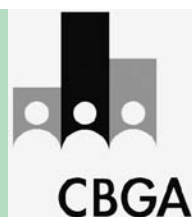


# Safe Motherhood, Public Provisioning and Health Financing in India

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**Indranil & Trisha Agarwala**



**Centre for Budget and Governance Accountability**

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Omissions and errors in the study are our own.

**—Indranil and Trisha Agarwala**



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# Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASHA	Accredited Social Health Activist
AWP	Annual Work Plan
AWW	Anganwadi Worker
BPL	Below Poverty Line
C&AG	Comptroller & Auditor General of India
CBO	Community-Based Organization
CHC	Community Health Center
CMoH	Chief Medical Officer of Health
DHA	District Health Authority
DLHS	District Level Household and Facility Survey
DoFW	Department of Family Welfare
DoH & FW	Department of Health & Family Welfare
EAG	Empowered Action Group
EC	European Commission
EmOC	Emergency Obstetric Care
FMG	Finance Management Group
FMR	Financial Management Report
FP	Family Planning
FRUs	First Referral Units
GDP	Gross Domestic Product
GiA	Grants-in-Aid
Gol	Government of India
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IMNCI	Integrated Management of Neonatal Childhood Illness
JSY	Janani Suraksha Yojna
LHV	Lady Health Visitor
MDGs	Millennium Development Goals
MIS	Management Information System
MMR	Maternal Mortality Ratio

MO	Medical Officers
MoH	Ministry of Health
MoH&FW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MoU	Memorandum of Understanding
MWCD	Ministry of Woman and Child Development
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NIHFW	National Institute of Health and Family
NNMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
PHC	Primary Health Center
PIP	Program Implementation Plan
PMG	Program Management Group
PNC	Post Natal Care
PPI	Pulse Polio Immunisation
PRI	Panchayati Raj Institutions
PWD	Public Works Department
QPR	Quarterly Progress Report
RCH	Reproductive and Child Health
RHS	Rural Health Statistics
RKS	Rogi Kalyan Samiti,
RMP	Registered Medical Practitioner
SC	Sub Center
SCs	Scheduled Castes
SCOVA	Standing Committee on Voluntary Action
SHG	Self Help Group
SHS	State Health Society
SNP	Supplementary Nutrition Programme
SoE	Statement of Expenditure
SRS	Sample Registration System
STs	Scheduled Tribes
TBAs	Traditional Birth Attendants
ToR	Terms of Reference
TT	Tetanus Toxoid
UC	Utilization Certificate
UP	Uttar Pradesh
WHO	World Health Organization

# Key Findings

## Maternal health outcomes in the study States and districts

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- Extremely high incidence of maternal deaths in the country with a majority of these in the low performing Empowered Action Group (EAG) states. As per Sample Sample Registration System (SRS) estimates, the Maternal Mortality Rate is 254 per 100,000 live births for India. Maternal Mortality Ratio (MMR) is much higher in the study states of Uttar Pradesh (440) and Chhattisgarh (335) as compared to the national average. Uttar Pradesh, which has around one-fifth of India's rural population, accounts for two-fifths of the recorded maternal deaths. The Empowered Action Group states, which have half of the country's rural population, account for more than 84 percent of maternal deaths.
- A majority of the maternal deaths are avoidable. Government interventions for reduction of maternal deaths have had limited success due to the lack of access to skilled health professionals and proper healthcare facilities. In India, less than half (48.3 percent) of the deliveries are assisted by health professionals and only two-fifths take place in institutions National Family Health Survey - III.
- There are significant state level variations in terms of access to institutional births or births assisted by skilled professionals. In Chhattisgarh, only 16 percent of deliveries take place in institutions, whereas in Uttar Pradesh it is 22 percent.
- Women in rural areas, women belonging to Scheduled Castes (SCs) and Scheduled Tribes (STs) or poorer sections of society have considerably less access to skills and institutions for child birth as compared to women in urban areas or those from the richer sections. A strong class gradient can be observed in access to institutional delivery – women from the highest wealth quintile could access institutions in 84 percent of deliveries, 6.5 times more than those belonging to the lowest wealth group
- Field evidence shows that institutions are accessed only during the last stages of pregnancy, and in many cases, the women are not even aware of their date of delivery. The decision to access institutional facilities lies entirely with their in-laws and husband since they seem to be the decision-makers.

- The Janani Suraksha Yojna (JSY) programme under National Rural Health Mission (NRHM) has contributed to the increased demand for institutional delivery in both the study districts – Lalitpur and Rajnandgaon.
- Antenatal Care (ANC) (provision of Iron and Folic Acid (IFA) tablets, Tetanus Toxoid (TT) vaccinations as preventives against anaemia, haemorrhage and sepsis) and Post Natal Care (PNC) check-ups were found to be largely ignored in the study states as per NFHS and District Level Household and Facility Survey (DLHS) surveys. However, field findings show that in Rajnandgaon, ANC was found to be better than in Lalitpur. Overall coverage of ANC in Lalitpur was found to be very poor, as indicated by DLHS-III surveys, with only one in five pregnant women getting all three required ANC visits. This was also the situation, as gleaned from field visits, with pregnancy not being considered a condition that requires medical attention.
- The study team also found that the food and nutritional requirements of pregnant and lactating women was grossly neglected. There were also misconceptions and superstitions surrounding additional nutritional intake during pregnancy; several respondents in Lalitpur district belonging to the Sahariya tribe believed that additional food intake would fatten the unborn fetus, and consequently, require going in for c-section.
- A close link was found between poverty and poor maternal health. Both the study states are EAG states, which are characterised by high MMR, low levels of institutional births, low coverage of ANC and high under-nourishment among women and children.

## Budgetary Processes and Allocations

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- The major interventions in maternal health are Reproductive and Child Health (RCH), currently a part of NRHM, and Rural Family Welfare Programme. In both study states, spending on maternal health was around 15-16 percent of total spending on health.
- The quantum of budget outlays for maternal health in the study states was on the increase in absolute terms, but the accretion in real was only marginal. Since introduction of NRHM, there has been a sudden increase in allocation of funds in the study states.
- The study brings out the meagre level of per-capita public spending on maternal health in both the states. In Uttar Pradesh, it was Rs. 1,439, and for Chhattisgarh, it was Rs. 1,182 in 2007-08.
- Out-of-pocket (OOP) expenditure on childbirth including Antenatal Care (ANC), Post Natal Care (PNC) and delivery in public and private health institutions was much higher in Uttar Pradesh (Rs. 1,730) in comparison to Chhattisgarh (Rs. 1,179), pointing to the inadequacy in public expenditure on maternal health in EAG states. OOP expenditure was found to be a major constraint in accessing health institutions during delivery, as found in the study. (Case Study III.1 in Chapter 3)

- The study brings to light the dearth of interventions on maternal health in both states, especially at the state level, which is further compounded due to the meagre amount of funds allocated to the schemes. The study states show different patterns of spending towards wage and non-wage components. In Uttar Pradesh a majority of state budget interventions goes towards wage payments while in Chhattisgarh there is substantial non-wage spending. This could be attributed to the huge vacancies in medical and paramedical staff in Chhattisgarh.
- Supplementary Nutrition Programme (SNP), which is a part of the Integrated Child Development Services (ICDS) scheme, has a potential to impact maternal health significantly. However, field observations show that pregnant and lactating women were hardly receiving their entitled take-home ration, and in many cases, were not even aware of their entitlements.
- NRHM focuses special attention on Empowered Action Group (EAG) states, i.e., the low-performing states, including Uttar Pradesh and Chhattisgarh, would get greater share of funds in proportion to their population. However, the study shows that both states are receiving much less share of funds in comparison to better off but much smaller states. Since the funding is based on a state's ability to spend efficiently, the backward states lose out in the competition for NRHM funds. This raises the question of whether transfers under NRHM are necessarily progressive or not.
- An important finding is the magnitude of underutilisation of funds in NRHM. Since 2005-06, both Chhattisgarh and Uttar Pradesh have received funds higher than what was allocated but expenditures fell short from what was allocated, creating huge unspent balances.
- Besides underutilised funds, there was poor quality fund utilisation. The quality of spending has been assessed in terms of the skewed pattern of utilisation across components. Spending was primarily on Family Planning and Janani Suraksha Yojna (JSY) while that on crucial components such as training of staff and upgradation of facilities was in fact reduced.
- There was also a disproportionate pattern of fund utilisation across the four quarters. Spending in both the study states was seen to occur only towards the last quarter, consequently leading to funds being spent in a hasty manner.
- Procedural bottlenecks in fund flow were another impediment found in the budgetary aspect of the study. Delays in transfer of funds from the Centre to the states led to unspent balances at the year end. These unspent balances in turn led to a cut in grants for the subsequent years. The delays seemed to take place at all levels of the administrative units, i.e., Centre, state, district and block.
- The study also questions the general notion that electronic transfers can do away with all delays in fund transfer. Rather, it shows that points of delays remain at various offices at the state and district levels.

## Quality of Services Delivered

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- The study brings to light the absence of adequate human resources at all levels of medical and frontline staff such as doctors, female gynaecologists, ANMs and paramedical staff. Chhattisgarh had 85 percent of specialists and 66 percent of medical officer posts lying vacant while supply of doctors was also limited with only two medical colleges. This indicates that even when beneficiaries want to access services they are unable to do so since service providers are inadequate, and begs the question: Does the problem lie in the states' inability to retain medical staff as well as the lack of priority given to their training and capacity building.
- Existence of huge vacancies and inability of NRHM to tackle the situation point to a faulty design of the Mission itself. It does not allow for permanent appointments but expects to solve the problem with contractual recruitments, leaving the responsibility of filling up vacancies to the states. The states already facing a constant shortage of doctors and paramedical staff, are also saddled with not having the required investment to set up medical colleges to deal with the human resource crunch. Unless the states are supported with statutory transfers, this problem is not going to be solved.
- To effectively provide safe motherhood, the presence of a fully equipped facility with referral transport is necessary. However, this was not the case in the study states. A majority of the facilities visited lacked the necessary equipment required to successfully manage emergency situations. Even where infrastructure {sub health centres Primary Health Centers (PHCs), Community Health Centers (CHCs)} existed, there was an absence of basic amenities such as staff quarters, electricity, water supply and motorable roads.
- Frontline workers such as Traditional Birth Attendants (TBAs), Accredited Social Health Activists (ASHAs), Auxiliary Nurse Mid-wives (ANMs) and anganwadi workers involved in maternal health were found to have overlapping roles. Barring a few exceptions, they were not seen to be working in a coordinated manner. In effect, most home deliveries were managed by the TBA/dai in both the study districts.
- The mitanin programme of Chhattisgarh was seen to have contributed to a strong cadre of ASHAs in the state. This can be taken as a model for other states like Uttar Pradesh where the ASHA programme is not yet well-established.
- With the advent of JSY, the work burden was seen to have increased considerably for the staff. Considering the pivotal role of frontline workers in maternal health, to what extent is the government addressing their problems and needs?
- A positive development has been that women have started accessing public health institutions even though it is mainly to get the benefit of JSY entitlements. This in itself can be seen as a step in the right direction with the people renewing their faith in the public health sector against the backdrop of the increasing privatisation of the health sector,

- The amount (Rs. 1,400) allocated per beneficiary under JSY was found to be inadequate. As the case studies show, the families were required to pay much higher amounts only during normal deliveries. Considering the expenditures incurred during ANC, Post Natal Care (PNC) or loss of wages due to child birth, the entitlement is inadequate.
- There have been considerable delays in payments of JSY funds due to local level problems as well as lack of funds, causing unnecessary inconvenience for the beneficiaries.
- Finance management was seen to be riddled with problems at the district level in both study states. There was an absence of programme management units in Uttar Pradesh and no dedicated staff to look into the financial and management aspects of NRHM during fieldwork. Lack of ownership in the Mission was observed among the officials.
- Not only were there delays in fund transfer but also in fulfilling reporting requirements. Considerable amount of funds at the state level were seen to be lying idle.
- Inappropriate maintenance of accounts and improper record maintenance was observed in the study. This was more rampant in the case of Uttar Pradesh. The records of JSY beneficiaries were not properly maintained in the Primary Health Centers (PHCs) visited. This implies that there is scope for corruption and highlights the need for social audits.
- The provision of 'untied funds', which gives autonomy to ground level staff to spend according to local needs, was not implemented properly. As shown in Box IV.7 of Chapter IV, not only was there underutilisation of funds but at times unnecessary items were also procured with it.
- The level of planning was also inefficient/ineffective in the study states. District plans were not prepared in Chhattisgarh and treated as a standalone process in Uttar Pradesh often being prepared in haste and discarded soon after. This raises another question: Whether implementation level officials have the requisite competence and capacity to plan their priorities and take administrative decisions. If not, what remedial measures have been taken by the government?
- The issue of fund utilisation is related to that of proper planning and fulfilling human resource gaps; and not just by fund transfer mechanisms. In a big state like Uttar Pradesh where there are over 70 districts and thousands of crores of rupees in devolved funds, the lack of adequate staff at crucial levels significantly delays the process. If the preparation of district level Program Implementation Plans (PIPs) are carried out in a proper way and funds are disbursed to the districts in a pool, as it is done in the case of transfers to the states, the problem of utilisation could be ironed out to some extent.
- The overall level of public spending needs to be stepped up in India to ensure health for all and safe motherhood in particular.





# Introduction

**K**iran Devi (24) is a wage labourer in Sirsi village of Lalitpur district in Uttar Pradesh. She stays with her husband, Ravi, and 70-year-old father-in-law. The family depends on wage labour but work is hard to come by these days as Lalitpur, along with several other districts of the Bundelkhand region, has been in the grip of severe drought for the past couple of years. Ravi was able to get seven days of employment through the National Rural Employment Guarantee Scheme in the last three months – the only source of income for the family of three. It has now become increasingly difficult to make ends meet. Even so, the young couple still yearns for a child.

Kiran is now three months pregnant. This is her fifth pregnancy, the previous four having ended in still births. The first two deliveries were carried out at home and the children did not survive. On the third occasion, the couple went to the local auxiliary nurse-midwife who advised them to take Kiran to the district hospital. The district hospital refused her admission as she had not gone into labour. When she was in the final stage of labour, they decided to take her to Lalitpur District Hospital, around 40 km away, but she delivered on the way. Once again, it was a still birth. The fourth time around, she was cautious and took the recommended iron and folic acid tablets and tetanus toxoid injections. They even tried out their luck at a private hospital, the only one in the district. Blood tests and ultrasound were done.

Yet, the baby died in the womb and the family was robbed of the last of their hard-earned savings. Kiran does not know what to do, where to go, or even, what her problem is. When asked why she did not go to a doctor, she pointed out that there is no gynaecologist nearby. In fact, there is not a single female gynaecologist in the entire district.

Kiran's adverse circumstances epitomise the plight of countless poor women in India – multiple pregnancies with few successful child births, frequent deaths at the time of delivery, reeling under poverty and undernourishment, with no access to basic healthcare facilities.

One of the grave challenges facing Indian society today is to ensure safe motherhood. This is evident from the fact that India is the largest contributor to the global burden of maternal deaths.

Improving maternal health is one of the eight Millennium Development Goals and it signifies two things – one, it is a matter of serious concern, and two, at least there is recognition of the problem at the level of policy makers, both internationally and nationally. But, despite all

the rhetoric about curbing maternal deaths, the target of reducing maternal deaths in India to one-third by 2015 (WHO, 2005) seems unlikely. Although the latest round of the Sample Registration Survey conducted by the Registrar General of India for 2004-2006 has come up with a reduced figure for Maternal Mortality Ratio (MMR: 254 per 100,000 live births), the WHO 2001 estimates suggest that of the 199,000 maternal deaths in South Asia, nearly 74 percent would be accounted for by India. Nonetheless, this total of 140,000 maternal deaths is far above the upper range of the SRS estimates for that time period.

India has been at the centre of the discourse on safe motherhood since the Cairo Conference of 1994 (International Conference on Population and Development III, 1994). As a result, external agencies have put significant pressure on the Government of India to take up the issue on a major scale. The government has responded to the international pressure, albeit partially. It launched the Reproductive and Child Health Programme in 1995, but at the same time, there were efforts to reduce public expenditure on health in order to comply with its Structural Adjustment Programme.

Naturally, the target-based approach of RCH took a beating. There was hardly any progress on many of the specific targets. The changing political context forced the government to rethink expenditure compression in important social sectors like health. It was recognised that safe motherhood and child survival cannot be ensured without strengthening the health system, which would mean stepping up public investment on health along with decentralising decision-making and planning and bringing in social accountability. To address these issues, Government of India (GoI) came out with the National Rural Health Mission in 2005-06 to significantly enhance public investment on health in order to provide 'affordable' health services to the poor in rural India. NRHM was launched with a lot of fanfare and with the expectation that it would bring about major improvements in the health status of the rural people. After three years of implementation, there was a semblance of order, with reports of positive developments but these only scratched the surface of the tremendously complex problem.

Before delving into the details of the factors affecting maternal health (or any other social sector issue), the basic points in question need to be identified, i.e., What are the major causes of maternal deaths? What are the remedies?

It may then be worthwhile to compare these with the approach followed currently. According to WHO, four-fifths of maternal deaths are caused by severe bleeding (mostly bleeding post-partum), infections (also mostly soon after delivery), hypertensive disorders in pregnancy, obstructed labour and complications after unsafe abortion. The rest of the deaths are believed to be caused by diseases that complicate pregnancy or are aggravated by pregnancy such as malaria, anaemia and HIV & AIDS. WHO acknowledges that most of the maternal deaths are avoidable and the healthcare solutions to prevent or manage the complications are well known. Hence, it asserts: Since complications are not predictable, all women need care from skilled health professionals, especially at birth, when rapid treatment can make the difference between life and death (WHO, 2006). The Indian government's approach largely reflects the internationally recognised line of

thinking. The key strategies in NRHM to curb maternal deaths include encouraging institutional deliveries, strengthening health institutions with special emphasis on Emergency Obstetric Care in First Referral Units and expanding Ante-Natal Care.

Anyway, several relevant questions crop up. How is the strategy being rolled out? Does it involve strengthening institutions? How would it expand ANC? Is the government talking about comprehensive primary healthcare or selective interventions to tackle basic emergencies? Does it also talk about universal healthcare or just target a few, leaving the majority out of its ambit? Further, what about the social determinants of maternal health? The WHO (2008) recognises that creation of healthy living conditions and equal distribution of power, money and resources would dramatically improve the health and life chances of billions of people (WHO, 2008). Is there any effort to incorporate the multifarious issues affecting people's health in general and maternal health in particular in the existing NRHM framework - the issues of employment, food and nutrition, shelter, social security, empowerment and discrimination? How serious is the government about stepping up public investment on health, at least to developing country average?

The level of public investment on health in terms of its share of Gross Domestic Product (GDP) signifies the priority accorded to health by the respective governments. If the government does not pay for citizens' health, they have to pay through their own pocket, or if they cannot afford treatment, they would go untreated and face untimely death or disability. Compared to the developing country average of 2.5 percent of GDP as government expenditure on health, India spends only about one percent – a level among the lowest in the world. However, the country as a whole spends heavily, more than 4.5 percent of GDP, mostly in the form of out-of-pocket expenses. These payments are regressive, causing indebtedness and poverty. The share of government expenditure in total health spending in India is only 17-20 percent. Only a few countries in the world have lesser government share in health spending – these include Myanmar, Burkina Faso, New Guinea and Pakistan. Despite claims by the government to increasing public spending to 2-3 percent of GDP, there is no fundamental change in the level of spending; the United Progressive Alliance government in its two terms has at best arrested the decline. The government wants to increase access to health. But, it seems that they want to do it without fundamentally altering the way health has been financed in India. How far is this possible? Do magic formulae work in the health sector?

The present study is a nascent attempt to probe into at least some of these questions and may come up with a new set of questions, if not solutions to the existing ones. The study group believes that public expenditure is essential for ensuring safe motherhood. It has considered the broadest possible determinant of maternal health for analysis, coming to the conclusion that the existing level of spending is inadequate and urgent efforts are required to enhance it.<sup>12</sup>

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1 When we compare public spending on health in India with the rest of the world, we find that not only the developed nations but Governments of some of the developing countries also spend much greater share of GDP on health. Apart from India there are only 7 countries in the world where government spent less than 1% of GDP on health: Myanmar, Pakistan, Dem Rep of Congo, Burundi, Azerbaijan, Guinea and Tajikistan - the poorest countries of the world. (HDR, UNDP, 2008).

The report examines the linkages between maternal health policies, government allocations in different interventions on maternal health, implementation of those programmes, and issues of access and effectiveness. The link between policies, outlays and outcomes is crucial to judge the government's commitment on the issues. Several studies have critiqued government policies; others have shown that spending is not adequate while some research have highlighted the issues in implementation. But, these aspects are generally seen in isolation and what government spends is a reflection of its focus areas. If there is a fundamental fallacy in the policy design, it would be represented in its budget. If funding for some activities is inadequate the implementation would automatically be hampered. The study does a situation analysis for a clearer picture on the gravity of the problem. It also looks into aspects of public spending at different tiers of government. Finally, it assesses the ground realities in terms of implementation and identifies key constraints in achieving safe motherhood.

Uttar Pradesh and Chhattisgarh were chosen as sample states with the understanding that the problem of maternal health is among the most severe in these states and considering that the aim of NRHM is to strengthen institutions in backward states. It assesses implementation of government institutions in the most difficult situations so that lessons can be drawn.

The report contains four major chapters apart from the introduction and conclusion. The first chapter lays down methodology of the study – methodology of budget analysis and fieldwork in the form of a pilot study. Chapter two comprises an in-depth review of outcomes on maternal health. The analysis has helped develop a better understanding of the intensity of the problem and issues around it, at least in the study area. The third chapter deals with outlays, trying to capture the magnitude of spending on maternal health at various levels – national, state, district and sub-district levels and even at the level of individuals. The mechanism of transfer of funds, the quality of spending, the issues in transfer of funds are also dealt with. Chapter four looks at problems of implementation at the grassroots level – the outputs – using in-depth interviews with service providers, beneficiaries; visited facilities etc to identify the key issues of implementation, quality of services provided and the people's response to services provided.

This research effort would be a step in the right direction if it could at least engender a debate on some of the difficulties faced by the majority of Indian women from disadvantaged sections of society to access safe motherhood, a **basic human right**.

Objectives  
Methodology of Budget Analysis  
Methodology of Pilot Study  
Data Analysis and Report Writing  
Field Constraints  
Profile of Beneficiaries  
Profile of Districts



Mother with child (2.5 months), Barh Block, Lalipur, Uttar Pradesh

## Chapter-I

# Objectives and Methodology of the Study

## I.1. Objectives

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The study provides significant insights into the linkages between maternal health policies, government allocations in different schemes and programmes, implementation of the programmes, and issues in access and effectiveness.

A proper investigation into the government's efforts to improve maternal health in the context of overall health system and the complex intra-governmental financial structures is extremely important. The study has been carried out in keeping with the following objectives:

- (a) Mapping the linkages between the government's commitment to maternal health and budgetary allocations at the Central and state government levels, the outlays delivered and outcomes achieved.
- (b) Analysis of financial flows to the district(s) from various sources, including Central and state governments and autonomous societies.
- (c) Extensive mapping of inadequacies and gaps in the supply side to address the issue of maternal mortality. Here, the attempt is to identify the causes and magnitude of the problem, specific local needs and the adequacy and quality of financial commitments exhibited by the government to address these needs in the study area(s).
- (d) Evaluation of some of the major schemes at different levels of implementation.
- (e) The nature and quality of service delivery of maternal health services available to the common people specific to the schemes that were examined. This includes a pilot survey of beneficiaries and service providers to understand critical gaps in implementation.

## I.2. Methodology of Budget Analysis

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The analysis of budget involved tracking allocations and expenditure at various levels of government to capture the magnitude and nature of spending. For this, it was crucial to understand the pattern of funding in India. This also involved identifying interventions on maternal health by various levels of government and the fiscal architecture through which funds are flowing from one tier of government to the other. The primary research unit in the district(s) includes com-

munity health centres (CHCs), primary health centres (PHCs), sub-centres, district hospitals and the communities. The study team collected preliminary information on specific cases from different institutions and from household visits in the first stage and prepared case studies.

### **I.2.1. Identification of Interventions**

In India, health is a State subject, but family planning is a subject of the Central List and medical education is in the Concurrent List. Maternal health, being an issue for both health and family planning, involving both the Centre and the states, is crucial. Like any other health concern, it is an outcome of complex interactions of several factors – issues of livelihood, employment, road network and other forms of transport are as important as provision of health services. Providing jobs through the National Rural Employment Guarantee (Act) Scheme or NREGS, ensuring food security through the Public Distribution System (PDS) or education would probably be crucial in curbing maternal deaths. But, the issue here is how far reduction of maternal deaths can be directly attributed to these interventions. If the entire expenditure on interventions such as employment, housing, education is taken, it may present a comprehensive picture but it would certainly lead to overestimation. Since there is no agreed methodology on the proportion and type of intervention are part of the maternal health budget, the study incorporates those interventions that are directly introduced for promoting maternal health.

The Union government intervenes on maternal health through three major schemes. Two of them are under the Ministry of Health and Family Welfare (MHFW); the most important one being the Reproductive and Child Health (RCH) programme, the other being the Rural Family Welfare scheme. Supplementary Nutrition Programme (SNP) implemented by the Ministry of Women and Child Development (MWCD) also focuses on maternal health. The state governments run hospitals specifically for maternity purposes and train health professionals and workers. Some states also have special incentive schemes for institutional deliveries. Scrutiny of state budget documents of Uttar Pradesh reveal that New Swaroop Rani Nehru Hospital and Child Hospital, Upper India Sugar Exchange Maternal and Child Hospital, PPC and Establishment Expenditure of Neonatal and Childcare are such specific interventions. In Chhattisgarh, the relevant interventions are prevention of sexually transmitted diseases (STD), training of women health workers and the Ayushmati Yojana.

### **I.2.2. Fund Flow Architecture**

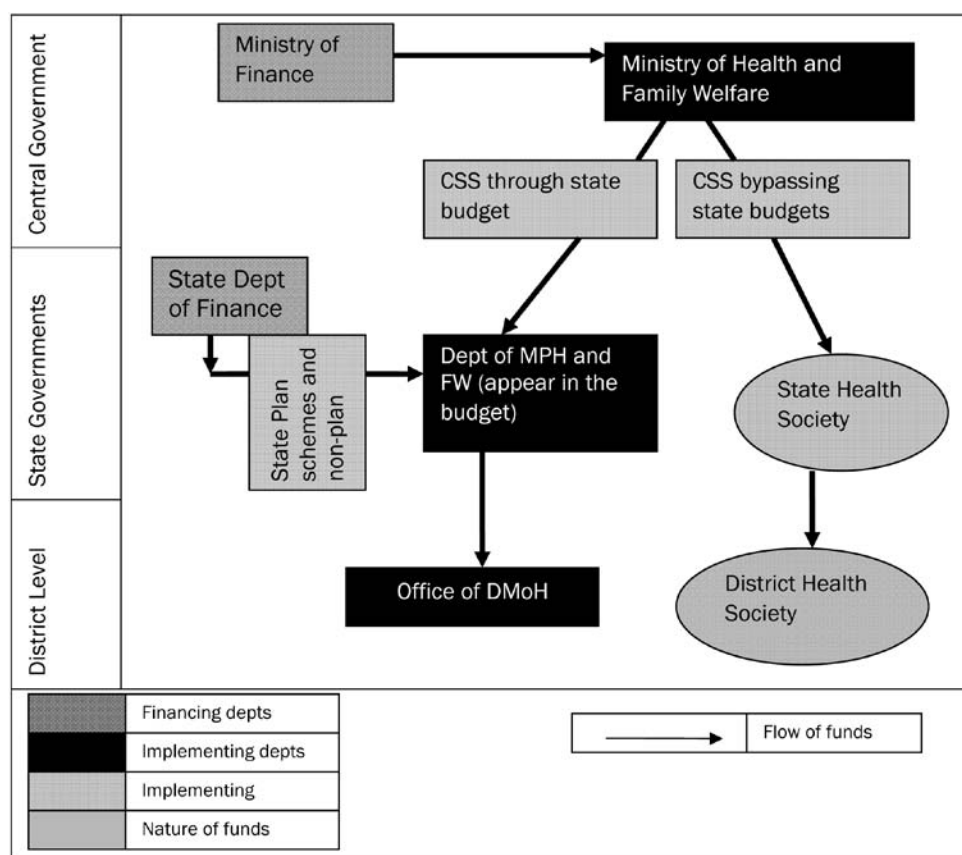
As examined in the previous section, there are broadly two types of interventions. Some are initiated by the Centre as Centrally Sponsored Schemes (CSS) while the others are state interventions. The financial architecture of the CSS is not unique and involves two broad channels. For some CSS, states are provided funds, which would then appear in the state budgets. Rural Family Welfare Service is one such scheme. Interestingly, one cannot locate RCH in the budget of the states. This is because under RCH, the Centre bypasses the state budget and sends funds to the State Health Societies (SHS). The fund flow architecture is delineated in Fig I.1

States have their own State Plan Schemes and non-plan interventions. In the state budget, there would be three major forms of interventions – the CSS routed through the state budget, the State Plan Schemes and the non-plan interventions. For the total expenditure on maternal health in the state, it is necessary to add CSS funds bypassing the state budget and funds that appear in it.

