be primarily done to understand resource allocation process. Economic review reports, health status reports, minutes of grama sabha and planning committee meetings, annual development plans, calendar for planning, administrative orders and circulars will be analysed. Framework followed for data collection is given in Table 1.

Study variables

Pattern of budgetary allocation and utilization will be captured as LSG bodies with projects on NCD control, budget allocated, number and type of health projects, budget allocated for NCD, number of projects in NCD, utilisation pattern of allocated projects, sector wise allocation and utilization, subsector wise allocation and utilization, category wise allocation and utilization and type of NCD projects. Explanatory variables will be profile of LSG bodies like level, region, political leadership, dominant communities, dominant livelihood means and profile of local body leaders like age, gender, political affiliation, education, occupation, experience, training, income, land holding, religion, caste and family members in politics or social leadership. For understanding the resource allocation process variables used will be adherence to guidelines, health status reports availability and completeness, regularity and timeline of planning committee meetings, composition of meetings, and pattern of projects considered for prioritizing.

Table 1: Framework for data collection.

Methods	Subjects/documents	Variables
Objective 1: Pattern of budgetary allocation		
Secondary data analysis using data extraction form	District level annual report, annual development plans, calendar for planning, administrative orders and circulars of selected LSG	Total budget, service sector budget, health sector budget, total no of projects. No and amount of health projects; in different system, NCD, CD, Infrastructure development, HR, medicines, equipment, NCD screening camps, medical camps, NCD clinics and camps, mental health, Cancer camps, community interventions for NCD, diet modification, physical activity, substance abuse, health awareness, non- health sector projects on NCD.
Primary data collection through interviews	LSG officials and elected representatives.	Profile of LSG: basic information, composition, profile of president
Objective 2: pattern of utilization		
Secondary data analysis using data extraction form	District level annual report Annual report and project documents of selected LSG	Proportion of budget utilized; in different systems, NCD, CD, infrastructure development, HR, medicines, equipment, NCD screening camps, medical camps, NCD clinics and camps, mental health, cancer camps, community interventions for NCD, diet modification, physical activity, substance abuse, health awareness, non-health sector projects on NCD.

Continued.

Methods	Subjects/documents	Variables
Primary data collection through interviews	LSG officials, Grama sabha members and elected representatives.	Factors influencing utilization, monitoring mechanisms, user fee, sustainability.
Objective 3: resource allocation process		
Document analysis using data extraction form	Minutes of Grama sabha	Document availability and completeness, timeliness, adequate participation; composition, ratio of experts to non-experts, participation of government officers, no and type of concerns raised, no and type of NCD related concerns, no and type of projects formulated, methods for prioritisation, project appraisal, and any economic evaluation methods employed
	Development report	
	Minutes of Vikasana seminar	
	Minutes of working group on health	
	District planning committee report	
Primary data collection through interviews	LSG officials, Grama sabha members and elected representatives.	Factors influencing allocation process, prioritisation and appraisal methods, and training in project formulation

Data analysis

Classification, labelling and organization of secondary data will be done initially. After data cleaning and coding, financial analysis will be done. Budget allocation and utilization will be summarized as mean and standard deviation and proportions in terms of actual amount and number of projects will be calculated for outcome variables. Appropriate financial analysis tools associated with fund allocation (budget analysis, allocation efficiency), bivariate (correlation, Chi square, t test and ANOVA) and multivariable analysis (regression) will be done. Efforts will be made to include gender dimension and representation of marginalized sections of society. Statistical analysis will be done using statistical package for the social sciences (SPSS) version 25.0 (SPSS IBM, Armonk, NY).

For process efficiency, analysis of process maps and stakeholder maps will be done. The plan of analysis will include, the description of the actors; the key actors and their beliefs, interests and influences of actors, the context; systemic factors (political, social, economic, others), external events that influence the context and the institutions; rules and norms followed, perspectives and practices at different levels.