### I.2.3. Secondary Database

In the course of the study, several documents were referred to. At the Central level, these were the Health Management Information System (MIS) data of the flagship National Rural Health Mission (NRHM), Union Budget documents, websites of MHFW and MWCD, annual reports of MWCD and MHFW. At the state level, detailed Demand for Grants of the Department of Medical and Public Health & Family Welfare (DMPH&FW) and Department of Women and Child Development (DWCD) have been referred to. For CSS bypassing state budget, the Utilisation Certificates (UCs), Financial Management Report (FMR), Physical Progress Report (PPR), State Program Implementation Plans (PIPs), Audit Reports were taken into account. In the districts, accounts of District Hospitals for treasury routes, FMRs, UCs, Audit Reports were examined. Data for funds transferred to blocks from the records at the districts were manually obtained.

**Fig I.1: Fund Flow Architecture**





### I.3. Methodology of Pilot Study

A Pilot Study was conducted to assess ground level realities vis-à-vis budgetary issues, in both the districts. A location-specific methodology was developed keeping in mind the fact that both Chhattisgarh and Uttar Pradesh have high rates of maternal mortality. Since it was a pilot study, the objective was to formulate case studies rather than attempt to arrive at generalisations.

#### I. 3.1. Sampling Methodology and Sample Coverage

Purposive sampling method was adopted for selecting the Blocks as well as population for primary study of households, anganwadi centres (government sponsored childcare and mother care centres), Sub Health Centres (SHCs) or sub-centres, PHCs, CHCs and district hospitals. The criteria for selection of blocks were based on their distance from the CHCs and district hospital.

The distribution of gram panchayats (GPs) and sample respondents in the two districts across the blocks is given in Table I.1. Four GPs have been covered in each district, and as far as possible, 40 individual beneficiaries, four accredited social health activists (ASHAs), 2 anganwadi workers (AWWs), two auxiliary nurse-midwives (ANMs), two staff nurses, two block medical officers, one anganwadi centre, two sub-centres, two PHCs, one CHC (only in Rajnandgaon) and one district hospital were covered in each district. To make up for sparsely-populated GPs, where it was difficult to get 25 respondents, the shortage has been covered in other GPs.

**Table I.1: Sample Units selected for the Primary Survey**

Districts	Block	GP	Respondent
Lalitpur	Jakhora	2	27
	Barh	2	25
Rajnandgaon	Dongargaon	2	28
	Chhuria	2	25
Total	4	8	105

Source: Pilot Study, Lalitpur and Rajnandgaon, May-June 2008

#### I.3.2. Tools used for Data Collection

In each GP, individual interviews were conducted with the respondents through a structured questionnaire. The main purpose of the interviews was to develop case studies of women who had recently given birth. The study questionnaire focussed on the individual's socio-economic background and experiences during childbirth and pregnancy. More specifically, there was an attempt to unearth the reasons for accessing or not accessing institutional facilities.

## **A. Preparatory Stage**

An extensive literature review was undertaken to comprehend the state strategy and policy environment in RCH-II Programme under NRHM. To study public provisioning in maternal health for safe motherhood, data and information were collected at two levels. First, at the state and district level by meeting government health officials and procuring relevant secondary data and, second, at the block, GP and village levels through a primary survey.

## **B. Fieldwork**

The study team comprised two researchers and a local field investigator and the survey was conducted in May and June 2008. In the first stage, the team held discussions with state and district level officials on the implementation status of various components of RCH-II. District level authorities provided data on the physical and financial details and progress reports. The implementing agencies concerned provided relevant secondary data, viz., audit reports, financial details, financial outlays on various components and physical progress reports. Interviews and discussions were subsequently conducted with stakeholders such as pregnant and lactating women, anganwadi workers, ANMs, ASHAs, and medical staff at sub-centres, PHCs, CHCs, first referral units (FRUs) and district hospitals

### **I.4. Data Analysis and Report Writing**

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The report attempts to comprehensively track financial aspects and other qualitative issues related to service delivery for maternal health and national and sub-national health governance. Data has been analysed not only through observations and interviews on the field but also through a comprehensive examination of financial data relating to maternal health.

### **I.5. Field Constraints**

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The major constraints at the outset of the study were to trace women who had recently given birth or were pregnant and were residing in the same village. It was difficult to complete the number (ten in each block) required for the study since they were very few. Also, records of maternal deaths and exact causes were difficult to access at the village and district levels. As a result, only estimations were provided which left a huge scope for inaccuracy. In addition, women were sensitive to answering questions on reproductive health hygiene, resulting in unclear and imprecise responses.

### **I.6. Profile of Beneficiaries**

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The surveyed respondents comprised of pregnant and lactating women of both above poverty line (APL) and below poverty line (BPL) income groups. Among social groups, scheduled castes (SC), scheduled tribes (ST) and other backward classes (OBC) have been covered. Anganwadi

workers, ANMs, ASHAs, block medical officers (BMOs), lady health visitors (LHV), staff nurses, block education educator (BEE), chief medical officer (CMO) at the GP, block and district levels have been included.

## **I.7. Profile of Districts**

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### **Lalitpur**

Lalitpur district was carved out of Jhansi district in 1974 and is the heartland of the Bundelkhand region. The district is bounded by Jhansi in the north, Sagar and Tikamgarh in the east and Guna (Madhya Pradesh), separated by the river Betwa, in the west. The geographical area of the district is 5,039 sq km. The topography is generally rocky and undulating. Mining has affected the area to quite an extent. The climate of the district is the Central India type sub-tropical and may be characterised by hot dry summers and cold winters. The usual months of rainfall are mid-June to the end of September, July being the month with the highest rainfall. However, the Bundelkhand region has been suffering from drought for the past five years, which has had a huge impact on the livelihood and sustainability of the people.<sup>1</sup>

As per 2001 census data, Lalitpur has a population of 8.7 lakh accounting for 0.6 percent of the total population of Uttar Pradesh. It has a very high rural population at 86.6 percent. The literacy rate of the district is only 50 percent with male literacy at 64.45 percent and female literacy at only 33.25 percent. The SC and ST population stand at 24.9 percent and 0.0002 percent. The sex ratio accounts for 884 females per 1,000 males while Infant Mortality Rate (IMR) is 97.4 per 1000, and Maternal Mortality Rate is 24 per 1,000. The main economic activities are agriculture and livestock rearing.

During the pilot study, it was observed that Lalitpur district of the Bundelkhand region was facing severe drought for the last two years. Livelihood was certainly affected since a large part of the population was dependent on agriculture. Mining/quarrying was another major economic activity. Many respondents were daily wage labourers, often engaged in jobs under the National Rural Employment Guarantee (Act) Scheme (NREGS), which promises 100 person days of work in a year. Owing to unemployment and the prevailing drought situation, parts of the population had migrated to greener pastures.

### **Rajnandgaon**

Rajnandgaon district is in the central part of Chhattisgarh. With a total geographical area of 8022.55 sq km, the forest area coverage is 2987.14 sq km. The climate is tropical with an average rainfall of 1274 mm.

It has a population of 12.8 lakh. As per the 2001 census, Rajnandgaon accounted for 6.16 percent of the total population of Chhattisgarh; with a high share of rural population at 82 percent;

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1. See URL [www.lalitpur.nic](http://www.lalitpur.nic)

The SC population is 9.9 percent and the ST population relatively high of 27 percent. The literacy rate stands at 77.2 per cent with male literacy 87.2 percent and female literacy 66.6 percent. The district has a favourable sex ratio of 1,023 but very high IMR at 112.5 per 1,000 live births. The three tribal blocks of the district are Mohla, Manpur and Chowki. The main tribes of the district are Gond, Kanwar, Halba and Baiga.<sup>2</sup>

Some of the villages visited by the study team were close to those affected by Left-wing extremism (several states of the country, particularly economically poor ones are facing the problem of Naxalite or Maoist violence). The team was informed that ANMs rarely visited the insurgency-affected villages where there were no functional PHCs or sub-centres.

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2. See URL [www.rajnandgaon.nic](http://www.rajnandgaon.nic)

Institutional Delivery  
Antenatal Care And  
Post - Natal Care  
Conclusion



Lactating mothers, Jakhora block, Lalipur, Uttar Pradesh

## Chapter-II

# Deficits in Maternal Health Outcomes

**M**aternal mortality is a phenomenon of the developing world, India being the largest contributor to the global burden of maternal deaths. Out of every 100,000 live births in developed countries, 20 women die during childbirth (UN Millennium Project 2005). The corresponding figure for developing countries is 440, meaning that women in these nations are 45 times more at risk of maternal death compared to their counterparts in the developed world. The national averages at times gloss over the intra-country disparities – between regions, income classes and social groups. Thus for poor women, women living in remote areas of a country or for those from deprived social groups, the risk of death is much more serious compared to women with better socio-economic and geographical conditions.

One out of every four women dying during child delivery worldwide is an Indian and around three-fourths of maternal deaths in Asia takes place in the country (UN Millennium Project 2005). According to WHO estimates, around 120,000–140,000 women died while giving birth or within 48 days of it in 2002<sup>1</sup>. The Registrar General of India (RGI) estimates that the overall Maternal Mortality Rate (MMR) in the country, which was in the vicinity of 400 in 1997–98, has come down to about 300 in 2001–03 (Sample Registration System, 2003). As per the latest round of its Sample Registration System (SRS) survey, the MMR is 254 per 100,000 live births, a 36.5 percent decline since 1997–98 (Sample Registration System, 2006). The RGI estimates project the MMR to be 195 in 2012 whereas it would be 231 using a log-linear trend. But both these estimates are nowhere near the targets of reducing the MMR to 100 by 2012 set by NRHM, or to 109 by 2015 as per the UN Millennium Development Goals (MDG).

There are significant state level variations in MMR with states having low per capita Net State Domestic Product (NSDP) faring much worse than those with high per capita NSDP. Almost two-thirds of the deaths occur in Empowered Action Group (EAG) states<sup>2</sup> and Assam where the decline is around 28 percent during the period under consideration. These states constitute a little more than one-third of the sample adult female population (34.8 percent) and nearly half the live births (46.5 percent). The sample states of this study Uttar Pradesh and Chhattisgarh have

1. The term 'maternal mortality' has been comprehensively defined by the Tenth Revision of the International Classification of Diseases (ICD-10) which has been revised approximately every 10 years since 1900. ICD-10 defines: "A maternal death as the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."

2. Empowered Action Group states – Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttaranchal (now Uttarakhand) and Orissa and Assam (SRS 2006)

high MMRs. During 2001-2003, the 'Lifetime Risk'<sup>3</sup> of maternal death of women in the age group 15-49 was reported to be 0.7 percent. This is substantially higher for women in the category EAG states and Assam (1.8 percent) with the worst in Uttar Pradesh where the lifetime risk is 1.9 per cent. The situation of EAG states, when compared with developed states like Kerala or Tamil Nadu, reveals the glaring inter-state disparities. MMRs in Kerala and Tamil Nadu are 95 and 111 respectively, almost one-fourth of that of EAG states. The lifetime risk in Kerala and Tamil Nadu is just 0.2 percent; thus a woman from Uttar Pradesh is 10 times more at risk of dying due to childbirth compared to a woman from Kerala. (Table II.1)

**Table II.1: Maternal Mortality Rate and Lifetime Risk 1997-2003**

India & Major States	Maternal Mortality Rate					Lifetime risk (%)			
	1997-98	1999-00	2001-03	2004-06	% decline 1997-2006	1997-98	1999-00	2001-03	2004-06
India	398	327	301	254	36	1.20	1.10	1.00	0.7
Chhattisgarh/MP	441	407	379	335	24	1.90	1.90	1.60	1.3
UP/Uttarakhand	606	539	517	440	27	3.00	2.70	2.40	1.9
EAG and Assam	520	461	438	375	28	2.20	2.00	1.80	1.4
Kerala	150	149	110	95	37	0.3	0.3	0.2	0.2
Tamil Nadu	131	167	134	111	15	0.3	0.4	0.3	0.2

**Source:** Sample Registration System, Registrar General of India, 1997-2003

The 'Special Survey of Deaths 2001-03' was conducted using Representative, Re-Sampled, Routine Household Interview of Mortality with Medical Evaluation (RHIME)<sup>4</sup> method by SRS. According to this survey, (Table II.2), the leading cause of death is haemorrhage (38 percent), followed by sepsis (11 per cent), and abortion (eight percent). The Global Burden of Disease estimates for South Asia also suggest that the major causes are: haemorrhage (31 percent), sepsis (14 percent), hypertension (14 percent), abortion (14 percent) and obstruction (ten percent) (Sample Registration System, 2006). The higher haemorrhage percentage is consistent with the high background rates of anaemia reported among Indian women and lack of emergency obstetric care in the country. Given these statistics, additional importance needs to be given to

3. The life time risk is defined as the probability that at least one women of reproductive age(15-49) will die due to childbirth or puerperium assuming that chance of death is uniformly distributed across the entire reproductive span. It has been worked out by using the formula: Life Time Risk =  $1 - (1 - \text{MM\_rate}/100000)^{35}$ .

4. Representative, Re-Sampled, Routine Household Interview of Mortality with Medical Evaluation. This is an enhanced form of "verbal autopsy".

women's nutrition through subsidised food supply, strengthening of nutritional support through the Integrated Child Development Services (ICDS) and proper disbursal of IFA tablets.

**Table II.2: Causes of Maternal Deaths from 2001-03, Special Survey of Deaths**

Maternal Causes	India		EAG states and Assam	
	Percent (%)	95 % CI	%	95 % CI
Haemorrhage	38	(34-41)	37	(33-42)
Sepsis	11	(9-14)	11	(8-14)
Hypertensive Disorders	5	(3-6)	4	(2-6)
Obstructed Labour	5	(3-6)	5	(3-7)
Abortion	8	(6-10)	10	(7-12)
Other Conditions	34	(30-37)	33	(29-37)
Total	100		100	

Source: Sample Registration System, Registrar General of India, 2001-03

The situation regarding maternal deaths has improved since 1998-99, according to data of the Registrar General of India (RGI), but the improvement is not as per expectations and India is unlikely to fulfil the Millennium Development Goals (MDG) commitments by 2015. Further, there are strong state level variations; states like Kerala and Tamil Nadu have either exceeded the MDG target or are very close to it. On the other hand, the situation in Empowered Action Group (EAG) states where overall levels of MMR are quite high, is disappointing. The rate of decline in these low-performing states is also significantly slower and this has widened the gap. The causes of maternal deaths cannot be delinked with the prevailing poverty and destitution among a large section of the population. Poor quality of employment or lack of it and absence of social security or at least maternity benefits for working women have a severe bearing on women's right to safe delivery. At the same time, the crumbling public health services such as lack of Basic or Emergency Obstetric Care (BEmOC/EmOC), or institutional support for delivery, or basic ante-natal services and nutrition have increased women's vulnerability to a great extent. The following sections take a look at the status of access to basic maternal health services in the sample states and districts, with different data sources. These are corroborated with our field level observations.

## II.1. Institutional Delivery

Most maternal deaths are avoidable, as the healthcare solutions to prevent or manage the complications are well known. Since complications are not predictable, all women need care from skilled health professionals, especially at birth, when rapid treatment can make the difference between life and death. For instance, severe bleeding after birth can kill even a healthy woman within two hours if she is unattended. Injecting the drug oxytocin immediately after childbirth

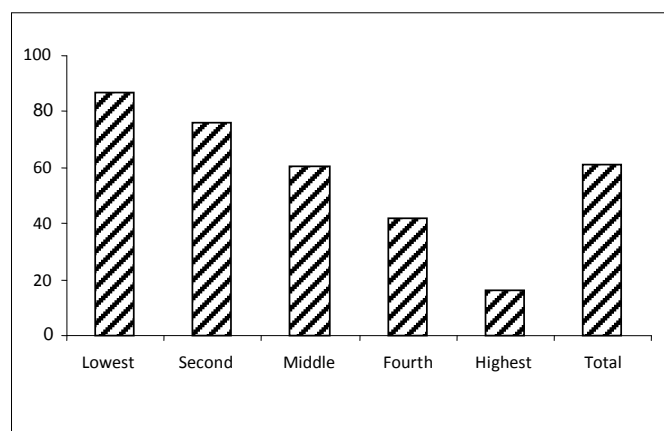


reduces the risk of bleeding very effectively.

One of the major reasons for the limited success in reduction of maternal deaths is the lack of access to skilled professional or health institutions. Less than half (48.3 percent) of the deliveries are assisted by a health professional in India and only 40 percent take place in institutions (National Family Health Survey, round III, 2005-06). Even so, this is a significant improvement from National Family Health Survey (NFHS-I) when almost three-fourths of the deliveries occurred outside the ambit of any health facility. Home deliveries, on the other hand, generally take place in the absence of any skilled professional. Only one in eight home deliveries is assisted by skilled professionals.

There are variations in access to skilled or institutional birth across place of residence of the women, their caste, income etc. Only 29 percent of the births in rural India take place in institutions, whereas 68 percent of deliveries in urban areas occur in institutions. Only one-third of Scheduled Caste (SC) women and less than a fifth of Scheduled Tribe (ST) women have access to institutional delivery. NFHS-III divides households according to wealth quintiles (these can be seen as proxy to household incomes). The data reveals that only 13 percent of the deliveries in the lowest wealth quintile take place in institutions due to which a majority of the poor women depend on home delivery. There is a strong class gradient that can be observed in access to institutional delivery – women belonging to the highest wealth quintile could access institutions in 84 percent of deliveries, 6.5 times more than their counterparts in the lowest wealth group. NFHS also shows that younger mothers, births of lower order and educated mothers tend to receive greater skilled assistance than older mothers or those with less or no education (Fig II.1).

**Figure II.1: Home Deliveries (Variation across wealth quintiles)**



Source: National Family Health Survey-III, 2005-06

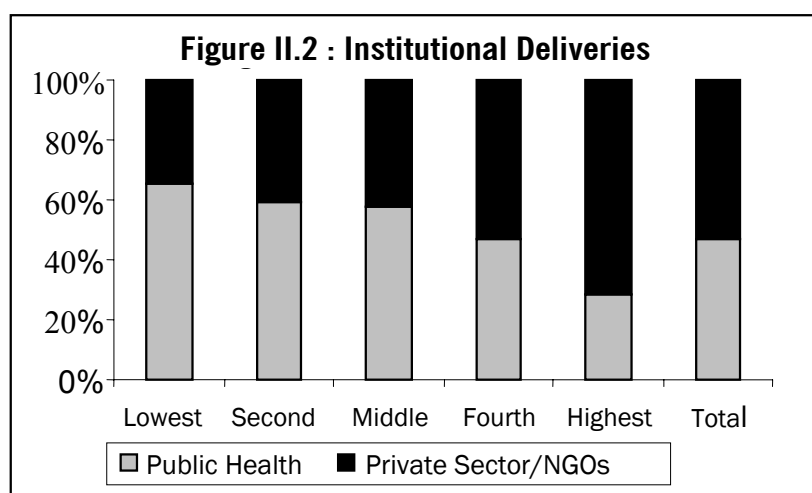
There are significant state level variations in access to institutional birth or births assisted by skilled professionals with states recording high MMR having lesser access to these. In Chhattisgarh, only 16 percent of deliveries take place in institutions, whereas in Uttar Pradesh, it is 22 percent (Table II.3). Surprisingly, a sizable proportion of home deliveries in Chhattisgarh are assisted by skilled professionals.

**Table II.3: Deliveries Assisted by Health Professionals and Institutional Deliveries**

Country/State	Deliveries Assisted by a Health Professional (%)			Births delivered in a health facility (%)		
	NFHS-1	NFHS-2	NFHS-3	NFHS-1	NFHS-2	NFHS-3
India	34.2	42.3	48.3	25.5	33.6	40.7
Madhya Pradesh	30	29.7	37.1	15.9	20.1	29.7
Uttar Pradesh	17.2	22.4	29.2	11.2	22.4	22
Chattisgarh		32.3	44.3		14	16

Source: National Family Health Survey - various years, 1992-93 to 2005-06

Only 18 percent of deliveries occur in public institutions, whereas 20.6 percent of deliveries take place either in private hospitals or NGO or trust hospitals. The poor are relatively more dependent on public institutions than those belonging to the rich wealth quintiles (Fig II.2 ). As income increases, relative dependence on private services also goes up. Significantly, one in every three institutional deliveries for the poorest wealth quintile takes place in private facilities despite the fact that private deliveries are costly. The reason may be that they are forced to access private institutions in the absence of functional public facilities. However, inequalities in access are much less in terms of public facilities than private or NGO/trust hospitals.

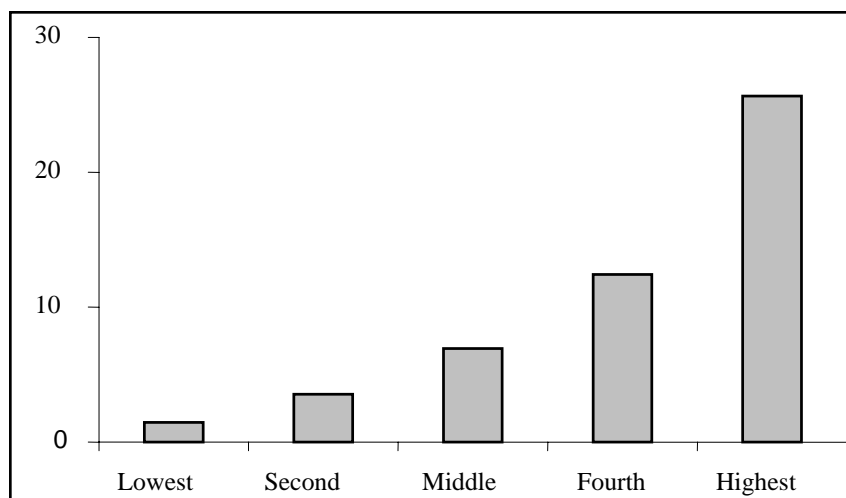


Source: National Family Health Survey-3,2005-06

Caesarean section is more common among women in the richest wealth quintiles with over one-fourth of the deliveries (25.7 percent) being done through this method (Fig II.3). Compared to this, only 1.5 percent deliveries in the poorest quintile are through caesarean section. As much as 28 percent of deliveries conducted in private sector institutions are done through caesarean

section whereas only 15 per cent of such deliveries are carried out in public sector. C-section should be used in specific situations; WHO recommends that about 10 percent deliveries may require this procedure. The irony of the situation in India is that while poorer women (for the last three quintiles it is used for less than 10 percent deliveries) do not have access to C-section even when it is considered necessary, the rich are often subjected to it in order to charge extra money.

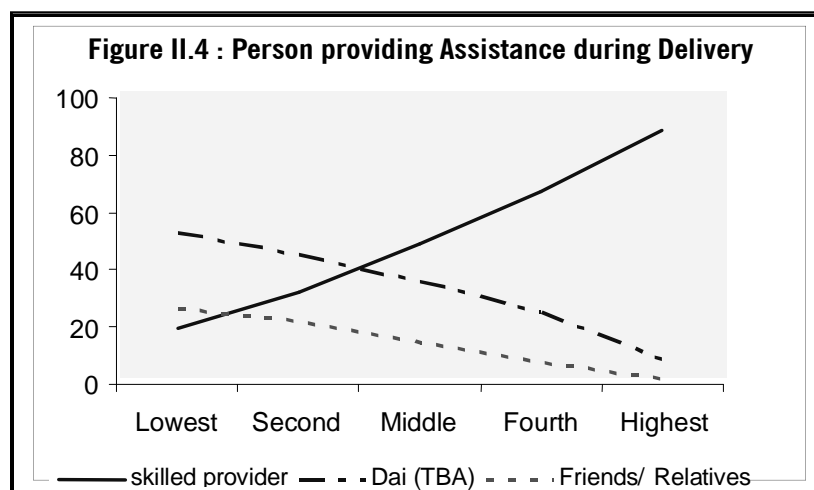
**Figure II.3 : Deliveries by Caesarean Section**



Source: National Family Health Survey-III, 2005-06

### II.1.1. Assistance during delivery

Obstetric care from a trained professional is critical in reducing maternal and neonatal mortality but most home deliveries take place without assistance from trained professionals (only one in eight cases). As much as 47 percent of births in the five years preceding the NFHS III was assisted by health personnel, which included 35 percent by a doctor and 10 percent by an ANM or LHV. More than one-third of births (37 percent) were assisted by a traditional birth attendant and 16 percent by friends, relatives or other persons. A strong class gradient exists so far as accessing assistance from skilled providers during deliveries is concerned. Less than one in five deliveries in the poorest section is assisted by skilled providers whereas nine in ten deliveries in the richest section are assisted by skilled personnel. The two lowest income classes mainly depend on trained birth attendants (dais/TBAs) or friends and relatives for assistance during delivery. The assistance of TBAs and relatives/ friends are rarely employed by the better-off sections (Fig II.4).



Source: National Family Health Survey-3, 2005-06

### II.1.2. Perception of Beneficiaries towards Institutional Deliveries

It was learned from interviews with beneficiaries that the woman or her family members did not plan to visit a sub-centre or PHC until the last stages of delivery. In many cases, the pregnant women were not aware of their date of delivery. Hence, they were unable to reach the facility in time. With implementation of *Janani Suraksha Yojana* (JSY) programme launched under NRHM which provides for cash assistance to pregnant women from BPL families when they deliver at an institution, the demand for institutional deliveries has suddenly increased. However, this does not mean that mothers are giving birth to healthy babies or are reduced risk themselves. Since the facilities are accessed only at the very end, pre-natal and post-natal check ups are totally ignored. In a handful of cases, institutional deliveries are opted for reasons of safe treatment in case of complications. A few respondents revealed that they had apprehensions about visiting the health facility as past experiences were not very encouraging. They alleged that they were sometimes charged for services even in government hospitals. A misconception among them was that the patient may have to undergo c-section and were reluctant to opt for the operation as it could make them extremely weak and unfit to resume work after pregnancy).

**Table II.4: Increasing Institutional Deliveries**

In lakhs	Institutional deliveries		Beneficiaries of JSY	
	Chhattisgarh	UP	Chhattisgarh	UP
05-06	1.03	19.22	0.25	0.12
06-07	1.31	21.23	0.75	1.69
07-08	1.49	23.25	1.76	8.64
08-09	1.79	18.18	1.41	15.64

Source: Health Management Information System, Ministry of Health & Family Welfare, as on 31<sup>st</sup> March, 2010

Giving birth at home continues to be preferred over institutional deliveries, and, in Lalitpur, safe delivery is not a priority. In keeping with the traditional practice, a facility is chosen only as a last resort, especially during an emergency. The comfort of the home and relatives being nearby are cited as some of the main reasons for opting for home births. If a woman's previous deliveries had taken place in her home, without any complications, it is most likely that she will deliver the next child at home. However, Table II.4 shows that institutional deliveries have increased in Chhattisgarh and UP, as does number of JSY beneficiaries.

## II.2. Antenatal Care and Post-natal Care

Antenatal care (ANC) as an intervention to identify women at risk for reducing the incidence of maternal mortality, started in the first half of the 20<sup>th</sup> century and has come a long way since then. But, despite increase in coverage across the globe, especially significant in developing countries, the potential of the intervention has remained unexplored. Apart from viewing ante-natal care as a limited tool of identification of risks, there are many other aspects which it can take care of, such as promotion of healthy lifestyles, formulation of a birth plan, and informing parents about parenting and consequences of child birth.

NFHS-III results show that mothers in India received ANC check-ups for only 77 percent of births during the three years preceding the survey. This is a marked improvement from the previous rounds where it remained almost unchanged at around 64-65 percent. Women who are not receiving ANC check-ups tend disproportionately to be older women, women of higher order of birth, women from STs, illiterate and poor women (Table II.5). Those who have received ANC check ups tend to favour institutional deliveries. It is two to four times more common among women who have received four or more check ups than those who have received 1-3 check ups. Coverage of ANC in Uttar Pradesh is less than the national average, for all the three rounds of NFHS. In fact, it went down drastically during NFHS-II, recovering in the subsequent period. Both Chhattisgarh and Madhya Pradesh recorded considerable improvement between the last two rounds of NFHS; in Chhattisgarh, from less than national average levels, the coverage reached almost 90 percent (Table II.5).

**Table II.5: Mothers receiving at least one Ante-Natal check-up**

Country/State	NFHS-1	NFHS-2	NFHS-3
India	62.3	65.4	77
Madhya Pradesh	52.1	61	81
Uttar Pradesh	44.7	34.6	67
Chattisgarh	-	57	89

**Source:** National Family Health Survey - various years, 1992-93 to 2005-06

Though there is some improvement in coverage of ANC over time, comprehensive antenatal care still looks a long way off (Table II.6). Only 2.8 percent women in Uttar Pradesh who were pregnant and 13 percent women in Chhattisgarh receive comprehensive ANC. As less as 8 percent and 21 percent received 100 IFA (iron and folic acid) tablets in the respective states.

**Table II.6: Number per 1000 women availing Antenatal Care & Post Natal Care**

	ANC		PNC	
	No of Persons who availed ANC	From government sources	No of Persons who availed ANC	From government sources
UP	640	448	710	321
Chhattisgarh	695	822	574	662
India	836	462	729	422

Source: National Sample Survey Organisation, 61<sup>st</sup> round

Tetanus toxoid vaccination an important intervention in neo-natal care under RCH but its coverage in India is far from complete. For births in the three years preceding the survey, NFHS-II shows that 24 percent of expectant mothers did not receive any tetanus toxoid injections during pregnancy, and another eight percent received only one injection. The proportion of those who received two or more tetanus toxoid injections during pregnancy rose from 55 percent to 67 percent between NFHS-I and NFHS-II. The coverage for Uttar Pradesh and Madhya Pradesh was even lower. In Madhya Pradesh, the proportion of women who received two or more tetanus shots during pregnancy went up to 55 percent from 42.8 percent during the first two NFHS rounds. For Uttar Pradesh, the figures were up from 51.4 to 37.4 percent. Though there was some improvement in coverage over the period, the situation of disadvantaged groups and people residing in rural areas was even worse.

Iron deficiency anaemia is the commonest form of micronutrient deficiencies and its repercussions are quite serious. The last two rounds of NFHS throw light on the nutritional status of women in India. It is shocking to note that there was a significant increase in the percentage of women with anaemia in the relevant age group during the period. The all India average has increased from 51.8 percent to 56.2 percent between NFHS-II and NFHS-III. An increasing trend can also be seen in Uttar Pradesh and Madhya Pradesh, though Chhattisgarh shows a significant decline. At the same time, the percentage of women with below normal body mass index (BMI) has decreased nationally and in Uttar Pradesh and Chhattisgarh. It has increased marginally in the case of Madhya Pradesh. This shows that even now, more than half of the women face anaemia and in more than one-third of them, BMI is below normal (Table II.7).

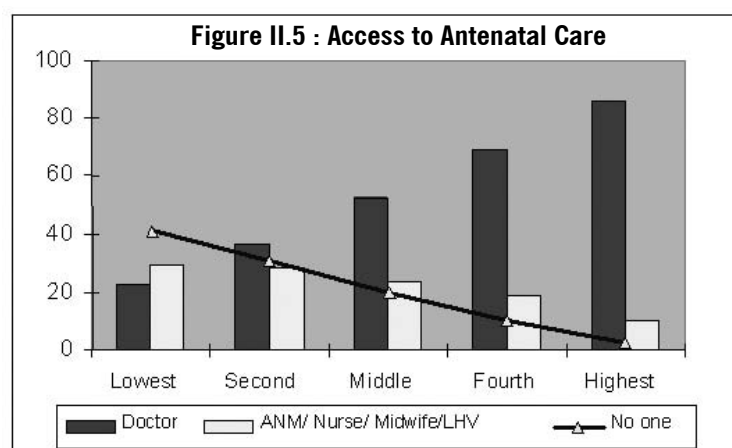
**Table II.7: Health Condition of Women**

Country/State	Percent of Women with BMI below normal		Percent of women age 14-49 with anaemia	
	NFHS- II	NFHS- III	NFHS- II	NFHS- III
India	35.8	33	51.8	56.2
Madhya Pradesh	38.2	40.1	54.3	57.6
Uttar Pradesh	35.2	34.1	48.7	50.8
Chhattisgarh	48.1	41	68.7	57.6

Source: National Family Health Survey - various years, 1992-93 to 2005-06

IFA supplements were provided to more than half (58 percent) of the women who delivered children during National Family Health Survey (NFHS-II) phase. NFHS-II data shows that IFA supplement coverage is only 32 percent in Uttar Pradesh and the corresponding figure for Chhattisgarh is around 59 percent. IFA supplement coverage goes down with the age of the mother, particularly those above 34. Similar declines are seen with the order of birth and for rural people, according to the survey.

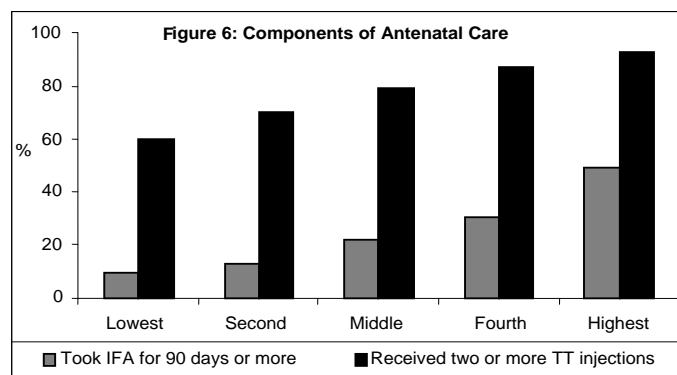
There also exists a strong class gradient in terms of access to ANC. In the lowest wealth quintile, 41 percent pregnant women did not receive antenatal care, whereas almost every pregnant woman (97.4 percent) from the highest income quintile received ANC. Women from upper wealth quintiles have greater access to doctors while seeking ANC while those from the lowest income groups depend more on ANMs, nurses, Lady Health Visitor (LHVs) or midwives. Among these, women in the lowest income quintile with access to any form of antenatal care, only one in every five could seek care from a doctor. More than four out of every five pregnant women in the highest income quintile visited a doctor. This clearly reveals that the poorer sections of society have lesser access to trained professionals and better quality healthcare. (Fig. II.5)



Source: NFHS-III, 2005-2006

Half the pregnant women in the poorest income quintile receive IFA, but only one in ten take IFA tablets or syrups for the full 90 days. Compared to this, 85 percent of pregnant women in the highest strata receive IFA tablets and half of them take it for the full 90 days. More than three-quarters of pregnant women receive two shots of tetanus toxoid injection. Though there exists a class gradient in access to TT injection, it is not very steep. Overall, only 3.8 percent pregnant women receive any intestinal parasite drug and access to it for women in better off sections is much higher than those in the lower strata. (Fig.II.6)

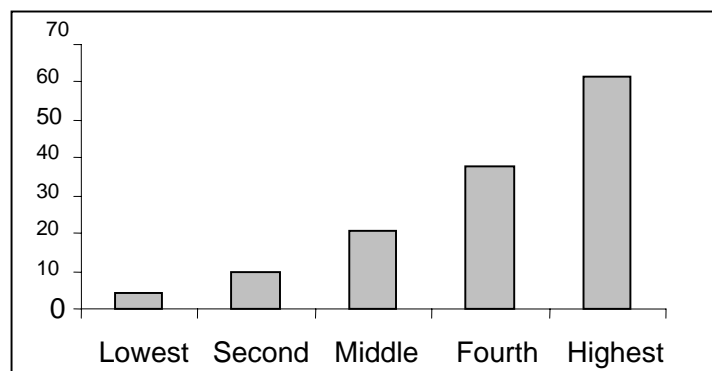
**Figure II.6: Components of Antenatal Care**



Source: National Family Health Survey-3, 2005-2006

Tests and measurements like weight, blood pressure, urine and blood tests are very important to monitor high risk pregnancies. For every service, there exist class gradients, which get steeper with increasing complication in the test. Ultrasound test has become very popular for detecting and monitoring pregnancies, especially among younger, well-off women in urban localities. Women from the poorer strata have very limited access to ultrasound tests, these being very sophisticated and, therefore, costly. Only 4 percent pregnant women from the lowest wealth quintile undergo ultrasound tests whereas 62 percent women from the richest strata access it. This points to the lack of access among poorer women to modern technology. Excessive use of ultrasound also indicates its use for sex determination, especially among the rich. (Fig. II.7)

**Figure II.7: Percent of pregnancies with ultrasound test**



Source: National Family Health Survey-3, 2005-06



Overall coverage of ANC in Lalitpur district is very poor. Only one in five pregnant women got all three required ANC visits, according to the District Level Household & Facility Survey (DLHS-III) findings, and a clear reduction from the previous round of DLHS when it was 30.4 per-cent. Rajnandgaon posted better results with almost two thirds of expectant mothers getting the stipulated three ANC visits (as per DLHS-III); an increase of 14 percentage points from the previous round. In Lalitpur, TT injection was also not regularly administered. The situation also worsened from the previous round of DLHS. As much as 88 percent of pregnant women received at least one TT injection in Rajnandgaon, a significant improvement from the previous round. (Table II.8)

**Table II.8: Antenatal Care in Lalitpur and Rajnandgaon**

	Districts	DLHS III (07-08)		DLHS II (02-04)	
		Total	Rural	Total	Rural
Mothers who had at least 3 ANC visits during the last pregnancy (%)	Lalitpur	19.9	16.8	30.4	24.4
	Rajnandgaon	65.3	62	51.5	47.5
Mothers who got at least one TT injection when they were pregnant (%)	Lalitpur	70.2	68.4	77.5	75.6
	Rajnandgaon	87.7	86.8	67.5	64.3

**Source:** District Level Household and Facility Survey, Round III

In both Lalitpur and Rajnandgaon districts, pregnancy was not considered a condition that required special medical attention. In most cases, the diet remained the same. In Lalitpur, women belonging to the forest-dwelling Sahariya tribe (which has been in the news for alleged starvation deaths) were found to reduce their food intake for easy child birth. They believed that increased food intake would fatten the unborn foetus and lead to obstructed labour and even require C-section. The two stipulated TT shots were also not administered in most instances since the supply of tetanus toxoid injection was not regular in either of the districts. IFA tablets were distributed but mostly for pregnant women. No doses for lactating women were found to have been administered.

In all the cases observed, the prime responsibility for ANC was on the ANM with the ASHA as a link. The detection and treatment of anaemia was completely absent. On the other hand, awareness about identifying high risk pregnancies was found among the majority of women in Rajnandgaon but dismal in Lalitpur. None of the ANMs had any knowledge on managing high risk pregnancies. When a situation arose at the primary level, which is a sub-centre, the patient was referred to the district hospital in a majority of the cases, bypassing PHCs and CHCs, which are accessed only if these are placed nearby.

## II.3. Conclusion

The analysis of outcome indicators depicts a bleak picture of maternal health in India, more so in the sample states. These states, along with other EAG states have high MMR, low levels of institutional births and below par coverage of ANC, high under-nourishment among women and children. It is observed globally that only poor women are dying while giving birth, whereas those who are better off find the experience of childbirth an enriching one. Unfortunately, the SRS surveys do not provide income class wise disaggregated information on maternal deaths. The fact that a majority of the deaths are taking place in states with higher prevalence of poverty may indirectly prove the point. Both Uttar Pradesh and Chhattisgarh, along with the sample districts of Lalitpur and Rajnandgaon, have significantly large sections of the population with low standard of living (Table II.9). As much as 88 percent of rural people in Lalitpur and Rajnandgaon have low standard of living. Furthermore, the percentage of population with low standard of living has increased over time, which can be clearly linked to the prevailing agricultural distress in rural India.

**Table II.9: Percent of Household with Low Standard of Living**

	DLHS III (2007-08)		DLHS II (2002-04)	
	Total	Rural	Total	Rural
UP	63.5	71.9	60	71.5
Chhattisgarh	73.2	82.7	69.9	81.4
Lalitpur	79.8	88.3	67	82.9
Rajnandgaon	80.9	87.7	77	85.7

Source: District Level Household and Facility Survey III

The link between poverty and high maternal mortality is not very difficult to establish. High incidence of poverty, lack of social security and low wages force women to take difficult work and longer working hours. In a situation where it becomes difficult to earn two square meals, accessing ANC to ensure safe delivery seems to be a luxury; a sacrifice of wage. Institutional delivery, c-sections also means loss of working days to most working women. Thus, they prefer home delivery, which is free from hassle of travelling and less costly. There are also clear class gradients in terms of access to institutions, ANC, prevalence of anemia. But the above argument somehow assumes that it is a conscious choice by women not to access institutions and negates to some extent the entire issue of access to health institutions. The following sections delve into the different aspects of service delivery, which are also very important. In a situation where quality maternal health services are easily accessible at low or no price even with abject poverty, safe motherhood can be ensured to a great extent. The above discussions suggest that low utilisation of health services and the resultant high MMR could be attributed to lack of proper health facilities in these states.

Major Interventions on Maternal Health

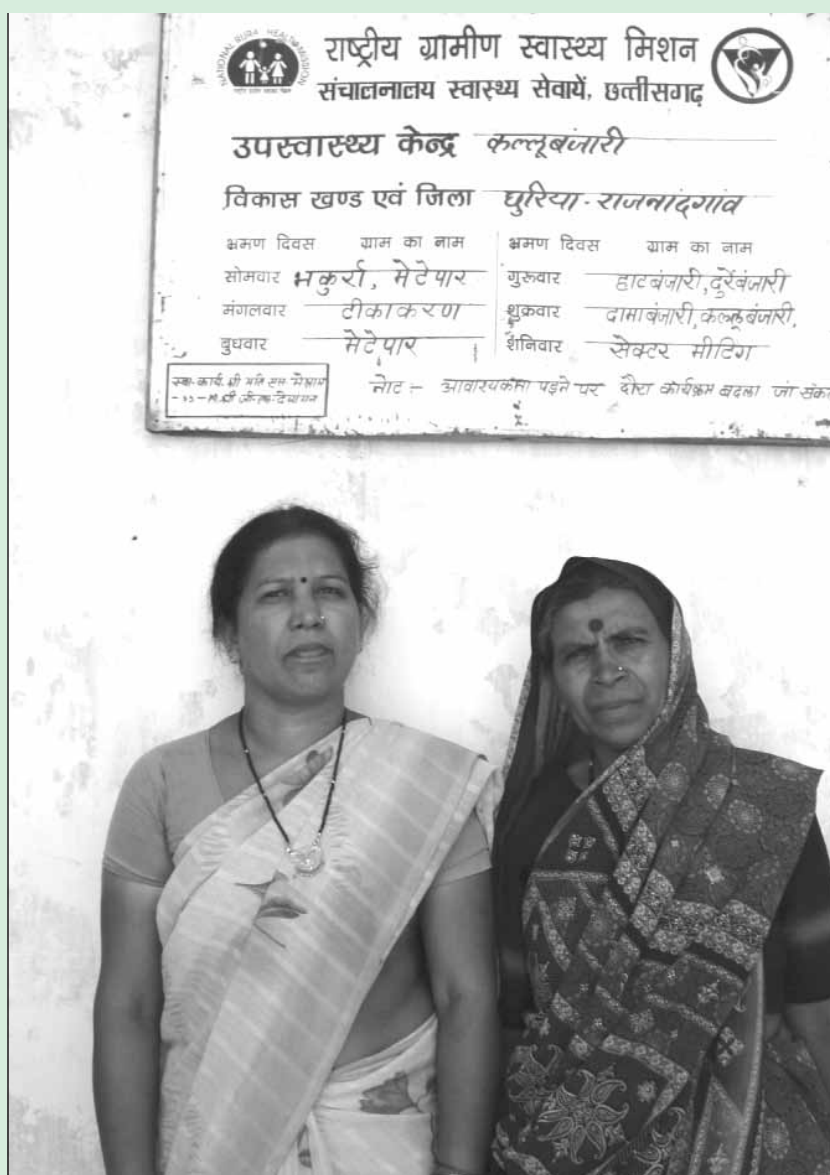
Placing Maternal Health Budget in Total Spending on Health

Supplementary Nutrition Programme (SNP)

RCH And NRHM

Extent of Underutilisation of Funds

Conclusion



ANM & ASHA, Dongargaon block, Rajnandgaon, Chhattisgarh

## Chapter-III

# Budgetary Outlays for Maternal Health Interventions

An unacceptably high level of maternal deaths, undernourishment, limited institutional access and absence of basic ANC services generally reflect the condition of maternal health in Uttar Pradesh and Chhattisgarh. In a situation of extremely high levels of poverty, underdevelopment and socio-economic deprivation, the responsibility to ensure safe motherhood clearly lies with the state. Government investment in providing maternal healthcare services, food and nutrition are as crucial as are investments on employment generation, social security and public distribution. Special attention needs to be given to those services specifically meant to ensure safe motherhood when looking at public investments on maternal health. There are other important factors, which indirectly affect maternal health, but these may not be within the scope of the present analysis. There are several reasons for using such restrictions. For instance, employment generation programmes enhance family income, women's income and their purchasing power, which may help them to access food, transport etc and indirectly contribute to their health. But how much of the investment on employment generation would go for improvement of maternal health is not certain; neither are these investments specifically meant for ensuring maternal health. On the contrary, investments on salaries of ANM or IFA tablets are directly meant for improvement in maternal health services and form part of the analysis.

### III.1. Major Interventions on Maternal Health

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Though health is a state subject (maternal health being part of family welfare under the aegis of the Union government), major investments on maternal health are made by the Centre. An overall scrutiny of budgets of the Central and state governments has helped identify interventions directly meant for safe motherhood. Major CSSs on health are rolled out through NRHM. Part A & B of NRHM include interventions on maternal health. SNP under the Integrated Child Development Services (ICDS) is the other important intervention for nutritional support to pregnant and lactating women along with children in the 3-6 years age group. A few state-specific plan schemes and some state-run maternity hospitals also form part of the discussion.

The financial structures of various CSSs are different. RCH (mainly part A & C of NRHM) is a 100 percent Centrally-funded scheme. It is at present part of NRHM in which the Central government either spends directly or provides funds to State Health Societies (SHS) as Grants-in-Aid, bypassing the State Budget. ICDS is Centrally sponsored, with 50 percent contribution from states for SNP. The major part of SNP is for provision of nutrition to children and a small portion is util-

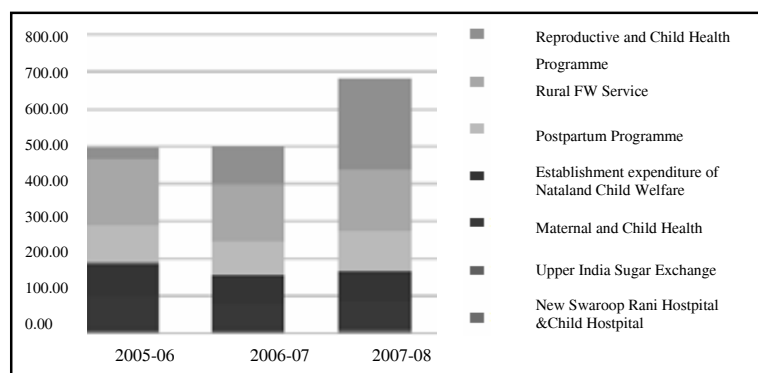
ised on dry ration for lactating and pregnant women. Unfortunately, these components cannot be demarcated, for if the allocated fund for SNP is totalled, there will be significant overestimation whereas it would be wrong to ignore the programme simply because of difficulties in estimating the share of funds that go to women. Hence, SNP is not included in the calculation of the 'maternal health budget' but keeping in mind the importance of the scheme for safe motherhood, its implementation and allocations are analysed in the study. Since both the Centre and states contribute to ICDS, SNP forms part of the state budget.

The other important central initiative is Rural Family Welfare Services, which mainly constitute the salary of ANMs with few other interventions relating to family planning. Rural FW Schemes funds are routed through the state budget. The study states have a few state plan schemes and state-run hospitals; for instance New Swaroop Rani Nehru Hospital and Child Hospital, Upper India Sugar Exchange Maternal and Child Hospital in Uttar Pradesh specifically for women and which form part of the state budget.

### III.1.1. Maternal Health Budget

The maternal health budget considered here is a restrictive one; it includes only those interventions directly meant for maternal health leaving out interventions that impact maternal health indirectly (a significant part of the budget, which does not directly involve maternal health)<sup>1</sup>. A scrutiny of Central and state budgets as well as budgets of the different health societies indicates that the major interventions are RCH and Rural FW Programme.

**Figure III.1: Composition of Maternal Health Budget in UP  
in Constant Prices (Rs. Crore)**



**Source:** UP Budget document, Various Years; Management Information System, National Rural Health Mission, [www.mohfw.nic.in](http://www.mohfw.nic.in)

1. Several inputs are required for maternal health and not all are included here. For instance, doctors, nurses, allied staff in the health system conduct ANCs, PNCs etc contribute to deliveries. However, their sole responsibility is not maternal health and their entire salaries cannot be part of maternal health budget. But leaving these items also leads to errors. In order to capture these services in maternal health budget, one has to compute what per cent of doctor's time and expertise on an average go into maternal health and hence take that proportion of total salary. This can be through rigorous processes, which was not possible under the present study. Hence we left that part. Similarly medical education has also been left out

Both in Uttar Pradesh and Chhattisgarh, there is some increase in the budget on maternal health in absolute numbers<sup>2</sup>. In Uttar Pradesh, the total spending on maternal health was Rs. 494.3 crore in 2005-06 and this increased to Rs. 918.2 crore in 2007-08, growing at a rate of 43 percent per annum (Fig III.1). In Chhattisgarh, it increased from Rs. 33 crore in 2003-04 to Rs. 118.5 crore in 2007-08 (average annual growth rate 65.5 percent) (Table III.1). But when the increase is compared in real terms (i.e., in constant prices), it looks much more moderate. For Uttar Pradesh, the average annual growth rate in real terms is around 19 percent and for Chhattisgarh it is around 34 percent. A look at the composition of the budget shows that much of the growth has taken place due to increase in spending under RCH since implementation of NRHM. In both the states, there were phases wherein expenditure in real terms declined from the previous year. The other component of the maternal health budget either vanished during this period, got merged with other schemes, or at best, remained static. Thus, the major trend in maternal health expenditure revolves around spending on RCH while other interventions are negligible and getting further marginalised.

**Table III.1: Composition of Maternal Health Budget in Chhattisgarh in Constant Prices (Rs. Crore)**

Programmes	2003-04	2004-05	2005-06	2006-07 RE	2007-08 BE
RFW Services	19.36	15.74	11.94	36.90	42.21
Training of women health workers	0.52	0.43	0.28	0.31	0.29
Prevention of STDs	0.2	0.17	0.26	0.11	0.12
Block level post-partum centre	1.3	1.12	1.20	0.00	0.00
District level post-partum centre	0.7	0.53	0.64	0.00	0.00
Ayushmati Yojana	0.1	0.08	0.05	0.20	0.23
Reproductive and Child Health	10.6	11.70	16.39	49.12	34.13
Total Maternal Health Budget	32.7	29.77	30.75	86.64	76.98

Source: Chhattisgarh Budget documents, various years; MIS, NRHM, www.mohfw.nic.in

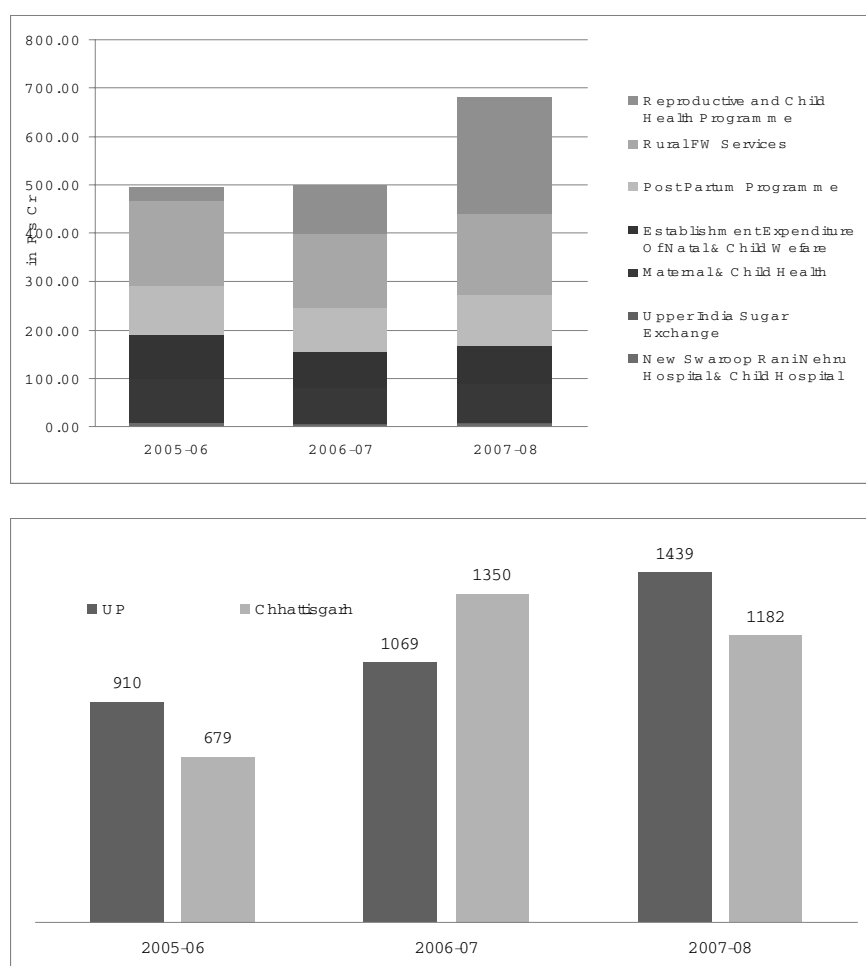
### III.1.2. Per Capita Public Spending on Maternal Health

An important parameter through which the level of spending on health can be judged is the per capita spending at constant prices. Spending may increase in absolute numbers but when total spending is deflated with population, the ratio allows comparisons of the level of spending with the changing population. The per capita public spending on maternal health in the two states has been very low though there was some increase over the years. In 2005-06, the spending on maternal health per live birth was Rs. 910 for Uttar Pradesh and for Chhattisgarh it was Rs. 679.

2. In UP the available data is from 2005-06 to 2007-08, where as in Chhattisgarh the reference period is 2003-04 to 2007-08.

In 2007-08, the figures for per capita spending were Rs. 1,439 for Uttar Pradesh and Rs. 1,182 for Chhattisgarh (Fig. III.2)<sup>3</sup>. At this point, it would be relevant to compare public spending on maternal health with what people spend out of their own pockets. Out-of-pocket (OOP) expenditure includes spending during delivery either at home or at institutions, based on information gathered during fieldwork or the findings of the National Sample Survey Organisation (NSSO) report. The research study also examines the spending on antenatal care or post-natal care (PNC) in the analysis of OOP expenses.