For analyzing qualitative component of primary data, deductive coding will be followed, as the checklist for data collection has been made in a thematic way. The newer subthemes emerging from already defined codes will be listed.

Ethical considerations

The study proposal has been cleared by the Institutional ethics committee of SCTIMST, Thiruvananthapuram (No: SCT/IEC/1849/FEBRUARY/2022). Data collection will be scheduled based on the convenience of the participants. Investigator will follow the informed consent process before collecting data. The participants will be briefed on the study objectives, purpose, benefit, risks and voluntariness to decide participation. The privacy, and confidentiality of the data will be ensured at all levels. Anonymity will be maintained throughout.

DISCUSSION

Findings of this study will help in understanding the current pattern of resource allocation and utilization in health sector LSG projects with special reference to NCD. The findings of this study will help policy makers to use this as evidence for future resource allocation exercises. A wide range of factors influence decision making in resource allocation like personal beliefs, public and institutional group pressure, politics, visibility of outcome of projects.[17,18] Previous works from Kerala have studied the link between the socioeconomic status of the Panchayats, people's participation rate in the planning process and the share of resources allocated to health.[29]

A number of analytical frameworks can be used to identify factors that shape political prioritization and policy-responses.[30-32] A study to identify factors leading to the inclusion of NCDs in policy agenda at a global level, was done using Shiffman and smith framework.[5,23] This framework uses a case study method and consists of four categories: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself. This is elicited with the help of archival research and interviews using a process-tracing method. Another study on priority setting to assess the factors involved in making health in urban poor settings a priority, semi-structured phone interviews and literature reviews were done using process-tracing method.[33] In this study we are planning to adopt selected policy frameworks to identify the determinants of prioritisation and for process mapping.

An evaluation done using in-depth interviews and analysis of change in local health planning processes on a project

aimed at capacity building for decentralized planning done in Maharashtra, revealed positive changes in intervention areas, including increased capacity of key stakeholders leading to preparation of evidence-based, innovative planning proposals, significant community oriented changes in utilization of health facility funds, and inclusion of community-based proposals in village, health facility-based block and district plans.[22] There is limited uptake of economic evidence for priority setting in health care. Scientific and objective priority setting techniques such as programme budgeting and marginal analysis and QALY league tables are seldom used.[34]

Paradigms in decision making for resource allocation have been suggested in previous works. Communitarian claim is one such example, where citizens take the lead in determining the principles or values that are to guide priority setting and others, primarily policy makers play out the process of health care planning.[35] Novel approaches to engage citizens in health priority setting were evaluated which raised questions on the role of public engagement in driving priority setting decision making.[36] In a study examining factors influencing the prioritization of NCDs , results show that most of the times actor power does not extend beyond the health sector and for increasing the role of guiding institutions and civil society, economic arguments, presenting rising costs and burden, are more helpful than the discourse on risk factors and diseases per se.[5]

The different approaches used in to guide resource allocation decisions approaches include evidence-based medicine, burden of disease analyses, cost-effectiveness analyses, and equity analyses. Studies on priority setting of health interventions, propose that instead of approaches that concentrate on single criteria only, we need to make choices taking into account multiple criteria simultaneously.[17]

CONCLUSION

The purpose of this study is to understand the decision-making process in allocation of funds itself and how it can be applied by health officials to influence allocation for NCD control per se. Outcome of this study will include building a framework for an evidence-informed approach for understanding and influencing decentralized health planning. Evidence on burden of NCD and effective interventions for its control should be applied while formulating health sector projects/policy at local level. A thorough understanding of resource allocation process in LSG planning and factors influencing prioritization is needed to devise strategies and approaches for effective engagement of health organizations in decentralized health planning.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Sujatha C, Kannan S. Decentralized planning for non-communicable diseases: protocol for an explanatory study of local self-government projects in Kerala, India. Int J Community Med Public Health 2024;11:4043-9.