**Figure III.2: Per Capita Public Spending on Maternal Health in U.P. & Chattisgarh in Constant Prices (Rs. Crore)**



**Source:** State Budget documents for state plan schemes or non-plan interventions and NRHM- MIS for spending on NRHM

- It should be noted here that this calculation of per capita spending doesn't include salary of doctors or staff nurse or paramedical staff at different stages of child birth. It includes salary of ANMs, though. The process of including doctors' salary is a cumbersome one and estimates generated indirectly through DELPHY method may be prone to mistakes. To carry out the exercise we have to see average doctor's time required for a normal and c-section. Then from reported cases of normal and c-section or other complicated deliveries we can probably find out total time required. But given the nature of budget data, it would be difficult to find out the total salary of gynaecologists, paediatricians or GPs- in fact it is difficult to find out the total salary of doctors or paramedical staff- such desegregation is simply not possible from budget.

## Findings

National Sample Survey (60<sup>th</sup> round) has provided estimates of average costs of childbirth in different institutions and during various phases of pregnancy and childbirth, from ANC to PNC and delivery. Table III.2 shows that the total OOP expenditure on childbirth, including ANC and PNC, was Rs. 1,888 in public institutions whereas in private institutions these costs were more than three times higher (Rs. 6,276). Cost of delivery in private sector on an average is 3.5 times more than in the public sector while for ANC these costs are almost four times as high. These figures also vary across states – costs of delivery in both public and private sector were generally higher in Uttar Pradesh compared to Chhattisgarh. However, the cost differentials between Uttar Pradesh and Chhattisgarh were more prominent in the public sector. The fact that there are substantial costs associated with childbirth even if services in the public institutions are availed, point out to the inadequacy in public expenditure on maternal health.

**Table III.2: Average out-of-pocket expenditure on different phases of child birth  
(Rs. per capita)**

	Phase of Care	Govt. Hosp.	Pvt. Hospital	All
UP	ANC	225	665	468
	Delivery	1,725	4,008	856
	PNC	282	464	406
	Total	2,232	5,137	1,730
Chhattisgarh	ANC	122	734	369
	Delivery	678	3,342	431
	PNC	100	643	379
	Total	900	4,719	1,179
All India	ANC	356	1377	905
	Delivery	1165	4137	1169
	PNC	367	762	595
	Total	1,888	6,276	2,669

**Source:** National Sample Survey Organisation, Report No. 507, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

OOP expenditure was cited as a major constraint in accessing health institutions during delivery by the survey respondents. Delivery at institutions includes several costs which could be avoided in home delivery like those for transport, stay, informal payments to hospital staff, bed charges etc. As a result, home deliveries are cheaper (Refer to Box III.1). According to NSSO, home deliveries in both rural (Rs. 414) and urban areas (Rs. 552) are done at one tenth of the cost of delivering at private institutions. The respondents preferred to get the delivery done by a



TBA or dai, who is paid in cash or kind depending on the household's ability to pay. Also, getting admitted into a health facility was seen as a loss of three days of work, which translated into reduced income considering that most beneficiaries were daily wage labourers. If a woman had undergone a c-section, she was usually kept at the health facility for a minimum of three days. For normal deliveries (unless there is some complication in cases where either the mother or the infant has to be observed), they were discharged after two days.

### Box: III.1

#### Case Study of Choleswari

Case study - Twenty-four-year-old Choleswari had a c-section delivery at the district hospital. Her baby is 20 days old and this is her second child. The overall costs of the deliveries came to Rs 3,980. The cost break-up is given below:

Medicines	Rs 2,500
Ultrasound scan	Rs 80.00
C-section	Rs300.00
Transportation costs	Rs 1,000
Per day charge	Rs 100.00
Total	Rs 3,980

Choleswari got married at the age of 21 years and had her first child after one year. Her first child was also delivered by c-section since it was a breach baby. The cost incurred was around Rs 7,000. She also underwent a hysterectomy after delivering the child.

This survey has tried to capture the different components of OOP expenditure at government hospitals. The data obtained shows that the major components of expenditure are drugs; more than half of the total expense. There were instances at district hospitals of family members being asked to purchase medicines from outside. However, enquiry at the drugstore suggested that the drugs were available. The following sections take a look at what extent of funds was being spend on drugs at various levels of facilities. The other significant head of expenditure is transport; there has been an increase in transport rates since the introduction of JSY (Table III.3).

**Table III.3: Break-up of Heads under which Expenditure is Incurred**

Items	Rates (in Rs.)
Ambulance/taxi rates to district hospital and back	500 (250 + 250)
Stay at the district (lodging & food)	200
Payment to ANMs and helper	300
Cost of medicines	1000
Total Expenditure	2000

**Source:** Safe Motherhood, Public Provisions and Health Financing in India: CBGA Primary study, 8-15 May 2008, Lalitpur district, Uttar Pradesh

## III.2. Placing Maternal Health Budget in Total Spending on Health

The relevance of safe motherhood initiatives can be understood while identifying the maternal health budget in the total expenditure on health in the state. Table III.4 shows that in both the states, spending on maternal health is around 15-16 percent of total public spending on health.

**Table III.4: Maternal Health Budget and Total Public Spending on Health (in Rs. Crore)**

	Chhattisgarh			UP		
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
Maternal Health	42.5	124.4	118.5	494.30	643.72	918.24
State Budget	331.36	506.3	646.68	3,067.43	4,301.83	4,624.38
NRHM	84.6	136.3	151.8	573.30	720.47	1,086.43
Total Spending on Health	415.96	642.6	798.5	3,640.73	5,022.30	5,710.81
Maternal Health as % of Total Spending on Health	10.21	19.36	14.84	13.58	12.82	16.08

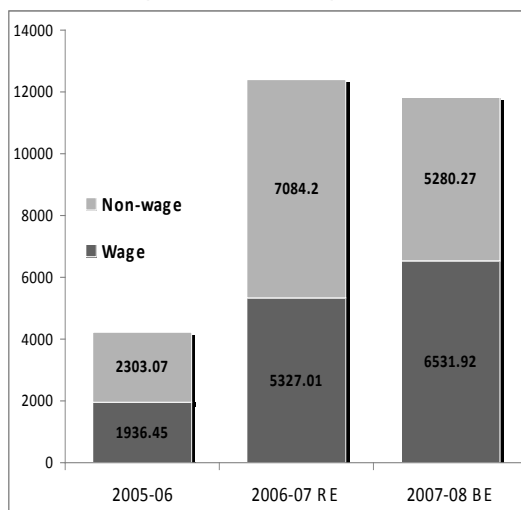
**Note:** Total spending on health in the state includes funds spent through state budget and NRHM. The Central government's contribution to NRHM does not figure in the state budget as funds go directly to the State Health Society, bypassing state budgets. The maternal health budget consists of schemes reflected in the state budget and those bypassing it like RCH.

**Source:** State budgets and MIS/NRHM.

### III.2.1. Wage, Non-Wage Break-up

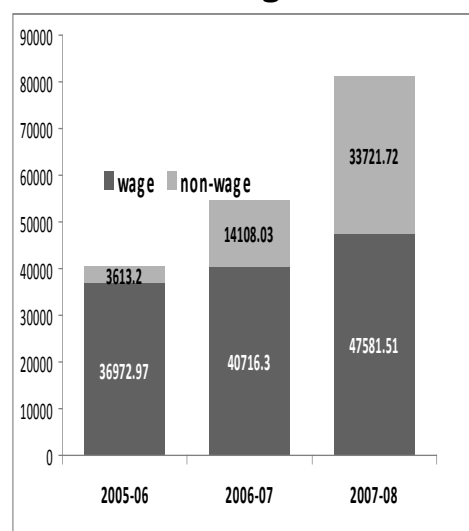
An important parameter to judge quality of spending is the distinction between wage and non-wage components. There is no doubt wages/salaries are extremely important in social sectors while the non-wage components include drugs, equipment, and other essential interventions required to keep the system functioning smoothly. However, there has been a tendency among the states to cut back non-wage spending to cope with efforts to contain fiscal deficits. Since salaries and wages are downward inflexible (do not decrease as a rule), it has been difficult to contain these items. (Fig. III.3a & III.3b)

**Figure III.3a: Wage Non-wage breakup in Chhattisgarh State Budget (Rs. Lakh)**



Source: Chhattisgarh State Budget, various years

**Figure III.3b: Wage non-wage Break up in UP State Budget (Rs. Lakh)**

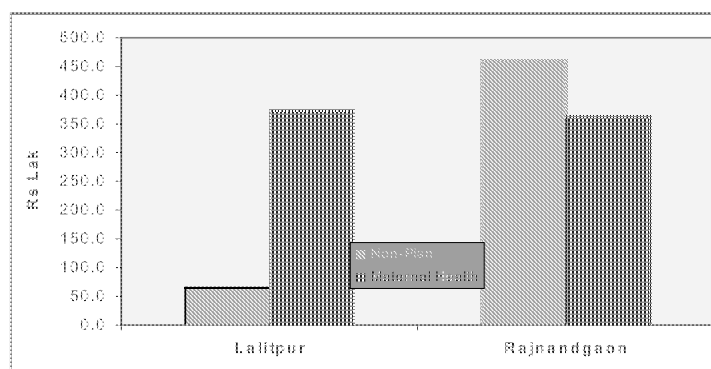


Source: UP State Budget, various years

The nature of spending on maternal health in terms of wage and non-wage components is completely different in the two states. In Uttar Pradesh, as depicted in the figure above, the share of non-wage components has increased mainly since introduction of NRHM while wage component growth has been significant. Compared to this, the proportion of wage and non-wage components have been even in Chhattisgarh, especially during 2006-07 and 2007-08. This could be due Post Partum Centres (PPCs), which had a high salary component, being taken out of the purview of the state budget and included in NRHM. In fact, in 2005-06 when PPCs were included, the total spending was higher and non-wage spending was around 12.2 percent. The absolute amount of non-wage spending went down slightly over the years but the decline in the wage component was much more significant. The lower share of wage in total spending in Chhattisgarh has to be seen in the context of huge vacancies of doctors, specialists and nurses and other people. This is discussed at length later.

Districts received funds for RCH through the societies as also through the treasury route. In terms of amount spent on RCH, there is a level of parity in both the districts (Fig III.4). Non-plan expenditures, routed through the treasury are significantly less in Lalitpur than Rajnandgaon. The latter received around Rs. 450 lakh in 2007-08 while Lalitpur got Rs. 67 lakh. This difference suggests that establishment expenditure in Lalitpur was low due to lack of basic facilities and human resources.

**Figure III.4: Comparison of Reproductive and Child Health and Non-plan Expenditures in the Districts in 2007-08 (in Lakh)**



Source: UP and Chhattisgarh State Budget, 2007-08

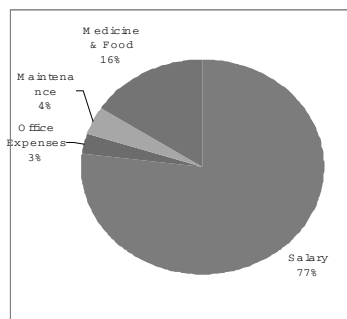
Non-plan expenditure in the districts is low overall. Figure III.5 suggests that a major part of the spending goes to meeting salaries. Available data on allocation and expenditure also indicate that utilisation levels are high (Table III.5). Since these are mostly committed expenditures, allocations are made according to tight budget lines and utilisation levels are high.

**Table III.5: Allocation and Expenditure in Lalitpur in 2007-08**

Broad Items	Allocation	Expenditure	Utilisation (%)
Salary	5535662	5209140	94.10
Office Expenses	218897	211313	96.54
Maintenance	269530	269005	99.81
Medicine & Food	1076107	1075733	99.97
Total	7100196	6765191	95.28

Source: District Hospital, Lalitpur, 2007-08

**Figure III.5: Components of Non-Plan Expenditure in Lalitpur in 2007-08**



Source: District Hospital, Lalitpur, 2007-08

### III.3. Supplementary Nutrition Programme (SNP)

Given the growing problem of undernutrition of women and children in India, provision of supplementary nutrition is undoubtedly very important. Though SNP has not been included in this maternal health budget analysis, it has the potential to impact maternal health significantly and constitutes an integral part of the ICDS scheme.

Since 2005-06, the Central government promised to bear 50 percent of financial expenses borne by the state governments for SNP. SNP provides for weaning food to children in the age group of 7 months to 3 years and hot cooked food to children in the 3-6 years age group besides 160 gm of take-home ration per day for pregnant and lactating women for 300 days. The allocation for children is Rs. 2 per day whereas for women it is Rs. 2.30 per day (Table III.6). The Food Corporation of India (FCI) is responsible for supplying foodgrains to fair-price shops for distribution to the anganwadi worker. However, field observations show that pregnant and lactating women were hardly receiving the take-home ration. In many cases, the women were not even aware of their entitlement. It is also difficult to track the amount that has reached the women owing to bottlenecks at the implementation level.

**Table III.6: New Financial Norms for Supplementary Nutrition Programme**

	<b>Existing Rates (per beneficiary per day)</b>	<b>Revised (per beneficiary per day)</b>
Children (6 months to 72 months)	Rs. 2.00	Rs. 4.00
Severely malnourished Children (6 months to 72 months)	Rs. 2.70	Rs. 6.00
Pregnant women and Nursing mothers	Rs. 2.30	Rs. 5.00

**Source:** www.wcd.nic.in, Ministry of Women and Child Development, Government of India

During the period 2005-06 to 2008-09, there was a growth in expenditure on SNP in both the states, though the trend is not uniform. The statistics for Uttar Pradesh show a decline in 2008-09 compared to 2007-08 while Chhattisgarh posted a reduction in spending in 2006-07 and a significant jump in 2007-08 followed by stagnation (Table III.7).

**Table III.7: Expenditure on Supplementary Nutrition in UP and Chhattisgarh  
(in Rs. Crore)**

<b>State</b>	<b>2005-06</b>	<b>2006-07</b>	<b>2007-08 RE</b>	<b>2008-09 BE</b>
UP	406.7	747.0	1109.4	953.2
Chhattisgarh	72.6	43.2	96.6	98.5

**Source:** State Budget documents, UP and Chhattisgarh

Uttar Pradesh received the lion's share of total funds released under SNP and this increased from 19 percent of total funds released in 2005-06 to 25 percent in 2008-09. During the same phase, the share of Chhattisgarh of funds released by the Ministry of Women and Child Development (MWCD), in fact, reduced from three to two percent with a jump in 2007-08 to five percent. (Table III.8) In terms of share, Uttar Pradesh witnessed a steady increase during the period while it was not so with Chhattisgarh.

**Table III.8: Release of Funds by MWCD to States for Supplementary Nutrition Programme (in Rs. Crore)**

State/UT	Released 2005-06	Released 2006-07	Released 2007-08	Released 2008-09
Uttar Pradesh	181.3	419.0	479.7	570.9
Chhattisgarh	31.3	29.5	104.5	54.3

Source: Ministry of Woman and Child Development, Government of India Gol, [www.mwcd.nic.in](http://www.mwcd.nic.in)

Available records for SNP beneficiaries in the two states indicate that an increase in numbers between 2007-08 and 2008-09. (Table III.9). These figures suggest that as much as 50 percent of children between 0-6 years and three-fourths women who had given live births during the fiscal year were beneficiaries under the scheme. No women covered by the research team had received any supplementary food and the high levels of under nutrition depicted in NFHS-III questions the data on beneficiaries as provided by MWCD.

**Table III.9: Beneficiaries of Supplementary Nutrition Programme**

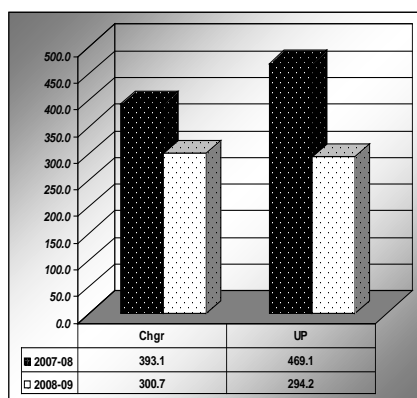
State	Total Children (6 months - 6 years)		Pregnant and lactating Mothers (P and LM)		Total Beneficiaries	
	2007-08*	2008-09 ^	2007-08	2008-09	2007-08	2008-09
Chhattisgarh	1906599	1773625	501686	478403	2408285	2252028
UP	20405306	18001270	3892754	3677541	4298060	1678811

Note: \*the 2007-08 figures are till Feb 2008; ^ 2008-09 figures are till Dec 2008.

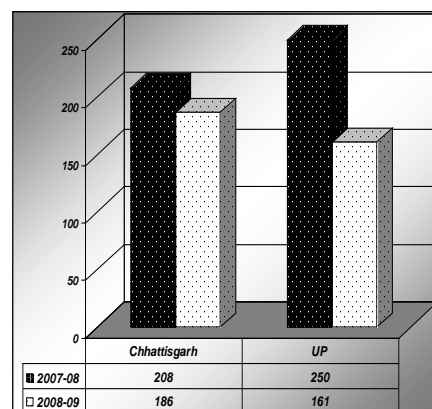
Source: Annual Reports 2008-09 and 2007-08, Ministry of Women and Child Development

Data on per capita expenditure suggests that between the two years, there was a decrease in expenditure in both states. This reduction was due to an increase in the number of beneficiaries in 2008-09. At the same time, allocations went down in the case of Uttar Pradesh, remained almost stagnant for Chhattisgarh while the overall level of spending was inadequate (Fig III.6a and III.6b). The funds available were sufficient to provide nutrition to the beneficiaries for 160 to 180 days, but the figures show a reduction in the actual number of days for which they got SNP care.

**Fig III.6a: Per Capita Expenditure on Supplementary Nutrition Provided**



**Fig III.6b: Expected Average Number of Days in a year of Supplementary Nutrition Provided**



**Source:** Annual Reports, 2008-09 and 2007-08, Ministry of Woman and Child Development

An analysis of outlays and outcomes in SNP show some increase in expenditures by the states and funds released to them by the Centre, with Uttar Pradesh getting a larger share. Field observations of the nourishment levels of pregnant and lactating women are, however, not in consonance with the figures of beneficiaries covered under SNP. The present level of expenditure and outcomes is also inadequate as the available funds could provide for 160-180 days of nutrition in accordance with SNP norms. The existing norms of daily provision of Rs. 2 for children and Rs. 2.30 for pregnant and lactating women are, moreover, not adequate.

### III.4. RCH and NRHM

RCH is the most significant initiative to ensure safe motherhood in which the Government of India receives funding support from the World Bank, Department for International Development (DFID), European Commission, United Nations Population Fund (UNFPA), United States Agency for International Development (USAID) and other bilateral donors. After completion of the first phase in 2004-05, the government entered into a Development Credit Agreement with the World Bank for financial assistance of 350 million US dollars where DFID would provide an assistance grant of 250 million pounds. The second phase, RCH-II, got underway in 2005.

The domestic component of the RCH budget has two parts; the first goes to the state treasury and figures in the state budget while in the second, the Central government purchases contraceptives directly from procurement agents. A major portion of the external funding either goes to the State Health Society concerned bypassing the budget as RCH Flexi Pool of NRHM or is spent for Central level activities like Information Education and Communication (IEC) and public-private partnership (PPP) initiatives. RCH Flexi Pool constitutes Part A of NRHM, Mission Flexi Pool forms Part B and Immunisation Activities Part C – all are considered part of RCH-II. The

part sent to the SHS bypasses the state budgets. Further, the SHSs do not fall under the ambit of auditing by the Comptroller and Auditor General of India (CAG). Rather, empanelled chartered accountants audit their accounts.

### III.4.1. Trends in National Level Expenditure

The expenditure on RCH increased significantly between 2002-03 and 2007-08 though it was more moderate from 2002-03 to 2004-05. It was only after introduction of RCH-II and its subsequent merger with NRHM that spending stepped up significantly. In the entire period under consideration, expenditure on RCH in Chhattisgarh increased consistently from the previous year, barring 2007-08. From Rs. 3.8 crore in 2002-03, it increased to Rs. 70.53 crore in 2006-07 but went down in 2007-08. In Uttar Pradesh, expenditure on RCH remained almost static during 2003-04 to 2006-07 though 2007-08 showed a significant jump (Table III.10).

**Table III.10: Expenditure on Reproductive & Child Health (in Rs. Crore)**

State/National	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Chhattisgarh	3.80	10.57	14.39	22.63	70.53	52.53
UP	77.78	106.45	105.96	183.22	159.40	400.24
India	1075.5	1245.55	1553.41	2776.92	4366.82	5657.27

**Source:** State figures of 2002-03 to 2004-05 are based on provisional data given in the answer to Lok Sabha Unstarred Question No. 1570 dated 03.08.2005, and Rajya Sabha Unstarred Question No. 1138 dated 01.12.2006. For 2005-06, 2006-07, 2007-08, HMIS, NRHM; Union Government figures are from [indiabudget.nic.in](http://indiabudget.nic.in)

### III.4.2. Are Transfers under NRHM Necessarily Progressive?

It was observed that states like Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan and Orissa have very poor maternal health outcomes. Recognising the backwardness of these states, the Union Government categorised them as high focus or Empowered Action Group (EAG) states. It is expected that focus on these states under NRHM would be reflected in the allocation and release of funds to them; meaning that these states would get greater share of funds in proportion to their population. Both the study states of Uttar Pradesh and Chhattisgarh are among the most backward in terms of maternal health indicators. Uttar Pradesh, along with Uttaranchal has 18.6 percent of rural population but 23 percent of total live births and 40 percent of maternal deaths. Chhattisgarh, though a small state, has development outcome levels much lower than the national average. Given the statistics, the assumption is that these states get a greater share of funds to curb maternal deaths but Table III.11 indicates that the situation is the reverse. Of the total NRHM funds in the period 2005-06 to 2008-09, Uttar Pradesh received only 17 percent of allocations – an amount less than half in proportion to maternal deaths and significantly smaller than its proportion of female population or live births. The situation was better in 2002-03 when there was at least some parity between maternal deaths and the expenditure. In 2002-03, Uttar Pradesh received 22.4 percent of RCH funds. Chhattisgarh too received much less share of



expenditure in this period. As much as 84 percent maternal deaths take place in EAG states, which also accounts for 57 percent of the live births. However, the allocation of funds seems to be based on their share in the rural population.

**Table III.11: Allocation and Release of Funds under National Rural Health Mission vis-à-vis requirements (as % of total )**

% Share	Maternal Deaths	Live Births	Rural Population	Allocations	Release	Expenditure
UP/Uttaranchal	39.9	23.0	18.6	17.1	19.2	17.8
MP/Chhattisgarh	12.4	9.4	8.2	8.6	8.8	9.3
Rajasthan	9.9	6.5	5.8	7.2	7.8	5.8
Assam	5.1	2.7	5.4	5.0	1.9	3.1
Orissa	3.7	3.1	3.9	3.8	3.7	4.2
Bihar/Jharkhand	14.8	12.1	10.9	9.0	8.5	12.8
EAG States	83.9	56.8	50.6	48.8	50.1	48.3
Kerala	0.8	2.2	1.9	2.3	2.9	3.2
Maharashtra	4.2	8.2	5.8	6.1	7.1	7.5
Tamil Nadu	1.9	4.3	3.8	5.1	5.8	4.7

**Source:** Maternal Deaths are calculated from 'Population Projections for India and States 2001-2026', Census of India, GoI and SRS Bulletin on Maternal Mortality in India 2004-06, RGI.

Fund position, allocation and Expenditure data and rural population data are from MIS, NRHM

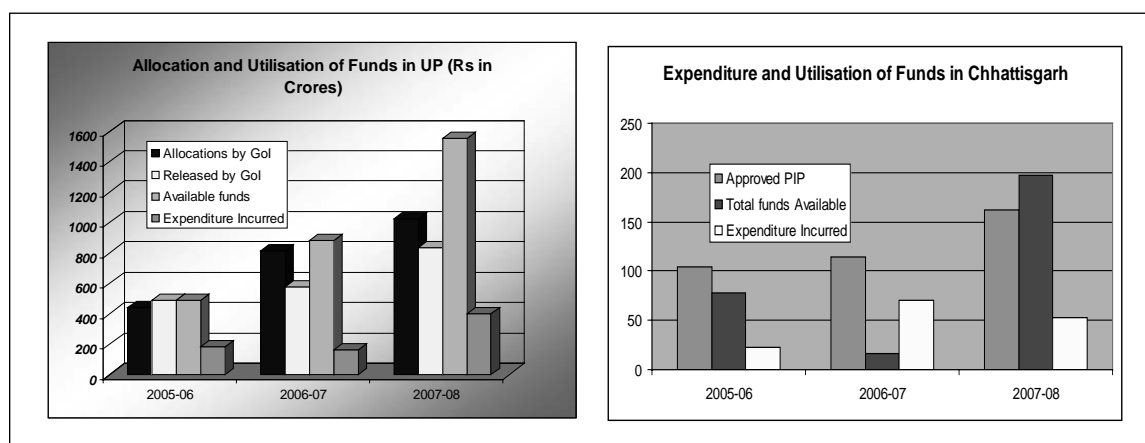
It is evident that the existing mechanism of fund allocation is enhancing the developmental deficit rather than eliminating it. The fact that the state with the highest population and huge developmental deficits receives a smaller share means that some better off states are actually getting larger shares and further sharpening the existing inequalities. For poorer states like Uttar Pradesh and Chhattisgarh, the situation has worsened under the current system of spending. Uttar Pradesh for example received a smaller share in 2007-08 than what it got in 2002-03. Better off states like Kerala, Tamil Nadu and Maharashtra on the other hand receive more funds compared to their share in allocation. Since these states spent funds more efficiently, their share in expenditure increased even further. At this juncture, the financing mechanism in NRHM needs looking into. Financial allocation under NRHM is based on Programme Implementation Plans (PIPs) prepared by states and subject to approval by the Centre. Though the first two instalments were released unconditionally, subsequent ones were being released subject to expenditure up to at least 50-60 percent. States which fail to spend their previous instalments were not receiving subsequent ones. When the new financial year starts, the unspent balance of the previous year is incorporated in the total envelope of allocation. However, while releasing the instalments, this unspent amount is deducted. The following sections demonstrate that there are components

within NRHM that are demand driven i.e., if states demand, with proper utilisation reporting, the Centre would provide additional funds. States that have been able to spend their funds more efficiently also got more funds in subsequent rounds. Thus, instead of financial allocations under NRHM being needs-based, the state's ability to spend has become the criteria for flow of funds. There is no doubt that this financial mechanism has fundamental fallacies but it needs further probing to know why some states are able to spend more funds while others fail to do so. The following section examines this question and the extent of underutilisation of funds at various levels of services. It also tries to gauge whether underutilisation is because of delays in financial flows, due to fallacies in the financial mechanism or fundamental issues in health system that the current mechanism is unable to address or recognise.

### III.5. Extent of Underutilisation of Funds

After the launch of NRHM in 2005-06, RCH-II merged with it and in the first three years, allocations to most states including Uttar Pradesh and Chhattisgarh under RCH activities of NRHM increased significantly. In 2005-06, total funds allocated to Uttar Pradesh was Rs. 437.8 crore. Funds released were higher than allocations, at Rs. 486.7 crore. In subsequent years, allocations increased significantly though funds released did not increase at par. This is mainly because of the backlog of unspent funds with the state. Expenditure at the state level decreased in 2006-07 (Rs. 159.4 crore) compared to 2005-06 (Rs. 183.22 crore) but increased significantly in 2007-08 (Rs. 400.24 crore). Expenditures clearly fell significantly short of funds allocated to Uttar Pradesh. Total funds available at the state was a whopping Rs. 1,555.33 crore in 2007-08, a significant part of which remained unutilised.

**Fig III.7: Allocation and Utilisation of Funds in Uttar Pradesh and Chhattisgarh**



Source: MIS of NRHM, [www.mohfw.gov.in](http://www.mohfw.gov.in)

Funds released for Chhattisgarh increased manifold since 2005-06. Spending also increased but not in keeping with the pace of fund disbursement to the state, resulting in significant underutilisation.

tion. Only 29 percent of available funds were utilised, creating a huge unspent balance. Although NRHM got under way in 2005-06, it was in 2006-07 that the Centre started releasing funds under the flagship programme. The amount of funds available to SHS Chhattisgarh more than doubled in 2006-07 compared to the previous year. State level expenditure also trebled but only 42.2 percent of funds available could be utilised. In 2007-08, the utilisation level plummeted even below the 2006-07 mark (Fig.III.7)<sup>4</sup>. There is a gradual increase in expenditure carried out by the state, but Chhattisgarh has clearly been unable to cope with the mammoth flow of funds.

Based on the individual state plans, the National Programme Coordination Committee (NPCC) approves the Programme Implementation Plan (PIP). The approved PIP adjusts for unspent balances in total allocation. When comparing utilisation of funds with approved PIP, it was found that the figures for Chhattisgarh for 2005-06 were even lower than available funds. Of the Rs. 104 crore approved for 2005-06 for Chhattisgarh, only Rs. 78 crore were available to the SHS as first instalment. Since utilisation was very low (21.7 percent of total PIP), the society did not get the following instalments. In subsequent years, expenditure vis-à-vis approved PIP increased. Due to heavy underutilisation of funds the previous year, the funds available increased greatly but approved PIP did not. Thus in 2006-07, expenditure compared to approved PIP was almost two-thirds. In 2007-08, it reduced to 32.3 percent.

According to the NRHM implementation framework, districts will prepare annual plans ultimately to be collated to form the state plan. These district plans would be the basis of transfer of resources from the SHSs. Similar to the Central transfer to states, districts will also receive funds as flexible pool, not as specific interventions. In Chhattisgarh, like in many other states, the formulation of district level PIPs had not taken place till 2008-09. As a result, funds devolved to the districts were according to specific components, in many instalments and not in keeping with the requirements of the districts. At the District Health Society, Rajnandgaon, only 57.2 percent of the total NRHM funds were utilised in 2005-06. Afterwards, there was a gradual decline in utilisation of funds. In 2007-08, only 47 percent of funds were utilised.

When the quantum of funds spent in Rajnandgaon is analysed, a significant increase is noticed during 2005-06 to 2007-08. Of the Rs. 2.19 crore available in 2005-06, Rs. 1.57 crore had been spent. In 2006-07, available funds and expenditure almost doubled. Out of the Rs. 4.34 crore available, the District Health Society (DHS) utilised Rs. 2.79 crore. There was a significant jump in both available funds and expenditure in 2007-08 also. Of the Rs. 6.7 crore available, the DHS utilised Rs. 4.16 crore. The carry over balance from RCH-I was used in Phase II but the closing balance of Rs. 146,000 in 2006-07 was neither returned to the SHS nor spent in the district. Within a span of three years, the quantum of funds devolving to the DHS had tripled. At the same time, the expenditure also increased significantly.

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4. Unlike earlier years, when funds disbursed to the districts were reported as expenditure, since 2007-08, the Finance and Management Report (FMR) has separate columns for funds devolved to districts and expenditure therein.

Unlike Rajnandgaon where there was no district PIP, Lalitpur had its PIP. Preparation of the PIP was handed over to some private agency in the absence of a separate District Programme Management Unit. PIP preparation was generally seen as a standalone process and it was not at all linked to transfer of funds from states. Throughout Uttar Pradesh, financial and management affairs at the district level are not handled by any nodal authority, leading to multitasking, lack of coordination between different activities and affecting utilisation of funds. However, there was an increase in available funds and expenditure in Lalitpur between 2006-07 and 2007-08. In 2006-07, of the total available funds of Rs. 3.4 crore, only Rs. 1.9 crore was spent, thus booking a 57.7 percent utilisation. In 2007-08, utilisation went up to 84 percent as Rs. 3.5 crore was spend out of the total available funds of Rs. 4.2 crore.

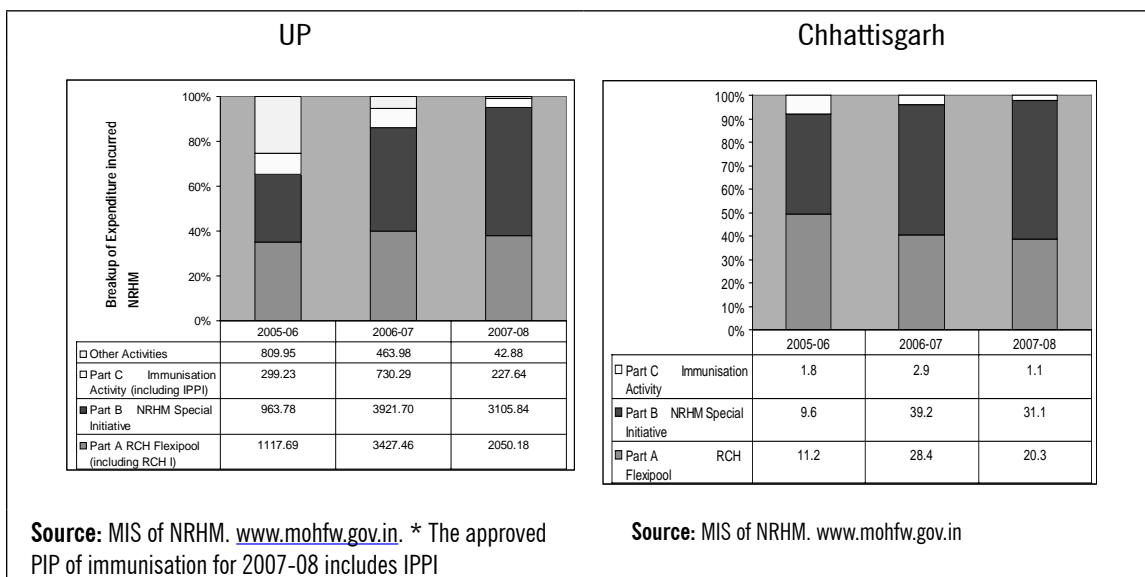
The pattern of utilisation in Uttar Pradesh and Chhattisgarh and subsequently at the districts, shows that there is some increase in 2007-08 compared to previous years, though overall utilisation remained low in the first few years. There can be several reasons for underutilisation. It could be that the states took time to understand the concepts envisaged under NRHM, especially fund flow mechanisms; it may also be linked to the political will of the states to implement the CSS or be the result of some systemic weaknesses. Before delving into the question of under-utilisation, it is important to understand the pattern of under-spending. The best way to do so is to look at the components of spending – the broad categories and the detail interventions.

### III.5.1. Spending across Broad Components

Three main categories within NRHM are relevant for maternal and child health – these include NRHM-A (RCH Flexible Pool), NRHM-B (Mission Flexible Pool or NRHM Additionalities), and NRHM-C which includes the immunisation programmes. The other component is pulse polio immunisation which had been in and out of part C during the initial years of the umbrella CSS.

The level of utilisation of funds for RCH activities in Uttar Pradesh has been dismal given that in 2005-06, only 37.6 percent of funds were utilised and this went down further in subsequent years. In 2006-07 and 2007-08, only 18 percent and 25.7 percent of available funds were utilised. Looking at the utilisation pattern across the four broad categories, some components show extremely low levels. In 2005-06, of the total Rs. 183.22 crore spent, as much as Rs. 142.88 crore was for Intensive Pulse Polio Immunisation (IPPI) campaign but utilisation in other components remained abysmally low. Fund use under RCH Flexi Pool increased significantly from 29 percent in 2006-07 to 59.8 percent in 2007-08 but in the three financial years under consideration, it was practically inconsequential. Against a total of Rs 788.5 crore released by the Centre in three years of NRHM, only Rs 125.2 crore was spent, the overall utilisation remained at 11 per cent (Fig III.8).

**Figure III.8: Expenditure across Broad Categories of NRHM in UP & Chattishgarh (in Rs. crore)**



In Chhattisgarh, spending across all components (including activities of RCH-I that were not completed) increased in 2006-07 compared to 2005-06. In 2005-06, almost a third of the funds spent were in RCH Flexi Pool Part A. In 2005-06, spending on NRHM Part B was very less. Expenditure under Part B picked up in subsequent years and in 2007-08 it almost covered two thirds of total expenditure. Though the share of RCH Flexi Pool in total expenditure remained almost the same for all the three years under consideration, there was a significant decline in expenditure in 2007-08 compared to the previous year. Spending on immunisation activities followed the same pattern; there was an increase in 2006-07 and a decline in 2007-08. In fact, the expenditure under Part C went down in 2007-08 to a level lower than in 2005-06 (Fig.III.8).(Table III.12)

**Table III.12: Utilisation across Different Components of NRHM in Rajnandgaon**

	2005-06	2006-07	2007-08
Total of RCH I	43.7	61.8	
NRHM Part A	63.6	45.7	62.0
NRHM Part B	98.6	50.4	20.9
NRHM Part C	37.3	77.6	75.0
Others	21.3	59.1	48.3
Total	57.2	52.9	47.0

**Source:** Data from District Health Society, Rajnandgaon, 2005-06, 2006-07, 2007-08

A detailed look at the expenditure figures in Rajnandgaon shows that utilisation of NRHM part A remained around 62-63 percent except for 2006-07, which showed a drastic decline. In contrast, fund utilisation under NRHM-B was very high in 2005-06 but slumped thereafter. In 2005-06, fund utilisation under NRHM-C, which essentially deals with immunisation, was very low. The situation improved after that. (Table III.13)

**Table III.13: Availability of Funds and Expenditure in under NRHM in Lalitpur  
(in Rs.)**

		<b>Cumulative Funds Received During the F.Y.</b>	<b>Total Available funds</b>	<b>Cumulative Expenditure During the F.Y.</b>	<b>Closing Balance</b>	<b>Utilisation</b>
2006-07	RCH Technical Strategies	17085011	3196926	14672123	111915	63.25
	NRHM Additionalities	4720000	6950000	3090000	230000	44.46
	Immunisation	2095925	3155953	1390429	1060028	44.06
	Total	23900936	33302879	19152552	9401943	57.51
2007-08	RCH Technical Strategies	10942388	4869460	13430330	3927072	90.32
	NRHM Additionalities	10684809	3884664	9314954	3199855	67.09
	Immunisation	4191360	4639524	3730357	448164	80.4
	Pulse Polio Immunisation	8730956	8743879	8520649	12923	97.45
	Total	34549513	2137527	34996290	7588014	83.05

**Source:** Monthly Financial Management Report, 2006-07 and 2007-08, Lalitpur

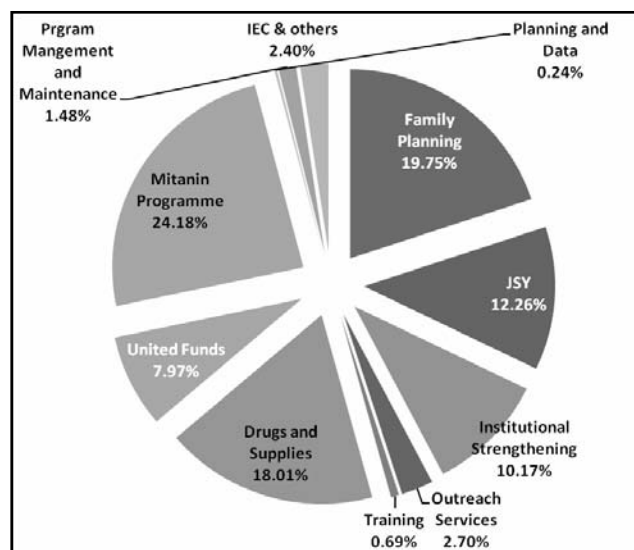
Among the broad categories, it has become difficult to compare the priorities since in the initial years there was some ambiguity over the exact grouping of certain components. For instance, Pulse Polio Programme had often been made part of NRHM-C and often kept as a separate entity in Part D. If there is any definitive pattern emerging from the above analysis, it is that NRHM-B gets greater priority day by day. This is a positive development.

### III.5.2. Component wise break-up of Spending

A component wise break-up of spending points to the priorities under NRHM. Unfortunately, such break-ups were not available at the State Department of Family Welfare in Uttar Pradesh. Hence, only data for Chhattisgarh has been scrutinised and analysed. The break-ups suggest an overwhelming priority accorded to Family Planning. Of total funds spent on RCH and NRHM Flexi Pool in Chhattisgarh, 20 percent were on Family Planning. Other interventions like Mitans (ASHAs or rural voluntary health workers), drug procurement and JSY also accredited for major

amounts. Significantly, utilisation under the Mitadin programme is high in Chhattisgarh because of the long history of the programme dating back to pre-NRHM years when there was already a large number of Mitadins (literally meaning ‘female friend’, derived from the Sanskrit ‘mitra’) in place at the state. However, the issues of decentralisation through disbursement of untied funds at various levels, institutional strengthening, training of health professionals, and outreach services essential for Chhattisgarh were, given lesser priority (Fig III.9).

**Figure III.9: Component wise break up of Expenditure in Chhattisgarh (2007-08)**

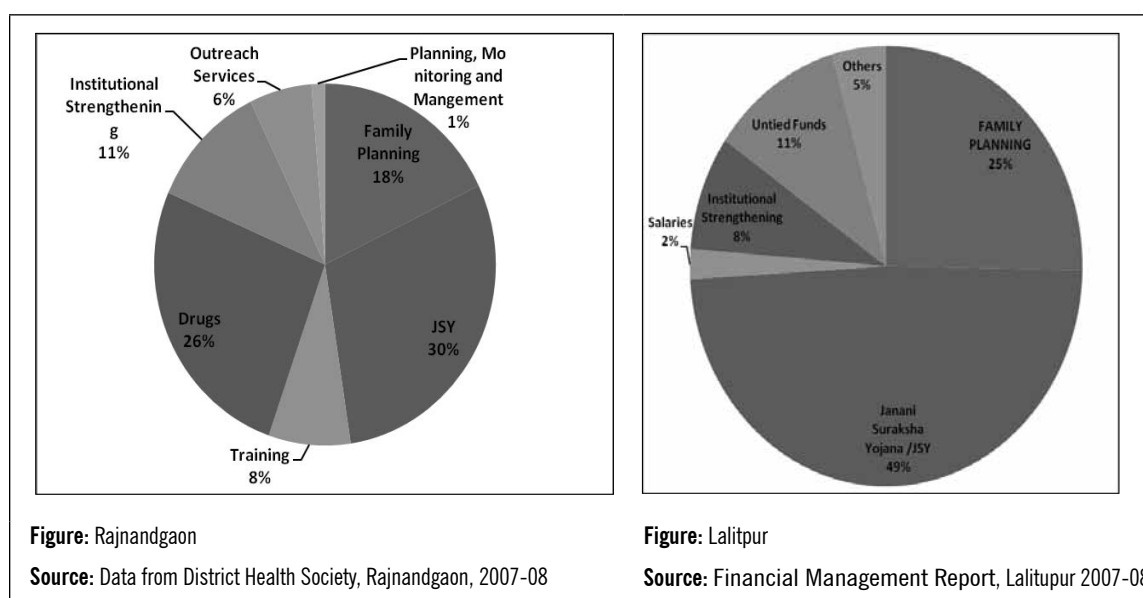


**Source:** Statement of Expenditure of Chhattisgarh, 2007-08. Programme Implementation Plan, 2007-08

Family Planning and JSY are the main components of expenditure even at the district level but there are variations in priority between Rajnandgaon and Lalitpur. Almost three quarters of the funds in Lalitpur, are spend on these two components. In contrast, in Rajnandgaon, these account for half the spending. The high level of spending on drugs in Rajnandgaon is a reflection of the fact that in 2007-08, the responsibility of purchase of drugs for Mitadin Kits was decentralised to the district though the response was not very encouraging. Such measures should be looked at in the context of capacity building at the district level.

Contrary to claims by the governments, Family Planning remains central to the agenda of CSSs on health and this study stands testimony to it. At all levels, FP remains the most prominent component. JSY is the other component that has really gained priority in spending. This is largely to do with the nature of the scheme, which is in the form of cash incentives and driven by demand for institutional delivery. In the next chapter, the implication of JSY on rural health institutions is examined. (Fig III.10)

**Fig III.10: Component wise break up of Expenditure at District Level (2007-08)**



### III.5.3. Underutilisation across Components

Utilisation of funds in Chhattisgarh was not uniform across the components with the state being able to spend money on some activities while funds for other areas remained idle. Areas like training of Mitans and staff, institutional strengthening and upgrading of district hospitals showed extremely low levels of utilisation. Further, untied funds for SHCs and Village Health and Sanitation Committees (VHSCs) were not utilised in 2007-08. The following table highlights some components out of a huge list of interventions assigned under NRHM. The purpose is not for a comparison between the years but to identify components with high utilisation and those with extremely low levels of utilisation. (Table III.14)

**Table III.14: Utilisation of Funds under Certain Activities of NRHM in Chhattisgarh**

2006-07	Per cent	2007-08	Per cent
<b>High Utilisation</b>		<b>High Utilisation</b>	
BCC/IEC	104.7	Family Planning Activities	101.0
Pulse Polio	99.9	Strengthening SIHFW	100.0
Janani Suraksha Yojana	119.2	Strengthening SHRC	98.8
Compensation for Sterilizations	204.8	Untied Funds for 517 PHC	102.6
District Action Plan	100.0	Pulse Polio	85.8
Up-gradation of CHCs to IPHS	94.2	NGO Preparatory Grant	96.7



Low Utilisation		Low Utilisation	
Training	65.9	Strengthening Mitnin Programme	0
Programme Management	58.5	Untied Funds for Village Water Health & Sanitation com.	11.2
Procurement of Drug Kit For ASHA/ PHC/CHC	36.0	Untied Funds for S.H.C.	18.9
Special IEC Campaign/Others	31.3	FRU	11.5
Selection & Training of ASHA	51.4	Swasth Mela	0
Mobile Medical Units	0	Up-gradation of District Hospital	0

**Source:** Financial Management Report, NRHM, State Health Society Chhattisgarh, 2006-07, 2007-08

Similar analysis at the district level also helps in identifying components with high and low levels of utilisation. In Rajnandgaon during 2006-07 and 2007-08, some common items could be identified which had high levels of utilisation and others with perpetually low levels. As seen at the state level, funds for Family Planning, JSY, IPPI and activities carried out by agencies like UNICEF (catch-up rounds) have been utilised. At the same time, training components and untied funds at different levels have experienced low or sporadic utilisation. With the process of preparation of district PIPs not gathering momentum, the utilisation on this item was virtually negligible. It is evident from the table that the issues of system strengthening like planning, monitoring, innovations and hiring of staff remain largely underutilised whereas entitlements gain major momentum. (Table III.15)

**Table III.15: Utilisation under Certain Activities of NRHM in Rajnandgaon**

2006-07		2007-08	
Low Utilisation		Low Utilisation	
Training of paramedical on SBA	44.1	Untied Fund for District Hospitals	0.0
Contractual staff salary (ANM, staff nurse, lab technician)	26.5	Incentives For 24 Hrs PHC	30.8
Training nodal funding	38.5	Untied Fund for Sub Centre	0.0
Strengthening routing SHC	0.4	District Action Plan	5.7
Untied fund for district hospital	0.0	Immunisation Activities	39.1
Mitnin Training Programme (SHRC)	34.8	Construction of (40 + 78) Sub-Centres	11.5
Incentive for 24 hour PHC (institutional)	0.0	MPW Training	0.0

Untied fund for Sub-Centre	0.0	Mitanin Training Programme (Funds from SHS)	50.6
ANM kit, kit A, kit B, PHC kit	0.0	High Utilisation	
High Utilisation		Janani Suraksha Yojna	86.1
Janani Suraksha Yojna	80.7	Family Planning Operation Compensation	70.4
Family Planning Operation Compensation	71.6	Strengthening Routing S.S.	95.3
Jeevan Deep Samiti	100.0	RCH Camps in Haat Bazar(Non Tribale Blocks)	99.9
Mitanin Education & Equipment Kit	100.0	Pulse Polio Immunisation	99.6
Pulse Polio Immunisation	98.7	RI Catch-up SSM (UNICEF Activities)	124.0

Source: Financial Management Report, Rajnandgaon, 2007-08, 2006-07

The situation in Lalitpur is no different from that of Rajnandgaon. The table below illustrates that issues of system strengthening like planning, monitoring, innovations and hiring of staff remained largely underutilised while entitlements went up. Also, utilisation at times only meant transferring funds to the next level. There was hardly any expenditure reporting from the block level, and hence, the data is incomplete. (Table III.16)

**Table III.16: Utilisation of Funds under Certain Activities of NRHM in Lalitpur**

2007-08			
HIGH UTILISATION		LOW UTILISATION	
Activity	Utilisation	Activity	Utilisation
Innovative/Demonstration Project to Promote Institutional Delivery	111.59	PNDT Implementation and Sex Ratio	0.00
Contractual staff & Services- Lab Technician	108.88	Logistics Management/Improvement	0.00
Family Planning	108.01	Strengthening of Training Institutions	0.00
Janani Suraksha Yojana/JSY	105.86	Selection & Training of ASHA	0.00
united fund for VHSC	100.00	RTI/STI services at health facilities	0.00
Strengthening of BCC/IEC Bureaus(District levels)	100.00	Untied Funds for Sub Centres	0.00
Operationalise 24x7 PHCs (24-hour Delivery services)	100.00	Child Health	11.11

Corpus Grants to HMS/RKS	100.00	Contractual Staff – ANMs	14.94
Pulse Polio Immunisation	97.6	Cold Chain Maintenance	16.96

#### 2006-07

Incentive to AWW/ASHA for Promoting Sterilisation	100	Dai Training	0.00
Janani Suraksha Yojana (NMBS)	99.8	Major Training (Exclusive of Dai Training)	0.00
Major Civil Works (Constructions./ additions)	99.6	Untied Grant to Village Health Sanitation Committee	0.00
United Fund For Sub-Centres	99.0	Block SPMU	0.00
RTI/STI Services (Diagnostic & Drug Kit)	96.7	Cold Chain Maintenance	0.00
Compensation Package for FP Services (NSV)	91.7	Monitoring Supervision & Evaluation	25.15
Family Planning Services	89.8	Innovative/Demonstration Project to Promote Institutional Deliveries	26.24

**Source:** Financial Management Report, Lalitpur, 2006-07 and 2007-08

The above discussion brings out the inability at the state and district levels to utilise funds in certain components. Components in the nature of entitlements are generally over spent, the case in point being JSY and compensation for Family Planning. At the same time, several system strengthening issues that could lead to better quality of services remained underutilised and this research study inquires into its reasons. One important factor can be delays in transfer of funds itself. Absorption of funds are also subject to proper human resource deployment at the programme management and implementation level, availability of proper information systems and the overall mechanism of transfer of funds besides addressing the requirements at the level of service delivery. These issues are discussed in the following sections.

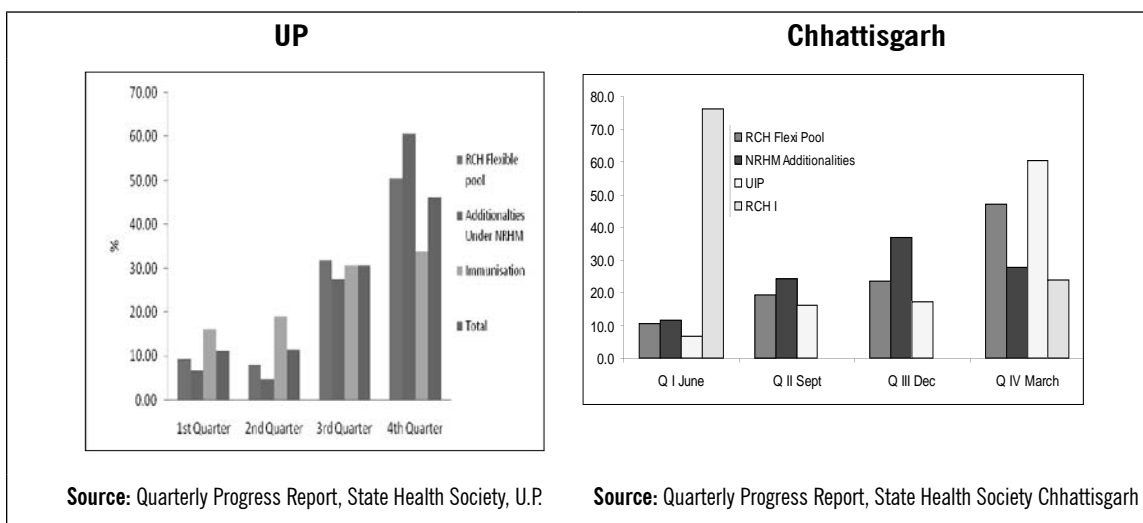
#### III.5.4. Spending across Four Quarters of Financial Year

An important element of this study is the quality of spending; whether funds are being spent all through the year or at the end of fiscal would determine the nature of spending and overall level of utilisation. The two study states spent major portions of available funds during the last two quarters of the financial years. Of the total Rs. 50,190 lakh utilised in the financial year 2007-08, Uttar Pradesh spent as much as Rs. 23,240.83 lakh during the last quarter. This is 46 percent of the funds spent throughout the year. The third quarter accounted for Rs. 15,456.49 lakh, around 30 percent of the total spending.

Compared to the high level of spending in the latter part of the fiscal, the first two quarters of 2007-08 saw very limited spending. Across components, the same pattern of skewed spend-

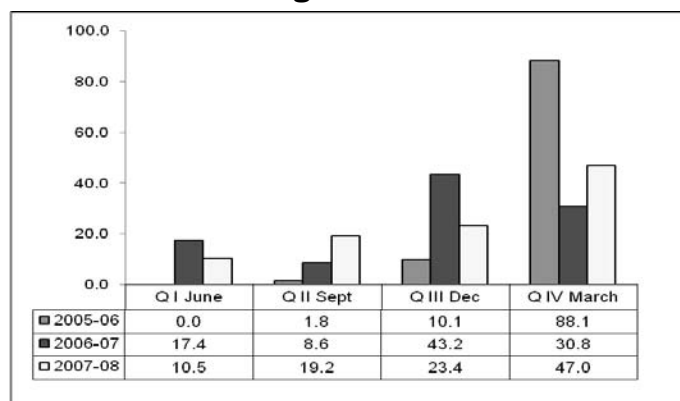
ing towards the last two quarters is observed in varying degrees. The spending pattern on immunisation activities was relatively well spaced with a little more than 30 percent of funds being spent in the last two quarters and the remaining one third in the first half. In the case of NRHM Additionalities, as much as 60 percent spending was in the last quarter and for RCH Flexi Pool, half of the funds were spent during the last quarter (Fig III.11).

**Figure III.11: Quarterly break up of Expenditure across Major Components (2007-08)**



During the initial years, the spending pattern of Chhattisgarh was also concentrated in the last two quarters. In 2005-06, as much as 88.1 percent of the expenditure occurred in the last quarter and more than 98 percent in the second half. In subsequent years, it gradually became more even. In 2006-07, 30.8 percent of spending was in the last quarter though almost three quarters of it was in the latter half of the year. In 2007-08, almost half of the funds spent were in the last quarter of the financial year (Fig III.12).

**Figure III.12: Quarterly Break up of Expenditure in Chhattisgarh since 2005-06**



Source: Quarterly Progress Report, State Health Society, Chhattisgarh

A scrutiny of specific activities of RCH indicates a similar skew - very low level of spending in the first two quarters and the bulk of spending in the latter half, specifically the fourth quarter. Barring 2006-07, almost half the spending was in the fourth quarter only. Spending in NRHM Additionalities in 2006-07 also tilted towards the fourth quarter.

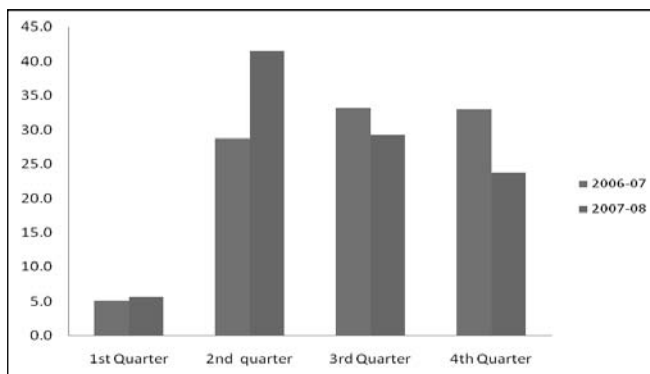
Two important facts emerge from the ongoing data analysis - (i) the study states have not been able to cope with the huge increase in allocation under NRHM, and (ii) what little expenditure took place in the states was during the latter half of the fiscal, more specifically the last quarter. Expenditures, which come in the form of entitlements (salary disbursement), however, have had consistently higher levels of utilisation. On the other hand, there have been delays in the clearance of Central funds, often transferred during the latter half of the year and at times in two or more instalments. The huge unspent balance at the yearend in the state concerned has led to cuts in grants for the subsequent years. A quarterly break-up of expenditure of funds reflects a concentration in the last phase of the year and consequent low utilisation.

The important question here (considering that NRHM is geared for creating better health infrastructure and developing institutional capacities, specifically in states like Uttar Pradesh and Chhattisgarh) is: Why do these states have low levels and skewed pattern of expenditure? The answer may lie in the mechanism of fund transfer under CSS; it may be that the states have taken time to cope with the newer forms of financial transfers and implementation mechanisms; or it may well be the case that the preparation at the Central level to implement such schemes was totally missing. An attempt is made in the following sections to find answers to some of these questions.

### III.5.5. Quarterly Transfer of Funds from Centre

Timeliness of transfer of funds is extremely important, as delayed transfers lead to delays in fund utilisation. Data on Grants-in-Aid transfers to Uttar Pradesh (for 2006-07 and 2007-08) indicate a relatively uniform distribution in the last quarter and almost insignificant transfer amounts in the first quarter. In 2006-07, it was almost uniformly distributed in the last three quarters, each receiving around one third of the total transfer. In 2007-08, the second quarter accounted for a sizable chunk of the funds while the last two quarters received 29.2 percent and 23.7 percent of the funds (Fig. III.13).

**Figure III.13: Quarterly Release of Funds to UP**



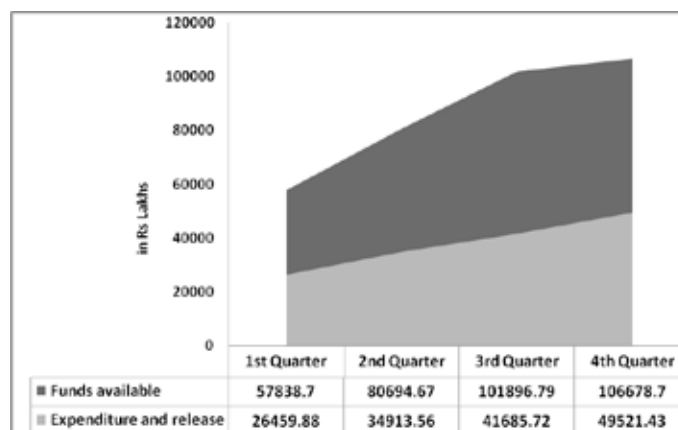
Source: Quarterly Progress Report, State Health Society, UP

Taking a look at the release of funds from the Centre to the SHS Chhattisgarh, substantial delays are noticed in terms of sanctioning the first instalment of release of Grants-in-Aid. For instance in 2006-07 the first instalment release was in July whereas in 2007-08 it reached only on September 24. Reasons for such delays could be inability to submit the Statement of Expenditures (SoE) and Utilisation Certificates (UC) of the previous year or availability of huge amounts of unspent balances with the state. Examining the break-up of different instalments, National PIP funds were sent in two major instalments in 2006-07. Besides, over 90 percent of the funds released were in the third quarter.

### III.5.6. Availability of Funds at SHS

Delays in release and receipt cannot explain the disproportionately high spending during the last quarter. The following diagram clearly shows that a huge level of funds remained unused at the SHS, Uttar Pradesh during every quarter. When funds received during the quarter are added to the opening balance, it equals the total availability of funds, while total spending in the state include funds released to the districts. In each of the four quarters in 2007-08, increasing amounts of funds lying unspent with the state are noticed (Fig III.14).

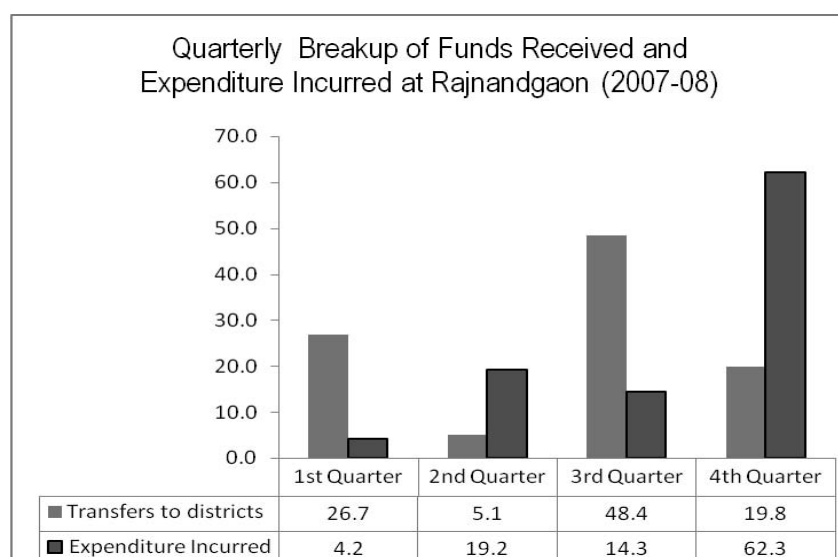
**Figure III.14: Quarterly Availability of Funds vis-à-vis Expenditure incurred in UP (2007-08) (in Rs. lakh)**



Source: Quarterly Progress Report, State Health Society, U.P.

A break-up of funds received during the years and the expenditures incurred shows that most of the funds were disbursed to the DHS in the third and fourth quarters. Similarly, spending was in the latter part of the year. In 2007-08, almost half the funds came in the third quarter. Though one fourth of funds sent to the DHS were during the first quarter, it only spent 4.2 percent of the money during that period (Fig III.15). This accounted for a huge unspent balance at the DHS.

**Figure III.15: Quarterly Break-up of Funds Received and Expenditure incurred in Rajnandgaon (2007-08) (in percent)**



Source: Data from District Health Society, Rajnandgaon, 2007-08

**Table III.17: Funds Received from Government of India and Disbursed to the Districts across Different Quarters in 2007-08 (in Rs. lakh)**

		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
At the SHS	Opening Balance	4651.4	2302.4	8706.9	6900.8
	Funds Received form Gol	143.8	6904.3	3191.5	162.5
	Expenditure Incurred	72.6	353.6	72.6	493.4
At the DHS	Opening Balance at DHS	237.2	391.6	327.1	594.4
	Funds Received from SHS	191.3	33.9	325.7	128.6
	Expenditure Incurred	35.1	78.3	58.5	254.1

Source: Data from District Health Society and State Health Society, Rajnandgaon, Chhattisgarh, 2007-08

Table III.17 shows a comparative picture of funds received at the SHS, disbursed to the DHS and the expenditure incurred at the two levels. While the SHS got most of the funds in the second and third quarter of 2007-08, it disbursed these to the DHS, Rajnandgaon only during the third and

fourth quarter. The expenditure during the first quarter is mainly the unspent balance left with the SHS. Though the SHS spends a miniscule amount of funds on its own, it had taken place only during the second and fourth quarter. Likewise, at the DHS, there was a surge in spending during the second and fourth quarters only. However, the flow of funds is not the only factor responsible for the inconsistent spending patterns as a substantial amount of funds remained underutilised in all the quarters with the SHS and DHS.

Funds disbursed to the blocks from the DHS, Rajnandgaon indicate a similar skew towards the second half of the year. Of the total funds disbursed to the blocks in 2006-07 and 2007-08, a little more than a quarter was in the first half and the rest during the third or the fourth quarters. Since a majority of the spending takes place only at the block level and the major role of the DHS and SHS are monitoring and timely disbursement of funds, this pattern of disbursement has had an adverse impact on overall utilisation (Table III.18).

**Table III.18: Funds Disbursed from District Health Society to Blocks in Rajnandgaon (2006 -07 and 2007-08)**

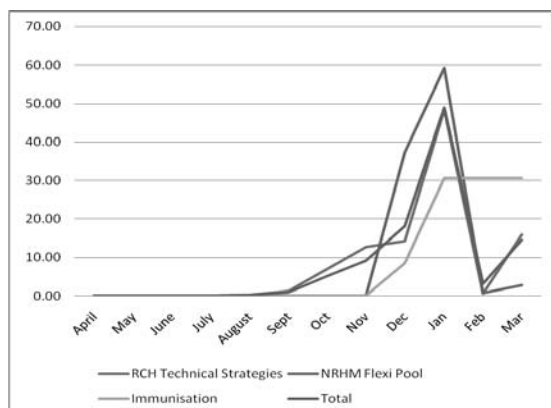
	2006-07		2007-08	
	Amount (INR)	Percent of Total Release	Amount (INR)	Percent of Total Release
1st Quarter	1433220	18.0	1170000	5.6
2nd Quarter	752000	9.4	3744237	17.8
3rd Quarter	2939220	36.9	10202625	48.6
4th Quarter	2842500	35.7	5892500	28.0
Total	7966940	100	21009362	100.0

**Source:** Financial Management Report, Rajnandgaon, 2007-08, 2006-07

The figure shows the monthly break-up of spending in Lalitpur. The lines show the extent of funds spent in major components of NRHM in different months of the year. There has been absolutely no spending during the first six months of the financial year. There was sporadic spending during October-November, which shot up in December-January and again in March. (Fig. III.16a&b)

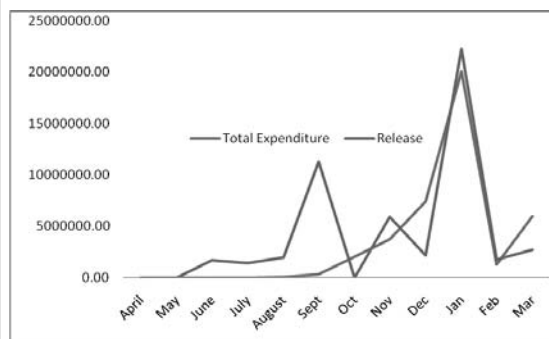


**Figure III.16a: Monthly Expenditure at Lalitpur (2007-08)**



Source: Office of the Chief Medical Officer of Health, 2007-08

**Figure III.16b: Funds Released and Expenditure incurred in Lalitpur (2007-08)**



Source: Office of the CMoH, Lalitpur

Release of funds to the district also takes place only in the latter half of the fiscal. The figure above shows the monthly break-up of expenditure vis-à-vis release of funds from Lucknow. Compared to the skewed pattern of expenditure, fund transfers were more even across the months. Though it is only in the month of January that majority of the transfers take place.

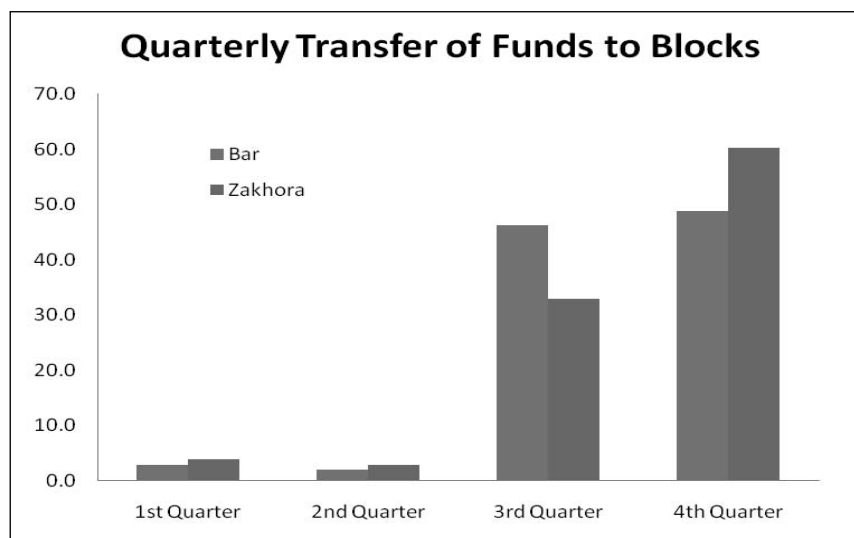
Transfer of funds from the state to Lalitpur takes place in multiple instalments. In 2007-08, funds were transferred in 23 instalments, each according to activities. In 2006-07 as many as 47 instalments were received at the district. Multiple instalments cause difficulty in tracking the transfers, managing them and transferring them to blocks and subsequent levels. In terms of quarterly break up of transfers, as the spikes in the following line diagram show, funds in 2007-08 have been transferred majorly in the second or fourth quarter with almost no transfer in the first quarter and small amounts in the third.

### III.5.7. Transfer of Funds to the Blocks

Transfer of funds to the blocks reflect the typical slant towards the latter half of the financial year. The sample blocks in Lalitpur were Jakhora and Barh. The data reveals that there were hardly any transfers taking place during the first two quarters of the financial year. In fact in 2006-07, there were no transfers up to the month of December. The situation improved slightly in 2007-08. Some negligible amounts were transferred to the blocks on account of JSY and miscellaneous activities during the first two quarters. A look at the items of transfers to block shows a definite picture emerging. Most of the transfers took place in JSY and Family Planning and very

little amounts on other accounts. The blocks being at the level of implementation, the nature of transfers to the blocks show the main emphasis of the NRHM programme (Fig III.17.).

**Figure III.17: Quarterly Transfer of Funds to Blocks in Lalitpur (2007-08)**

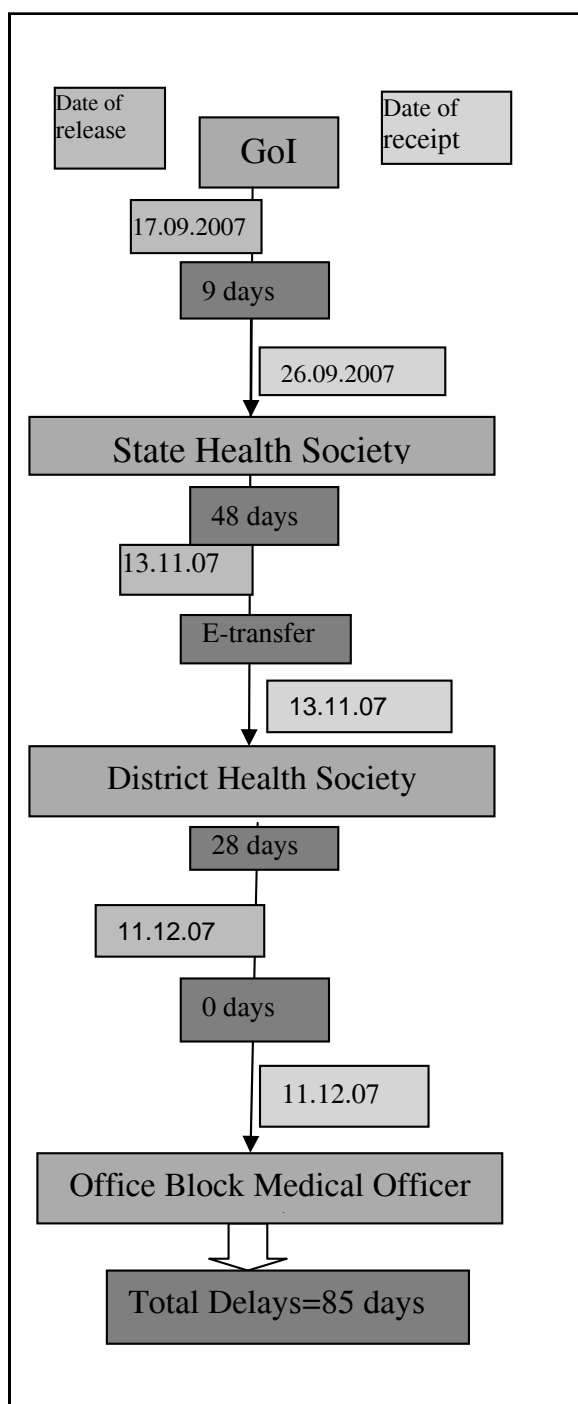


Source: Ledger Books, Office of the Chief Medical Officer of Health, Lalitpur (2007-08)

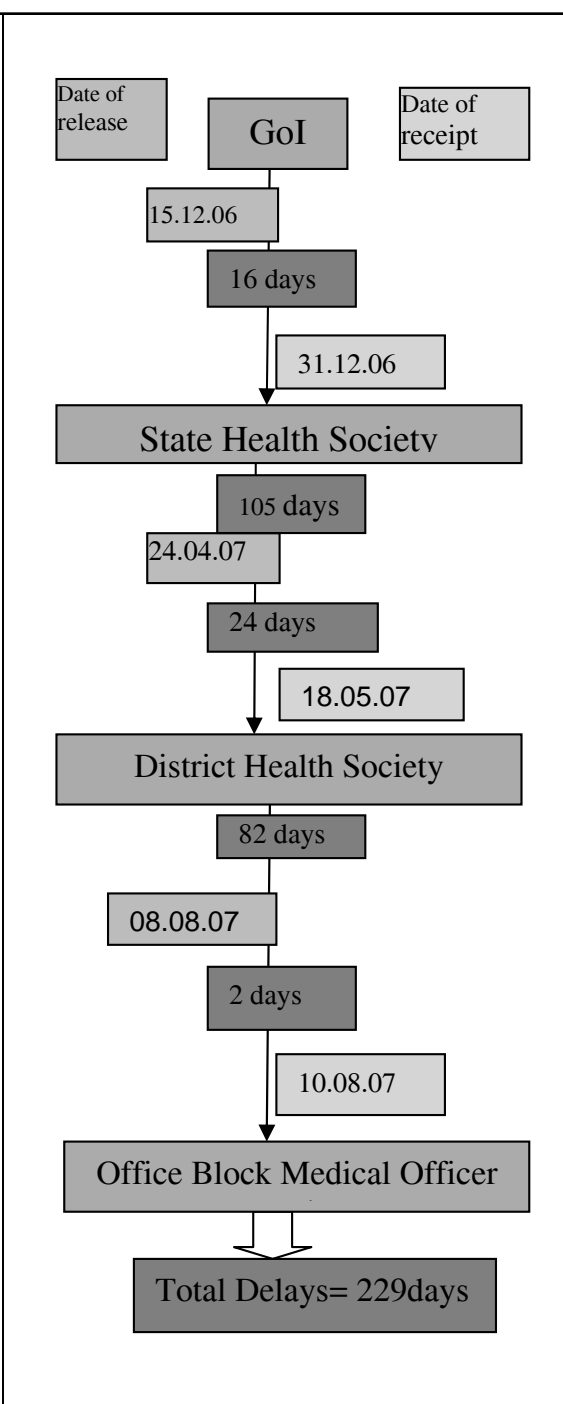
### III.5.8. Tracking Delays in Fund Flow

The current exercise tries to track transfer of funds from the level of the Central government to the blocks through various stages at the state and district. A specific example chosen is that of Mitranin Training in Chhattisgarh, tracked through the SHS to the district and finally to the blocks. Two situations are compared; one prior to introduction of electronic transfers and the other post its introduction. In 2006-07, funds were released from the Centre on December 15<sup>th</sup>, 2006, which reached the SHS, Chhattisgarh on December 31<sup>st</sup>, 2006 with a delay of 16 days. It remained idle for 105 days at the SHS and finally the first instalment was released on April 24<sup>th</sup>, 2007, which was in the next fiscal. It received the same fate at the DHS and remained idle for 82 days and finally reached the blocks on August 8<sup>th</sup>, 2007 after a gap of 229 days from the date of release from the Centre (Fig III.18 b). Compared to this, the total number of days consumed in the passage of funds from the Centre to the blocks under electronic transfer was only 85 days (Fig III.18 a.). But a closer look shows that the reduction in delays mainly due to e-transfers is limited. It can be elaborated by replacing the delays in transfer from one level to other in situation 'b' and assume e-transfer. It is found that in situation 'a', it could save only 26 days. This contradicts the general notion that e-transfers can do away with all the delays in transfer of funds. The main points of delays remain at various offices at the state and district levels rather than the process of transfer itself. The study tries to find out why funds remain idle at the offices.

**Fig III.18a.Mitanin Programme  
in Chhattisgarh (After Electronic Transfer)**



**Fig III.18b. Mitanin Programme  
in Chhattisgarh (Before Electronic Transfer)**



Source: Office of the Chief Medical Officer of Health, Rajnandgaon

### III.6. Conclusion

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The detailed analysis of budgets on maternal health has a few important pointers for policymakers. First, the aggregate level of spending is low. This is true for both health related activities as well as for nutrition. Apart from a few Centrally Sponsored Schemes, there is hardly any initiative on the states to tackle maternal deaths even though there is the recognition that safe motherhood is an important challenge. Further, there are significant out-of-pocket expenses incurred due to childbirth, severely affecting the poorer sections of society.

It is acknowledged that NRHM has brought in some improvements in the level of spending at the states. There has been some increase in spending at the state, district and block levels under the flagship health scheme but it is not adequate. We have also seen that the current mechanism of transfer of funds under NRHM is actually going against the backward states- as they tend to receive lesser amount of funds compared to their load of the problem.

The irony is whatever little amount of funds that get disbursed are not spent. This remains a major stumbling block in increasing allocations. The issue here is to try and dig out reasons for low fund utilisation – is it because of the delays in transfer of funds that utilisation is affected, or it is the lack of capacities at the states to spend funds? The quarterly break-up of fund flow reveals that a substantial portion of funds reach the district only in the second half of the financial year and hampers utilisation. However, that is not the entire picture as considerable funds remain idle at various levels. Then, is it due to lack of capacity of the state and districts to carry out certain interventions that funds remain unspent? What does absorption capacity really mean? Does it mean adequate human resource and infrastructure? Or does it also mean adequate training and incentive to perform properly? Are the reporting and monitoring requirements and guidelines hindering utilisation? Are these interventions proposed under NRHM relevant for these states? The next chapter would answer some, if not all, of these questions.

Provision of Ante-Natal Care  
Institutional Deliveries  
Post-Natal Care  
Inadequate Facilities  
Service Providers  
Lack of Skilled Human Resource  
Lack of Capacity Building and Training  
Bottlenecks in District Level Planning  
Absence of Programme Management Units  
Delays in Transfer Of Funds  
Delays in Fulfilling Reporting Requirements  
Inappropriate Maintenance of Accounts  
Procedures and Guidelines Related to Delays  
Conclusion



Pregnant mother, (9th pregnancy), Jakhora block, Lalitpur, Uttar Pradesh

## Chapter-IV

# Major Constraints in Service Delivery

Uttar Pradesh and Chhattisgarh, like many other poorer states in India, are caught in a vicious cycle of ill health, poverty and under investment. It was seen in the previous chapter that the role of the state has been undermined by chronic levels of under investment in crucial aspects like nutrition and maternal health. Even sporadic increases in spending since the introduction of NRHM have not been absorbed properly. Inability of these states to cope with increasing spending makes the case stronger for those who propose to reduce state investment. They argue that there is no dearth of money and it merely depends on the willingness of service providers to supply good quality services – that the system is corrupt and needs to be left to the market so that these inefficiencies are ironed out. This section contests such fundamentally flawed contentions with the argument that quality of service delivery and ability of the system to spend more funds are actually contingent upon more investments. Crucial aspects such as infrastructure, human resources, aspects of planning and monitoring need to be strengthened in order to expect the desired quality of services. It looks at these aspects to understand the linkage of system strengthening with budgetary outlays and financial flows and identify constraints in both the processes. The study team has also tried to understand the perspective of both service providers and beneficiaries and see if policy perspective matches the aspiration of stakeholders.

## IV.1. Provision of Ante-Natal Care

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Ante-natal care is the first contact point of pregnant women with service providers. ANC, mostly carried out by ANMs, is a low-cost intervention with enormous benefits of safe motherhood. However (as was evident in Chapter II, Outcomes), the coverage of various interventions is limited and the quality of ANC services unsatisfactory. Given the enormous emphasis on institutional delivery under NRHM, the focus on ANC seems to have reduced with decline in coverage.

Dissemination of information on nutrition and hygiene is an important aspect of ANC and perhaps one of the most neglected. In both Lalitpur and Rajnandgaon districts, pregnancy was not considered a condition that required any particular medical attention and often, the diet remained the same. As already pointed out (see Outcomes), Sahariya tribal women in Lalitpur believed that increased food intake would fatten the unborn foetus causing difficult delivery and, possibly, C-section. The belief could stem from the fact that the cost of C-section is exorbitant,

which they can ill-afford. Field observations also found that most pregnant women or lactating mothers (in both the study districts visited) were unable to go to the *Anganwadi* centres for the dry ration they are entitled to under SNP. This is because most such centres were practically non-functional, given the low unit costs for dry rations provided by the Central government.

The two required tetanus shots were also not administered in most instances. On inquiry, the study team was told that the supply of TT injection was not regular in either district while IFA tablets were distributed mostly for pregnant women. (see Outcomes for ANC vis-à-vis ANM, ASHA and health centres).

### Box IV.1

#### **Case Study 1: District Hospital, Lalitpur**

Guddi from Lalitpur district is in the last stages of pregnancy. She had three children, all delivered at home, out of which she lost two to typhoid and tetanus. She had not taken TT shots in one of her pregnancies. This time around, she has been immunised for tetanus and consulted the ASHA but still has no idea about JSY. Now 32 years old, Guddi wants to give birth to her fourth child in hospital for a safe and healthy delivery. However, that would depend on availability of a bed in the maternity ward.

Guddi is found to be lying on the floor outside the maternity ward of the district hospital. She has been in this condition for three days. The nurses have not been able to tell her anything about her pregnancy, in terms of her delivery date. As she cannot speak properly, the study team has been able to glean some information about her from her relatives. Immediately after her relatives were interviewed, the young woman was promptly shifted to the ward.

#### **Case study 2: Kailoni village, Barh block, Lalitpur district**

Rupa from Kailoni village is a goatherd and has three children. She lost seven children at various stages over the years. Some were delivered in institutions and the rest at home. She has had to incur out-of-pocket expenses ranging from Rs 400-800 at the institutional level in Lalitpur, Bhailoni and Barh. Three months pregnant again, she is aware about the necessity of immunisation but has yet to be inoculated. She has been informed by the ASHA that Rs 1500 would be given to her under JSY. Nevertheless, she has not received any ANC and PNC counselling. Nor has received any raw material from the *Anganwadi* centre. She plans to deliver her future child in an institution so that she can receive the money.

## IV.2. Institutional Deliveries

The cases of Guddi and Rupa (Case studies 1 and 2) (Box IV.1) comment on the situation encountered by women who have had a growing interest in institutional deliveries but lack access to the facilities. It is not simply a lack of money but response and initiative which is missing from the service providers at public facilities. In Guddi's case, it may have been that she was not kept in the ward due to shortage of beds, or that cases of greater severity were given priority over her.

Overall, in both the districts, visits were made to ten facilities. Of these, there were three Sub-Centres, four PHCs, one CHC and two district hospitals. ANMs, staff nurses and doctors were present in all but only one doctor (CHC, Dongargaon) could give time for an interview. Also, none of the CHCs or PHCs had a female gynaecologist. In both the districts, the doctors at the district hospitals were also carrying on their private practice.

In terms of equipment and infrastructure, blood banks were not available in the district hospitals. The Lalitpur District Hospital would usually transfer/refer cases to the hospital in Jhansi, which is more than 70 km from Lalitpur, whenever there was a shortage of blood samples. There was also a severe shortage of lab technicians. The number of TBAs, who were earlier part of the health system, have gradually been reduced. This has severely impacted the work of ANMs who now complain of being overburdened with work, more so because TBAs had technical expertise. In contrast, the ASHAs have not been able to assist in child delivery due to lack of technical expertise.

The life-saving services that are required to effectively manage and treat complications arising during pregnancy, childbirth and the post-partum period come under EmOC. Essentially, this would mean the presence of skilled health providers, preferably a gynaecologist, referral transport and a fully-equipped health facility that can manage complications. The inadequacy in equipment and human resources at District Hospital, Rajnandgaon, and PHC, Khoba, Chhuria Block, Rajnandgaon (Case studies 3 and 4) (Box IV.2) clearly show that the facilities are ill-equipped in managing and handling EmOC.

### Box IV.2

#### **Case Study 3: District Hospital, Rajnandgaon**

The District Hospital is severely understaffed and has poor infrastructural facilities. There are only two doctors who deal with deliveries and women's health problems. They have to handle all the pregnancy cases in addition to hysterectomies and tubectomies. There are only 15 beds, three *dais* and one sweeper in the maternity ward. As reported by the staff nurse, the main problem ailing the hospital was not just shortage of staff but also shortage of medicines, especially injections/injectable drugs. In addition, there is no blood bank or a neo-natal care unit. The other problems include lack of generator, proper lighting and cooler.

Despite many attempts to contact the doctors, none of them were available for an interview. Hence, it was not possible to get their viewpoint. This also proves that there was a staff constraint.



**Case Study 4:**  
**PHC, Khoba, Chhuria Block, Rajnandgaon**

The primary health centre had been opened only a year-and-a-half back. It was housed in a ram-shackle building which was an old *Panchayat Bhawan* (local administration building). Ironically, the infrastructure is in a far poorer condition than the neighbouring sub-centre. There are two rooms out of which one has a bed for the patients. The other room is used for consultations and medicine storage. An ANM, a pharmacist and a TBA are part of the staff in the PHC. Until now, only two deliveries have been done through the PHC (the ANM had to go to the patient's house to assist in the delivery).

*The study team observed that the PHC was dingy and dirty. A patient was found to be lying on the bed with no attendant. Nobody was present in the PHC on first instance. Subsequently, the ANM was called.*

Home deliveries were more frequent in Lalitpur, carried out mostly by the TBA or *dais*. However, it was difficult to ascertain whether a clean delivery kit was used. A clean delivery kit provides the necessary tools and instructions to achieve the World Health Organization's 'Five Cleans' throughout the birthing process – clean hands, clean delivery surface, clean cord cut, clean cord ties, clean cord stump care. Adherence to the 'Five Cleans' is necessary to prevent the mother and infant from getting infected, and for the purpose, the clean delivery kit contains soap, plastic sheet, new razor blade and clean thread.

**Box IV. 3**

**Case Study 5:**  
**Siron Khurd village, Jakhora Block, Lalitpur**

Lado is a habitant of Siron Khurd village, Jakhora block of Lalitpur. She is 35 years old and has recently given birth to a boy who is about a month old. This is her eleventh child and like his siblings, was delivered at home. Lado belongs to the Sahariya tribe who populate parts of Bundelkhand and Rajasthan. She is a daily wage labourer and currently working under the NREGA scheme. She was married at the age of 12 and had her first child when only 16. The ASHA had informed her about immunisation and also about JSY. However, she did not get her tetanus injections at the time of her pregnancy. On being asked the reason, she said the ANM does not visit her residential area. Even when she was called, the ANM did not stop over despite passing by her house. As a result, Lado did not find it necessary to go to the sub-centre to get immunised.

There had been no intervention made by the AWW. She is illiterate and does not want to continue having children anymore. Nonetheless, she feels that permanent birth control methods like sterilisation would weaken her immensely and this would mean a loss of working days. She has not yet used any other birth control method. When asked why she had not had a single institutional delivery, she responded by saying that in most instances, she was unable to tell the due date of delivery. There were no symptomatic indicators for her to assess when the child would be born. Most of her children were born while she was doing her daily chores. In addition, due to the compelling nature of the situation and distance, she could not be taken to the PHC. Hence, a *dai* was called to deliver.

Lastly, safe delivery was not seen as an issue. Households did not see a connection between safe delivery practices and health facilities. Low levels of awareness on pre and post-natal care was seen to exist as seen in Lado's case. A startling fact that came to light was that a woman's own health during and after pregnancy was totally ignored. Poor health such as anaemia and malnutrition was rampant among the women interviewed.

### IV.3. Post-Natal Care

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Awareness level among the community about PNC was almost nil in Lalitpur. After delivery, the woman was usually confined to her house for a period of 10 days or so. Thereafter, her child would be looked after by the siblings/relatives. Knowledge about post-delivery immunisation was very low among the mothers. Unless the ASHA or ANM directly intervened, she would not go to the *Anganwadi* Centre or sub-centre. In Rajnandgaon, the situation was slightly different with PNC found to be above average. Most mothers were aware about not feeding water to the infant until 6 months. Also, spacing was maintained between children. On an average, women got married at 18 years and above and had three to four children. The *Anganwadi* Centres have been partly entrusted with the task of providing ANC and PNC. However, only in a few cases were they seen to have provided additional food items to pregnant and lactating women. Awareness about immediate and exclusive breast feeding till 6 months was not high in both the districts. The three PNC visits essential during PNC were largely followed in both the districts. Nonetheless, it was observed that the mothers were not fully aware about the necessary care and precaution to be taken for the infant's health as well as their own.

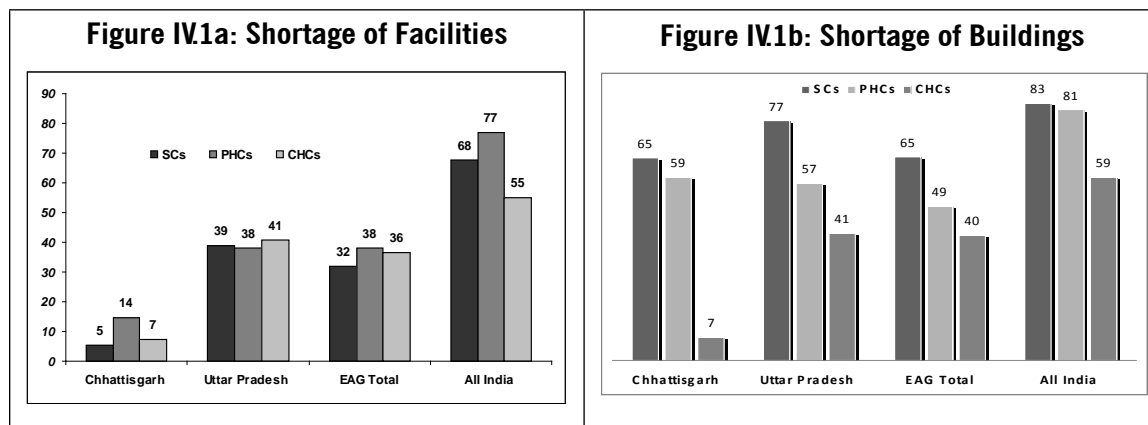
### IV.4. Inadequate Facilities

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Lack of basic health facilities is one of the important factors responsible for poor health indicators for both the states. The latest round of Rural Health Statistics depicts this. According to population norms, Chhattisgarh requires around 5,000 sub-centres, 843 PHCs and 147 CHCs. Officially, around 4,692 SHCs, 518 PHCs and 118 CHCs were functioning in 2008. The shortfall was highest in the PHCs – only 60 percent of the required PHCs being functional. At the same time, shortage in CHCs, viewed as the First Referral Unit (FRU) under NRHM, is 20 percent. The situation in UP is much more severe. Only 61 percent of the required SCs and PHCs and 44 percent of the CHCs are functioning in Uttar Pradesh. This means that the state needs 13,031 more SHCs, 2,313 PHCs and 483 CHCs, which in turn requires mammoth capital investment largely expected to come from the state budget. As seen in the previous chapter, capital investments on health in Uttar Pradesh are far below expected levels. (Fig IV.1a&b)

Moreover, many of the PHCs were recently converted into CHCs. The study team observed that the remodelling existed only on paper and nothing concrete was being done. Similar were the cases of conversion of CHCs into FRUs, and PHCs into 24 × 7 ones. The very low levels of utilisation of funds under NRHM on these accounts are testimony to the fact that nothing significant

has happened in the first three years of rolling out of NRHM. On paper, there were three FRUs in 2008 in Lalitpur, but the entire district had very few specialists, all of whom were working at the district hospital. An FRU needs to have a minimum of four specialists, which was out of question in any of the sub-district level hospitals in Lalitpur. The situation was no better, if not worse, in Rajnandgaon.



Source: District Level Household and Facility Survey, Round III

Shortage of facilities essentially means that there is pressure on existing facilities. On an average, every PHC in Uttar Pradesh caters to 48,124 people and a CHC around 504,416 people. Likewise, in Chhattisgarh, a PHC caters to 36,692 people and CHC around 197,764 people. These are much higher than the standard norms for PHC and CHC in general and even higher when compared to requirements in tribal areas. Operating with such high levels of patient load means that the facilities require to function at higher levels of efficiency; that PHCs and CHCs do not fall short on human resources and that all amenities function properly. The following paragraphs take a look at the ground realities in Lalitpur and Rajnandgaon.

#### IV.4.1. Buildings

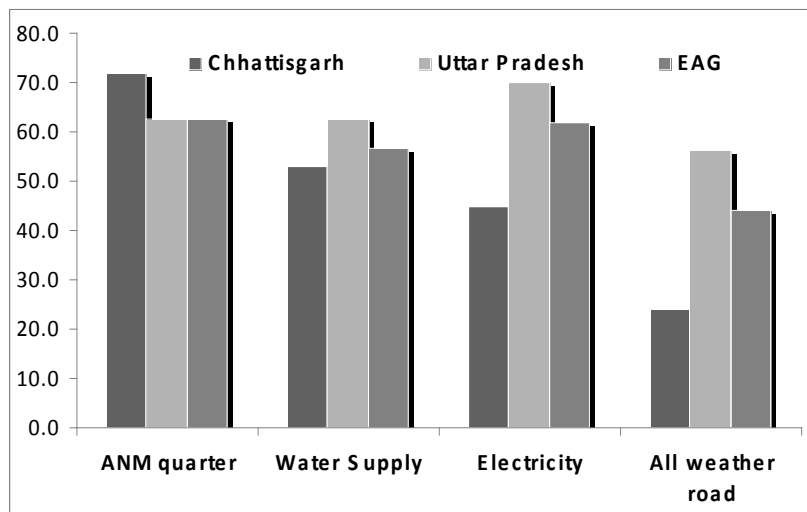
Many SHCs and PHCs were functioning without buildings of their own, either operating in rented buildings or panchayat buildings. Two-thirds of SHCs in Chhattisgarh and more than three quarters of those in Uttar Pradesh do not have buildings. This means that in Uttar Pradesh alone, more than 12,000 SHC buildings are required. Money for SHC buildings come from NRHM funds but remain underutilised. For PHCs and CHCs, the funds have to come from state budget and if new ones are to be created, the requirement for buildings/infrastructure would entail enormous funds. It would be difficult for the states to meet the requirements until and unless there are Finance Commission transfers from the Centre.

#### IV.4.2. Basic Amenities

The existing facilities lack basic amenities like staff quarters, electricity, water supply or motorable roads. More than two-thirds of the SHCs in Chhattisgarh do not have ANM quarters due to which they need to travel long distances to reach their workplace, leading to irregularities in

attendance, working for short duty hours etc. Many PHCs and SHCs are not connected with motorable roads and this hampers access to the health centres, especially during the rainy season and for people/patients with no mode of transport. (Fig IV.2)

**Fig IV.2: Basic Amenities in Sub-Centres**



Source: District Level Household and Facility Survey, Round III

#### IV.4.3. Referral Transport

RCH II policy guidelines call for provision of ambulances at PHCs, CHCs and FRUs for effective handling of EmOC. During the field study, it was found that ambulances were available in all the PHCs, CHCs and district hospitals visited but patients usually had to hire a private vehicle such as a taxi or a jeep to reach the facility. This was mainly because the government ambulances were either used for other emergencies or the driver was not available. This has cost implications and also discourages the woman concerned from accessing the facility (as in the case of Choleshwari in the previous chapter).

### IV.5. Service Providers

#### IV.5.1. ASHAs

The ASHA scheme is one of the new schemes introduced in NRHM, along the lines of the *Mitanin* programme in Chhattisgarh. The Accredited Social Health Activists (ASHAs) are village level volunteers mobilising people for institutional deliveries and are perceived as a link between the community and health service providers. ASHAs were seen to be playing an active role in both Lalitpur and Rajnandgaon. However, there was a marked difference in the way they worked in the two districts. In Lalitpur, the ASHA package had been introduced only a year back and was yet to be fully functional barring a few exceptions such as Nirendra Raja (Case Study 6). They were

active mainly due to JSY. In Rajnandgaon on the other hand, the ASHA or *mitanin* (as they are referred to in Chhattisgarh) package had been introduced in the state since 2003. The scheme has been functioning for almost five years and is running effectively.

The selection process and criteria for ASHA in the two districts differed. In Lalitpur, ASHA was usually selected by the *Pradhan* or village head (an essential criteria for her selection is that she should be a daughter/daughter-in-law of the village), and held a somewhat powerful political position since only the village head could remove her from the post. The selection criteria for ASHAs are not very strict and it is usually found that she belongs to an upper caste or a landed household. There is also no monitoring of ASHAs, as observed in the field, and she is found to be answerable to no one in particular. In contrast, the ASHA/*mitanin* in Rajnandgaon are selected in a participatory manner and their effective functioning had a trickle-down effect on JSY. Most of the women in Rajnandgaon knew about JSY and have availed of its benefits. Also, most of the *mitanins* had undergone some form of training every year. In some cases like Ratnibai Uike (Case Study 7), the *dai* had become an ASHA. It is suggested here that TBAs/*dais* who are no longer officially part of the current health structure can be brought into its fold. This may work well since a TBA/*dai* already has the prerequisite training for handling deliveries.

#### Box IV. 4

##### **Case Study 6:**

##### **Kailoni village, Barh block, Lalitpur**

Nirendra Raja is working as an ASHA since the past year in village Kailoni, Barh block. She is 28 years old, has three children and studied up to 8<sup>th</sup> standard. She is one of the few ASHA's that we found to be present and active. She was given training at the block level on immunization, nutrition, awareness generation on ANC and PNC. She has assisted in 13 deliveries from which 9 were under JSY. Incidentally, all the 9 deliveries took place at the Sub-Centre, Bhailoni (the sub-center at Bhailoni was widely preferred by most block residents). The other 4 took place at PHC, Barh and District hospital, Lalitpur respectively. We were informed that the ANM visits the village only once a month since she comes from Lalitpur. Also, the rapport between Nirendra and the AWW was not good. The AWW also comes from Lalitpur. Hence, most of the responsibilities relating to maternal and child health have fallen on Nirendra. On asked how she was selected to the post of an ASHA, she revealed that it was a more an issue of survival rather than of prestige. Since her husband was unemployed, with three children to feed and an old mother, she felt that this was the only viable option for her. However, she is yet to get paid for 3 deliveries. She mentioned that there was a huge delay in JSY payments initially. She happened to show us the cheques under JSY that she received. Her biggest dilemma is that she has not been able to encash a single one of them owing to her not having a bank account. As related by her, we assessed that the problem lay in her not being verified. Also, the bank officials did not give her any information or assistance.

## Box IV. 5

### Case Study 7:

#### Kallu Banjari village, Churia block, Rajnandgaon

Ratnibai Uike, from Kallu Banjari village in Churia block in Rajnandgaon, is 35 years old and has been a mitanin for the past three years. Prior to that, she was a TBA for 15 years having done TBA training at Churia block. She is seen to be very dedicated and hardworking. On being asked why she had decided to become a TBA, Ratnibai recounts that it was her mother-in-law who persuaded her into becoming one as she was also a TBA. Ratnibai observed the respect and recognition her mother-in-law received as a TBA, which served as one of the primary motivations. Initially, she used to only accompany and observe her mother-in-law. Later, she started going by herself especially after her mother-in-law became too old and weak to make visits.

Around three years back, Ratnibai attended a five-day mitanin training session after which she became a mitanin. She feels her work is more effective now since she can combine the skills learnt as a TBA in her new voluntary health worker's role. Besides, the contacts she makes in the village as a TBA prove helpful. Since May 2007, she has assisted in 20 deliveries under JSY.

### IV.5.2. ANM

The ANMs interviewed in both districts had more or less the same responses regarding many issues. The constraints they had to face were lack of proper infrastructural facilities such as few beds, no female doctor and overall paucity of staff. In addition, their weekly visits to the villages turned out to be an arduous task due to lack of transportation. In Lalitpur, a major problem faced by them is patient management since most patients come to the PHCs and CHCs at the last stages of pregnancy. The ANMs are hence unaware of the pregnant woman's past history. Most of the time, they have not gone through any PNC check-ups. In addition, there are problems due to lack of awareness and education among the patients. The ANMs also face pressure from the politically powerful to give them the JSY package and, in fact, feel that the maternity scheme has added to their woes. Institutional deliveries have increased overnight but the existing facilities and human resources have not been scaled up at the same level. The perception about JSY was more positive in Rajnandgaon despite shortages in infrastructure and human resources.

The main reason for shortage of ANMs at PHCs, (out of 33 sub-centres, 13 are vacant) was that there were no proper residential facilities provided. More importantly, no security guard or TBA is assigned at the sub-centre. This seriously hampers the work since the ANM does not have anyone to accompany or assist her during emergency situations, especially at night. Mostly through their own initiative, they carried out their work as in the case of Anamma of Bhailoni SHC. Barh block, Lalitpur (Case Study 8). In Rajnandgaon, the situation was slightly better, mainly because of the *mitanin* scheme. The ANMs were seen to be functioning in a cohesive manner with the *mitanins*. In both the districts however, they complained about the huge amount of paperwork and documentation such as maintaining registers. These additional duties also kept them away from their field visits.

## Box IV. 6

### **Case Study 8: Bhailoni Sub-Centre, Barh Block. Lalitpur**

Annama has been an ANM for the last 18 years at Bhailoni sub-centre, Barh Block. The sub-centre is a picture of tranquility, and surprisingly, very clean. At first glance, it has all the necessary equipment though the research team was told that there is no bed; only a table for deliveries. The other constraints which Annama faces are shortage of drugs and medical supplies, lack of proper ventilation, no power back-up and a very small room. There is also no boundary wall, which poses a security problem. She has four villages to cover that she visits twice a week. A part-time TBA, Ramku, is her trusted assistant. They both manage to handle around 30-35 deliveries a month. Since January 2007, 245 deliveries have taken place at her centre. Earlier, only the mothers who were at risk would come but with the introduction of JSY, the number has increased significantly. The most common risk after delivery was post-partum haemorrhage (PPH).

In the past 18 years, there have been 5-6 cases of C-section that were referred to the PHC or district hospital. Annama has received Rs 10,000 as untied grant twice in 10 years, used for purchase of furniture. Some other issues which came up were that there was no field supervisor and the PHC doctor would rarely pay a visit. Since the TBA hardly got paid, Annama would have to bear the extra costs. The main problem she felt was that there was no incentive to work. With no promotions or transfers, the ANMs had little motivation. She alleged that the work environment at the PHC was marred by politicking due to which she has always refused to be posted there. She is quite happy at the tiny sub-centre where she has more freedom and less interference.

*Bhailoni sub-centre is one of the few centres that had a fairly good reputation in the entire block. This was mainly attributed to the ANM's style of working and handling patients. She was considered to be very sincere in her work and also managed to make a place for herself in the village. Most of the deliveries were found to have taken place in the Bhailoni centre.*

### **IV.5.3. TBA or Dai**

The traditional birth attendant was not very visible in the entire health structure. Previously, they used to assist the ANM. However, after the ASHA package has been introduced, her role has become miniscule. The ANMs do not find the ASHAs to be of much use since they cannot assist in any delivery cases nor do they possess any technical knowledge or experience. On the other hand, TBAs have proved to be more useful as they can actually assist the ANM in deliveries. The other issue is that of low wages. The TBAs get paid a measly sum of Rs 200 for their work. Full-time TBAs in the sub-centres have been made part-time, thus increasing the workload of ANMs.

## IV.6. Lack of Skilled Human Resource

### IV.6.1. Vacancies at Service Delivery Level

A major reason for poor health services is lack of skilled service providers in the states. The situation is particularly bad in Chhattisgarh because many of the doctors who were working in undivided Madhya Pradesh (till November 2000 when Chhattisgarh was carved out of the state) left for the new MP after bifurcation. This has led to a huge number of vacancies in Chhattisgarh. If the situation regarding staff positions from 2003-04 to 2006-07 is compared, it is observed that there are increases in filled posts at every level but the increase is inadequate and huge vacancies still exist. The shortages are maximum in the case of doctors and specialists. In 2006-07, 47.7 percent of posts of doctors were vacant, compared to 64.5 percent in 2003-04. In Chhattisgarh, out of the 1,006 sanctioned posts of doctors, only 291 posts were filled, leaving 71.1 percent vacancies. The lack of skilled doctors in the state remains the single-most important factor that the state has found difficult to grapple with. Since there were no recruitment guidelines formulated at the state, no regular doctors could be appointed. Though there are efforts to appoint consultants on contractual basis to fill up the vacancies, there continues to be a dearth of doctors in the state. One of the most critical human resource gaps found at the level of CHCs and PHCs is staff nurses. The state has only 754 staff nurses for 146 CHCs and 707 PHCs.

Further, frequent transfers of multi-skilled doctors also affect functionality of the PHCs, CHCs. (Table IV.1)

**Table IV. 1: Vacancies in Skilled Service Providers in Chhattisgarh**

Group	2003-04			2006-07		
	Sanctioned	Filled Up	Vacancy	Sanctioned	Filled	Vacancy
ANMs + LHVs	5729	4667	18.5	6470	5275	18.5
MPW + Supervisor	3785	3121	17.5	4467	3149	29.5
Doctors	1455	516	64.5	2571	1345	47.7
Specialists	650	103	84.2	1006	291	71.1

Source: NRHM, Programme Implementation Plan, 2007-08, State Health Society, Chhattisgarh

The situation is almost the same at the district level. In fact, the higher the level, the greater the number of vacancies. As much as 73.7 percent sanctioned posts of Class I Medical officers are vacant, whereas 58.2 percent posts of Class II medical officers are vacant; 26.6 percent of LHV posts and 13.2 percent posts of Lady Health Workers are vacant. The medical officers were concentrated only at the level of the district hospital; out of 17 Class I medical officers working in the district, 12 were posted at the DH. (Table IV. 2)



**Table IV. 2: Vacancies of Human Resource in Rajnandgaon**

	<b>Sanctioned Posts</b>	<b>Filled</b>	<b>Vacant</b>	<b>Vacancy</b>
Class I Medical Officers	57	17	42	73.7
Class I Medical Officers Posted at the District Hospital	17	12	6	35.3
Class II Medical Officers	134	58	78	58.2
Class II Medical Officers at District level	27	13	14	51.9
Class II Non-Medical Officers	3	3	1	33.3
Nursing and Allied Staff	458	396	73	15.9
Staff Nurse	24	33	-	
LHV	64	47	17	26.6
Lady Health Workers	356	309	47	13.2

**Source:** Office of the Chief Medical Officer of Health, Rajnandgaon, 2007-08

Block level officials were of the view that lack of proper staff affects implementation greatly. In Dongargaon block, none of the three specialist posts were filled due to which, caesarean deliveries were not carried out at the CHC. In the last 20 years, there has not been a single permanent recruitment at the CHC. Activities like PPI booths also get severely affected due to vacancies and this impacts the quality. According to the Block Medical Officer of Health-BMOH, Dongargaon, the Block Programme Management Units (PMUs) were yet to be set up. One of the major problems of functioning is frequent transfers of doctors. In Rajnandgaon (from July 2006 to 2008), the Chief Medical Officer of Health (CHOM) has been transferred several times. Heavy workload and reporting requirements on the ANMs constricts service delivery activities. There are huge reporting requirements at the districts, which becomes difficult to manage in the absence of staff.

The situation is no different in Uttar Pradesh. At every level of service delivery, vacancies have been found; the vacancy levels are high with higher level of service delivery. In the first place, the state lacks in terms of CHCs and there are several vacancies for the post of specialists in the existing ones (Table IV.3). Non-functional CHCs directly impact outcomes as the community health centre is the most critical point in service delivery for reduction of maternal and child deaths. Many PHCs have been converted to CHCs without providing basic human resources and other facilities. Although many CHCs have been declared FRUs, these are still without adequate staff, particularly specialists.

**Table IV.3: Vacancies in Skilled Service Providers in UP**

Particulars	Required	In position	Shortfall	% Vacancy
Multipurpose worker (Female)/ANM at SCs & PHCs	24181	21900	2281	9.43
MPW(M) at Sub Centres	20521	5732	14789	72.07
Health Assistant (Female)/LHV at PHCs	3660	2128	1532	41.86
Health Assistant (Male) at PHCs	3660	4061	-	
Doctor at PHCs	3660	NA	NA	
Obstetricians & Gynaecologists at CHCs	386	123	263	68.1
Physicians at CHCs	386	123	263	68.1
Paediatricians at CHCs	386	13	373	96.6
Total specialists at CHCs	1544	413	1131	73.3

Source: Bulletin on Rural Health Statistics in India, March 2007

Lalitpur being one of the least developed districts in Uttar Pradesh, lack of skilled medical personnel is more prominent. Going up to the level of medical officers, higher levels of vacancy are observed. There is also an acute shortage of paramedical staff, like pharmacists and Male Health Workers. (Table IV.4)

**Table IV. 4: Vacancies in Para-medical Staff in Lalitpur**

Designation	Sanctioned Posts	Filled Posts	Vacant Posts	Vacancy
Male Health Observer	24	23	1	4.2
Male Health Worker	72	43	29	40.3
Female Health Observer	36	32	4	11.1
Female Health Worker	218	155	63	28.9
Pharmacist	29	7	22	75.9
Total	379	260	119	31.4
Vacancies in Medical Officers in Lalitpur				
Level	Sanctioned	Filled	Vacant	Vacancy
Level 1	53	43	10	18.9
Level 2	14	10	3	21.4
Level 3	11	5	6	54.5
Level 4	15	5	9	60.0
Total	93	63	28	30.1

Source: Office of Chief Medical Officer of Health, Lalitpur

## IV.6.2. Vacancies in Programme Management and Finance Staff

There are substantial vacancies in Programme and Finance Management Staff at the district and state levels. Out of seven sanctioned posts at the State Programme Management Unit, only four were filled in Chhattisgarh at the time of the survey. Out of the 16 districts, four did not have any district programme manager while in six districts each, there were no accounts or data officers. During the first three years of NRHM implementation in Uttar Pradesh, no PMUs were formed at the state and district levels. The programme management aspects were dealt with by the state Family Welfare Department and district health administration. This has led to difficulties in implementation of NRHM in the state, (This issue would be discussed in the following sections).

Lack of proper staff at all levels hamper various activities including implementation, planning, monitoring, reporting, training etc. Several instances could be found where lack of proper staff has affected implementation. For example, in four out of nine blocks in Rajnandgaon, the post of Block Educator was vacant with the job being carried out by other staff, including drivers. Naturally, the work suffers because of limited capacity in comprehending guidelines and lack of interest in reporting. Since there is no data officer and finance staff at the block level and data provided from the blocks are not accurate, this impedes the planning process as well. The audit report of the SHS at Lucknow points out that lack of programme management and accounts staff at all levels leads to poor reporting in financial data.

The issue of human resources is more complex than it seems. There are several shades to the problem. First, the states need to have huge funds to recruit quality human resources. But, it is not just a question of inadequacy of funds. Even if sufficient funds are arranged, the availability of skilled people would remain a major issue. States like Chhattisgarh simply do not produce the requisite number of doctors, nurses or paramedics to deal with the problem. This brings up the question of creating more medical and paramedical teaching institutions, which would again require huge funds, teachers etc. These things cannot be carried out on a short-term basis. Long-term planning would be crucial. Ensuring supply of human resources may be necessary to solve the problem but this may be difficult as health service providers are often reluctant to take rural postings. The presence of huge private health sector in urban areas provides them an alternative employment avenue. How to attract health professionals to public institutions in rural areas is the big question, though it can easily be said that the issue is related to working conditions under the rural health system. If doctors and nurses have to work in institutions that do not have basic amenities like quarters, basic equipment and drugs, the motivation level is bound to be low. So, the issue of human resources is closely linked to revamping the rural health system. At the same time, the problem appears to be more serious in the case of vacancies in specialist posts. One small measure can be to link PG admissions to rural postings or experience of working in rural areas. It is important to retain health professionals in public institutions, which can best be done through proper incentives, promotions etc.

### IV.6.3. Contractual Recruitments: Stop-gap Approach to Deep-rooted Problem

Though there is a recognition of these aspects under NRHM and at the level of the states, the umbrella health intervention does not pay enough attention to the magnitude of the problem by trying to recruit staff on contract or per case basis etc. These are piece-meal measures and cannot really transform the health sector. A huge amount of government posts are being filled through contracts. In fact, there is a ban on permanent recruitments under NRHM. Contracts are given only for short duration. In Uttar Pradesh, the contracts are for 11 months, the recruitments often political and the contracts seldom renewed. This leads to limited sense of responsibility and low morale. The remuneration offered is generally low and hardly attracts technical staff. As a result, posts of doctors remain vacant, as is the case with Chhattisgarh and Lalitpur district in Uttar Pradesh, though non-technical recruitments take place.

The Comptroller & Auditor General of India (CAG), in its mid-term review of NRHM, has made the following observations:

In five states/union territories (Chhattisgarh, D & N Haveli, Gujarat, Madhya Pradesh and Puducherry), 29 to 57 percent of contractual staff left before completion of their contract period. As the delivery of public health services requires continuous presence of service personnel, high turnover of the contractual manpower especially of medical officers would make quality service delivery difficult. (page 67, CAG, GoI, Report No. 8 of 2009-10)

These are serious comments made by the premier audit authority of the country. For instance, the data staff at the SHS, Lucknow, are recruited on contract. During the study team's visit to the state, the data manager had left his job before his tenure could get over. In his absence, the state unit could not provide any information on fund utilisation in the state. Similarly, the State Programme Manager and State Finance Manager of Chhattisgarh left their jobs in the middle of the study tour, leading to irregularities and delays. If such important positions are not filled on long-term basis without adequate remuneration and incentives, long-term programme implementation and planning cannot take place properly.

### IV.7. Lack of Capacity Building and Training

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The health system at the levels of the states and districts clearly lacks the capacity in dealing with the emerging managerial, accounting and planning challenges in NRHM. There is a recognition of the problem at the state level but the situation is yet to change. Chhattisgarh lacks adequate training facilities at the state level. Although the State Institute of Health and Family Welfare (SIHFW) is established, there is only one sanctioned post, i.e. the Director. The SIHFW also lacks a proper training faculty and experts. Besides, the slow pace and unsatisfactory quality of district level training of doctors and paramedics impedes effective implementation. There are several instances where lack of training has affected implementation at every level. The pilot project of the Unicef's Integrated Management of Neonatal and Childhood Illnesses

(IMNCI) training started in Rajnandgaon was discontinued abruptly after the fourth round. IMNCI training has been carried out for *Mitanins* but such training has not been organised for doctors. Rajnandgaon district has been supplied with zinc tablets, but with no training on its administration, the medicines remain unused. Contractual doctors have been appointed but they remain untrained. These instances highlight the need for training and capacity building and the issue of proper planning of training activities, which would influence the quality of implementation under the scheme.

## IV.8. Bottlenecks in District Level Planning

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There is a lack of capacity at the state to train district level officials, along with a shortage in adequate training of staff at the district and sub-district levels. The task of translating physical interventions into financial requirements continues to be done mechanically. There is a lack of capacity at most levels to appraise plans submitted by the lower levels. The amount of time and effort required for carrying out bottom-up planning is not adequately provided for, owing to excessive workload and non-availability of crucial staff (e.g. SPM/DPM, Finance Officer, and Data Officers). In any financial year, the period during which planning for the next financial year is done, i.e., the last two quarters, is very hectic as most of the programme implementation activities are also simultaneously taking place around that time.

Until 2008-09, district PIPs were not formed in Chhattisgarh. A technical group coordinated by the State Human Rights Commission (SHRC) comprising SIHFW, Unicef, RRC for RCH together with the NRHM/RCH Programme Management Unit, initiated the planning process from January 2008. The programme teams of various national programmes were part of this process. Three consultative meetings were held besides rigorous correspondence and discussions among various stakeholders. Although the process of formulating the state PIP for 2008-09 was done in consultation with district level officials, the district PIP is not yet formulated. Thus, the concept of formulating the state PIP by compiling district PIPs remains merely a concept! Even the kind of consultations required to prepare PIPs were not carried out in 2006-07 and 2007-08. As a result, the National Programme Coordination Committee proposed several changes in the PIPs for 2006-07 and 2007-08. Due to non-formulation of district level PIP, the allocation of funds also remains arbitrary. There are instances of funds being disbursed to Rajnandgaon for activities completely irrelevant for the district.

In Uttar Pradesh, both at the SHS and at Lalitpur, PIP preparation is seen as a standalone process. In the first place, the state PIP is not a consolidation of district PIPs and to top it, the PIP is not consulted for fund disbursement. In most of the districts including Lalitpur, preparation of PIPs have been outsourced to some agencies, thus undermining the entire concept of bottom-up planning. The latest CAG report on NRHM recognises this issue.

## IV.9. Absence of Programme Management Units

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One of the glaring problems of implementation of NRHM in Uttar Pradesh is the lack of Programme Management Units at the state and district levels and dedicated staff for management and finance. Most of the activities are being done with the help of line department officials. Due to this, several concerns emerge.

- The state PIPs are formed without much consultation. There is hardly any link between the PIP so formulated, and funds allocated to the districts.
- There is no dedicated staff to look into the financial and management aspects of NRHM, leading to enormous delays in disbursement of funds, submission of reporting requirements, perusal of demands for funds from the bottom, to name a few.
- There are over ten accounts maintained in the state society making it difficult to manage these properly.
- Maintenance of reports and data are extremely poor. The State Health Society could not provide the survey team requisite financial data for 2006-07 since the data officer, appointed on an eleven-month contract, had left the job. This clearly shows the lack of coordination between different functionaries and the futility of appointing contractual staff for such a short duration.
- No official in the entire state could provide the survey team any insight on implementation of NRHM on the whole (this includes the Mission Director and Additional Director). As a result, no significant observation could be derived from interactions with the state and district officials.
- There is clearly a lack of sense of belongingness among officials for the Mission that gets reflected in the vague and indifferent responses provided during the interactions.
- Lack of dedicated management and accounts staff at the district and block levels result in poor reporting of financial data. In most cases, releases are considered as spending and reported accordingly.

## IV.10. Delays in Transfer of Funds

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### Uttar Pradesh

Involvement of multiple line departments and hence, numerous windows, thereby causing huge delays:

- The sanction orders reach the office of the Principal Secretary that are then passed on to the department heads to subsequently reach the respective sections.

- The section prepares the fund requirements for the districts and submits it to the Mission Director, who after sanctioning it, sends it to the Finance Department.
- This then goes to the section concerned that issues Sanction Letters, which are sent manually to the districts; the funds are transferred electronically.
- Funds are still being sent based on demands from the districts, an individual demand for a specific activity being sent separately. This means that there are a large number of releases leading to unnecessary complexity in fund management, especially at the district level. After the demand letters reach the Programme Officer in the state, it takes, on an average, 70 days for the funds to be sanctioned.
- The process of sending manual sanction letters also causes delay. There is always a gap in receiving sanction letters and funds reaching the bank account of the district. In 2007-08, on an average, there was a delay of 16.4 days in the process of receiving funds and the sanction letters.
- Funds that have once reached the district are further delayed before being disbursed to the blocks. In 2007-08, funds were sent to the blocks and other implementation offices in the district in 34 instalments. Considering all such transfers, the average delay works out to be 38.32 days. Instances of delays of as much as 189 days are also reported.

## **Chhattisgarh**

Funds at the state level lie idle. Though there are norms that the state is bound to disburse funds within a fortnight of the receipt of funds from the Centre, this does not happen all the time. There are several reasons for delay that could be identified through interactions with state level officials. Allocation of funds to districts takes place on the basis of funds unspent at the district in the absence of the District PIP. At times, districts fail to provide expenditure details in time. Since allocations are made only when reports from all the districts arrive, a delay in reporting by some districts causes delays pertaining to receipt of money for all the districts. In some of the schemes like JSY and FP Compensation, districts need to send demands and funds are sent only when all the district demands arrive. This also leads to delay. Delays in sending funds to districts may be to the tune of 26 days, even 48 days or more.

In Chhattisgarh, electronic transfer of funds from SHS, Raipur to the districts was introduced in October 2007. Before that, funds were disbursed through cheque mode. The process of sending funds through cheque caused huge delays. There are instances of delays to the extent of 78 days. In 2007-08, before electronic fund transfer was introduced, 23 days were lost on an average. In 2006-07, the average delay was of 16 days, with the maximum being of 76 days. A comparison of fund transfers in the *Mitanin* Programme in 2007-08 shows that introduction of electronic transfer has reduced delays in transaction. The discussions in the previous chapter, however, point out that this alone cannot control all the delays caused at various levels.

Funds lie idle in the bank account of the DHS for several days. For instance, under the *Mitanin* Programme, funds received on 18<sup>th</sup> May were disbursed on 8<sup>th</sup> August. DHS being the nodal point of implementation of the programme, the delay can be due to several reasons. Funds are transferred through cheques, through direct communication to the development blocks, reducing the days of delay to a minimum. In the absence of the Health Management Information System (HMIS) of the Ministry of Health and Family Welfare' (MHFW) and internet banking at the block level, informal communications and direct contact smoothen the process. Overall, a review of the process of fund flow reveals that it takes two to three months for funds to reach the blocks.

#### **IV.11. Delays in Fulfilling Reporting Requirements**

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The state needs to streamline the audit mechanism for finalising the audit reports and getting the status of unspent balances. There are huge delays in submission of Audit Reports, FMRs in Uttar Pradesh. For instance, the audit report for 2005-06 had been submitted on December 29<sup>th</sup>, 2006 with a delay of 151 days (the due date for its submission was July 31<sup>st</sup>, 2006). The audit report for 2006-07 was submitted on October 29<sup>th</sup>, 2007 with a delay of 90 days. Delay in submission of Quarterly Progress Report (QPR) has reduced in 2007-08 compared to 2006-07, though delays average 12 to 17 days in both the years.

In Chhattisgarh, the audit report for 2005-06 was submitted on November 23<sup>rd</sup>, 2006 with a delay of 115 days (the due date for its submission was July 31<sup>st</sup>, 2006). The audit report for 2006-07 was submitted on November 14<sup>th</sup>, 2007 with a delay of 106 days. Delays in submission of QPR has been in the range of 102 to 194 days for the first two quarters, but in 2006-07, there were 64 days and 27 days of delay in submission of the first two QPRs respectively. In 2007-08, the QPR for the first quarter had not been sent till May 2008.

#### **IV.12. Inappropriate maintenance of accounts**

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The audit processes under NRHM is carried out by independent chartered accountants, thus bypassing the state audit processes. The Audit Reports of the Empowered Action Committee of RCH in Uttar Pradesh conducted for 2005-06 and 2006-07 have come up with important observations:

- The maintenance of books of account at various levels is not satisfactory. At the district level, maintenance of ledgers, subsidiary records and documents, periodical reconciliation of bank accounts, submission of SoE is not up to the mark.
- During examination of supporting vouchers, it was observed that payments have been made to contractors before obtaining technical completion reports.
- For advertisement on Doordarshan and All India Radio, parties were selected without seeking competitive bidding.



- SoEs are not prepared on the basis of information derived from cash books and ledgers but on cheques issue register.
- There are expenditure on account of JSY, compensation for sterilisation at the PHCs and CHCs. The receipts from beneficiaries are not obtained in time; further, these receipts are not maintained properly. Receipts have not been properly documented against payment of honorarium to ASHAs.
- Bank accounts were not reconciled during the FY 2006-07 resulting in non-passing of outstanding entries periodically.
- Funds amounting to Rs 14.71 crore have been spent on training of ASHAs without any record of attendance.
- During verification of letters (dated 30.09.05) received from Unicef for utilisation of Rs 1,54,13,634.00 against payment of Rs.1,90,00,000.00 under the head IIP in 2004-05. it was observed that UC enclosed was on provisional basis. Moreover, no bills and vouchers were enclosed.

#### IV.13. Procedures and Guidelines related to Delays

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According to the Joint Review Mission Report, there is no clarity in procedures and guidelines for utilisation of untied funds. (Refer to Box IV.7) This has been observed during the survey team's discussion with district and block level officials also. Unclear guidelines have led to underutilisation of funds for 2006-07 and 2007-08. Further, most of the Central guidelines are in English and written in very bureaucratic language, making it difficult for lower level officials to follow.

CMOs are not aware of administrative and financial powers as Mission Directors. Most of the CMOs are acting as CMO 'in charge', and hence, do not have the authority to sign. This causes huge delays in implementation (Joint Review Mission, RCH II).

The Union Government had provided six percent of the Flexible Pool to the State as Programme Management Cost. The SHS did not share this fund with the districts till March 2008. In Rajnandgaon, the expenses were borne though income from interests.

Lack of contingency funds affected office work (DPM, Rajnandgaon). Guidelines for JSY have changed several times since the introduction of the scheme in Chhattisgarh. Initially, ANMs were allotted cash without proper appraisal. There were huge delays in reporting, causing delays in getting further instalments. Currently, bearer cheques are being issued to beneficiaries at the block level. However, there continue to be limitations in sending vouchers on time.

## Box IV. 7

### Utilisation of Untied Funds in Rajnandgaon

Several implementation issues came up in the analysis of utilisation of untied funds. Based on an analysis of expenditure trends at the state and the district levels, there is huge underutilisation of untied funds. The untied funds are quite unique in nature for the health system, providing for autonomy to ground level staff to spend according to their local needs. This is in variance with the usual forms of funds where there are pre-assigned tasks identified with the available funds.

In the absence of clear-cut guidelines from the upper tiers of administration, the ANMs at the SHCs or the doctors at the PHCs are unable to utilise the fund. Since the untied fund is operated through a joint account in the name of the *sarpanch* (elected head of the *Gram Panchayat*, or village assembly), the involvement of Panchayati Raj Institutions (PRI) is very crucial. Occasionally, funds remain unspent also because of non-cooperation of PRI members, according to some of the ANMs interviewed. It was noted in Chhattisgarh that unnecessary items were procured with the untied funds. The state level officials intervened to stop these activities. At times, plans prepared at lower level have been rejected at the higher level. For instance, the proposal for utilisation of untied funds for District Hospital, Rajnandgaon, which was approved by the district magistrate was rejected by the NRHM review team. This points to the limited capacity of implementation level officials to plan their priorities and take administrative decisions.

**Table IV.5 : Expenditure on Untied Fund in Rajnandgaon**

SHC Mohad, Dongargaon			SHC Salhota, Chhuriya		
Date of received	Amount Received	Expenditure	Date of received	Amount Received	Expenditure
08.12.05	10000	1500	29.03.06	10000	9000
12.04.06	8800	15000	03.05.06	8800	
14.03.08	10000	4000	24.03.08	10000	
Total	28800	20500	Total	28800	9000

**Source:** Office of Chief Medical Officer of Health, Rajnandgaon

Table IV.5 above depicts the utilisation of untied funds in two SHCs. Though the utilisation is quite high at Mohad SHC located in Dongargaon, in Salhota the utilisation has remained very low. Mohad where the SC is functional since 38 years, and with a permanent building and senior ANM could utilised most part of the fund in the maintenance and construction activities. Whereas the reason for underutilisation cited at Salhota is the absence of a building of its own, which limits the possibilities of maintenance and repairing work.

## IV.14. Conclusion

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Several important inferences regarding maternal and child health, especially in EAG states, can be drawn from the foregoing field observations and data analysis. Awareness of ANC was found to be weak in both the states although it was a lot more in Chhattisgarh. Visits to ANMs for check-ups at the time of pregnancy were found only in a few instances. The importance on JSY has drawn lots of energy within the health system and, as a consequence, the focus on ANC got reduced. Similarly, woman's health and nutrition was found to be extremely poor and neglected. The foodgrains pregnant and lactating women were entitled to from the *Anganwadi* Centre hardly reached them, many of whom were not even about it. The absence of the TBA/*dai* in the entire maternal health service delivery structure has overburdened the ANM to a large extent. The ASHA has not been able to fill the gap that has arisen. Except in the case of JSY, there was a lack of clarity on the exact role of ASHA. The ANM, ASHA, and AWW were not seen to be working in a cohesive manner. The acute shortage of staff in PHCs, CHCs and district hospitals, specifically for maternal health, was found to be a major constraint.

In both the states, since the introduction of JSY, there has undoubtedly been an increase in institutional delivery. Unfortunately, the institutions lack basic facilities and human resources, and could not cope with the increase in deliveries. The main incentive for reaching the institution is not safe delivery but the cash benefit under JSY. Though there is hardly any benefit, institutional delivery in any case costs a substantial amount of money and home deliveries are cheaper. In the process of overemphasising on institutional delivery, the emphasis on ANC has gone down and its coverage has reduced over the years. This is linked to the increased workload of the service providers.

Overall, the health institutions have not been strengthened but put to a tougher task under NRHM. While the current mechanism talks about system strengthening, it has overlooked one of the most significant issues - creation of skilled human resources. Stopping permanent recruitment, closing down training institutions, bypassing the bottom-up planning approach has created a weak system. Further, there is no accountability towards the people; the issues of decentralisation and social auditing are grossly neglected. The audit process is highly diluted, the records are not properly maintained and there is rampant corruption in the system.



## Conclusion

The rural health system in India has undergone various changes since the introduction of NRHM. Most visible of these changes is that women are beginning to go to institutions for delivery – there has been a significant increase in institutional delivery in the study states, Uttar Pradesh and Chhattisgarh. The other important development is the recruitment of ASHAs or village level volunteers. These developments, whether promising or not, need to be examined in perspective since the reasons for not accessing health institutions in the past are well documented. Some of these are also observed through the study – distance from institutions, lack of transport, ill-equipped institutions, absence of staff, informal payments, costs of medicines and indifferent attitude of service providers. Some stakeholders argue that women are going to the institutions because of the monetary gains assured to them through JSY. But this argument underestimates the fact that it has generated positive enthusiasm. The public health system, which hitherto offered no incentives, is now offering cash benefits to access the services. Considering that government health institutions are the only option for a vast majority, JSY has in a way successfully drawn them in, and brought pressure on the system to deliver.

This was noted during the study team's interaction with the Deputy Medical Officer of Lalitpur district in Uttar Pradesh. He complained that since JSY was introduced, it had caused tension among the community and the health administration even faced “gherao” (picketing protests) over the issue. He said there was a delay in payment for six months (2006-07) due to unavailability of funds from the state, due to which the people agitated. This was unprecedented “as people are generally very cooperative here”, he explained. A scrutiny of accounts records at the district level showed that there were delays in funds transfer from the state. The district office on the other hand, was neither prepared nor had adequate funds to support the phenomenal increase in institutional deliveries. The example reflects that the people have hopes and aspirations from the system, some of which are expressed through anger.

The question is whether the health system is equipped to cope with the increased pressure. The present study indicates that it is not in several respects. There are not enough beds at the health centres; there is an acute scarcity of doctors, trained staff nurses; ANMs; PHCs have been upgraded to CHCs or FRUs without any concrete improvement and so on. A number of other studies have also pointed out the problems of institutional delivery post JSY. How are these issues to be addressed? Should JSY be discarded because it has brought to the fore the problems of the crippled health institutions or accepted because it has moderately succeeded in bringing

the targeted people to the institutions? And, should coverage of ANC be a parameter for policy adjustment?

Field observations and accounts at the districts show that ANC levels have gone down and ANMs have failed to cope with the increased pressure due to institutional deliveries. It seems that the focus of the entire system is only on JSY. Several PHCs and SHCs reported lack of TT injections for a considerable period during the financial year(s) covered by the study. The role of TBAs has also been clearly neglected. ASHAs are expected to replace them, which seems unlikely, at least for the time being.

Both Chhattisgarh and Uttar Pradesh are characterised by MMRs in the range of 350-plus per one lakh live births, very low levels of institutional births, insufficient coverage of ANC. The situation calls for remedial action from the State and poses key challenges like building the rural health institutions afresh, with a special focus on backward states. The introduction of NRHM was recognition of this problem, at least on paper. At this juncture, a review of the NRHM objectives for strengthening the institutions, and incongruities thereof, is required. The Mission Framework document envisages a wide range of issues including conversion of CHCs into FRUs with EmOC, to provide adequate human resources and training of staff at various levels, improvement of programme management, decentralised planning, monitoring and implementation. But its goals often get hindered in the implementation strategies. For example, NRHM asks states to fill human resource vacancies and infrastructural gaps themselves but only offers contractual appointments of AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) doctors and additional consultants, without addressing the ramifications.

How do the states fill vacancies? Chhattisgarh has 85 percent of specialists and two-thirds of MO posts vacant while supply of doctors is also limited as it has only two medical colleges. The situation is no different in Uttar Pradesh or any other EAG state. The states try to address these issues through piecemeal measures, knowing well that the financial requirements for setting up medical colleges or nursing colleges and recruiting doctors/paramedical staff on a large scale are beyond their capacity. Much of the responsibility to increase the number of beds and create new institutions also lies with the states. At the current level of public spending on health, which as a share of GDP is among the lowest in the world, the ambitious targets cannot be reached.

Unless there are Central government initiatives to provide adequate funds through Finance Commission transfers or allowing states to borrow significantly along with a quantum increase in overall public spending on health, the situation is unlikely to improve. On the contrary, until recently, there was a restriction on states to increase spending under the Fiscal Responsibility and Budget Management (FRBM) Act. The share of states in total spending on health has also reduced continuously over the last five years, indicating that they are incapable of addressing the issue themselves. These aspects are nowhere in the current discourse of NRHM and institutional strengthening as desired by the Mission will not take place until these larger issues are addressed.

As already mentioned, there has been some growth in the funds disbursed to the states after NRHM was rolled out. But, the increase in spending at the state, district and block levels is not adequate, leaving huge unspent balances. The quarterly break-up of fund flow shows that a bulk of the funds reaches the districts only during the latter part of the financial year, hampering the ability to spend. A major bottleneck is wide-scale vacancies, related to which is the issue of capacity building of staff to deal with the boost in level of spending and comprehending the advance guidelines of NRHM. District level planning, which was absent earlier, has been introduced under NRHM. Unfortunately, the process has not shaped up properly in Chhattisgarh, mainly due to lack of initiative from the state and capacity of officials to plan and appraise plans. In Uttar Pradesh, the absence of a proper State Programme Management Unit has led to a chaotic situation. Unclear guidelines, for instance regarding untied funds at various levels, have caused delays in fund utilisation. Utilisation has also been more in activities in the form of entitlements like JSY and Family Planning or activities run on Mission mode like Pulse Polio Immunisation. Activities that require innovation have largely remained underutilised.

These observations can be viewed from two angles. While Central government representatives cite underutilisation as the reason for less fund allocations to the states, it can alternatively be argued that there is a need to enhance the absorptive capacities of states. However, the lack of absorptive capacity of the state is an outcome of chronic lack of investment on fundamental issues of infrastructure, availability of drugs, skilled human resource etc. Improving absorptive capacity is a long-term process and would require sustained efforts towards strengthening management and institutional capacities, filling up of vacant posts, higher salaries, much greater expenditure on drugs and other consumables etc. States that have some system in place have made better use of the current mechanism while others have failed. Ironically, NRHM, which was meant for strengthening health systems in states with greater developmental deficits, has ended up enhancing those very deficits.

NRHM lays enormous emphasis on timely reporting, timely completion of audits and electronic transfer of funds. Electronic transfer of funds, it has been observed in the study, can reduce delays in transfer of funds to some extent but it is not sufficient. For several reasons, the funds remain idle at various levels, especially at the state level. One of the key reasons can be the implementation framework itself.

The standard criticism of Centrally Sponsored Schemes is that they are not geared to meeting the priorities of the states due to which the states do not endorse them. NRHM tries to address this problem through the concept of 'flexible pool', whereby the states would be provided with lump sum funds that can be spent as per their priorities. NRHM also proposed bottom-up planning, starting from the village level up to the state. In this model of decentralisation, districts are supposed to play a pivotal role. It proposed that funds would be disbursed to districts as flexible pool, i.e., lump sum amount to be spent according to the District PIP.

In reality however, District Plans were either not made (Chhattisgarh) or were a standalone process (Uttar Pradesh), prepared in haste and dumped soon after. Prior to NRHM, the state bureaucracy was used to disburse funds according to activities and continued to do so even under Mission mode. Given the wide range of aspects that are covered by NRHM, most states have more than 150 activities. In a state like Uttar Pradesh, which has more than 70 districts, funds disbursement for 150-odd activities is a mammoth task. It becomes even more complicated because of the reporting requirements and absence of adequate staff. In order avoid multi-tasking, state level officials to wait for reporting from the districts and then simultaneously send funds to all of them. With variation in the level of spending across districts, this practice causes significant delays.



## Policy Suggestions

**B**ased on the research and field observations of this study, some important areas have been identified that need to be urgently addressed to make even a perceptible difference in the maternal health service delivery system of the country, especially in low-performing states.. These are:

**Financing:** There is an overwhelming emphasis on mechanisms of fund transfer under NRHM. This cannot be an end in itself and speedy transfer of funds is ultimately linked with proper planning and its execution as also employing the required workforce at crucial nodes. The overall spending on health should increase substantially to ensure universal access to safe motherhood. The financing mechanism should reflect a rights-based approach rather than the practice of targeted interventions currently being pursued. Infrastructure and human resources should be accorded greater priority in fund allocations. Total public spending on health as a proportion of GDP should at least be stepped up to the developing country averages (2.5-3%). This would however not be sufficient but can be seen as a intermediate goal.

**Janani Suraksha Yojana:** The scheme needs significant rethinking. Findings from the field and NSSO suggest that the initiatives under JSY are far from adequate and entitlements should be hiked. Payments should be made at various stages of pregnancy so that nutrition and ANC get due attention. Entitlement for women should increase substantially to meet the expenses incurred during pregnancy, wage compensation for the pregnant woman.

**Human Resources:** Special attention should be given to fulfil human resource vacancies at various levels. Reviving public medical education would be crucial towards this. Public service for a few years, particularly in rural and backward areas, can be made mandatory for doctors to get registration. The focus should be on training and upgrading skills of existing staff, for which training institutes at the state level can be revived and new ones set up. Adequate incentives should be provided to medical and paramedical staff to encourage rural and difficult area postings. Emphasis should also be on permanent recruitment or long-term contract at every level.

**Nutrition:** Nutrition of pregnant women and lactating mothers require greater attention. Strengthening the Public Distribution System is essential in this regard. The existing scheme of SNP needs to be given due importance. Pregnant/nursing women can be provided cooked meals to ensure food and nutrition security.

**Social Security:** Social Security for women in the unorganised sector can be a major step towards safe motherhood. Maternity leaves, crèches, wage compensation for ANC check-ups should be part of the safe motherhood agenda.

**Transport:** Every sub-centre and PHC should be equipped with well-functioning ambulance facilities. Village panchayats can also be provided with ambulances. Ambulances should be connected with helplines and ASHAs, TBAs should be provided with calling facilities to access ambulances.

**Drugs:** Ensuring availability of TT injections and IFA tablets remain a major challenge to improve ANC coverage. The drugs and medicines should be free of cost to all beneficiaries. The practice of forcing patients to purchase drugs should be checked and proper and adequate supply ensured.

Overall, the health institutions have not been strengthened but put to a tougher task under NRHM. Even though in letter it talks about system strengthening, the current mechanism has overlooked the most significant issue – creation of skilled human resources. The ban on permanent recruitments, closing down training institutions, bypassing the bottom-up planning approach have all contributed to weakening an already debilitated system. Further, there is no accountability towards the people; the issues of decentralisation and social auditing are grossly neglected. The audit process is highly diluted, the records are not properly maintained, and there is huge corruption in the system. A rearrangement of the financial mechanism with greater share of states and redoubled emphasis on decentralisation may be pointers for a future roadmap on the government's maternal health interventions in the country.

*Ultimately, the State has the collective moral responsibility to improve the life chances of poor wage labourers like Kiran Devi. If it does not perform its duties to ensure the rights of pregnant and nursing women to health, food and nutrition; to ensure them social security and meet the education, health other basic requirements of their children, the Kiran Devis of the country would continue to suffer or even die for something so natural like childbirth.*

NRHM is at best a small step forward in the endeavour to guarantee universal access to health. A quantum jump in health spending would be crucial to supplement the measures initiated through umbrella health intervention.

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