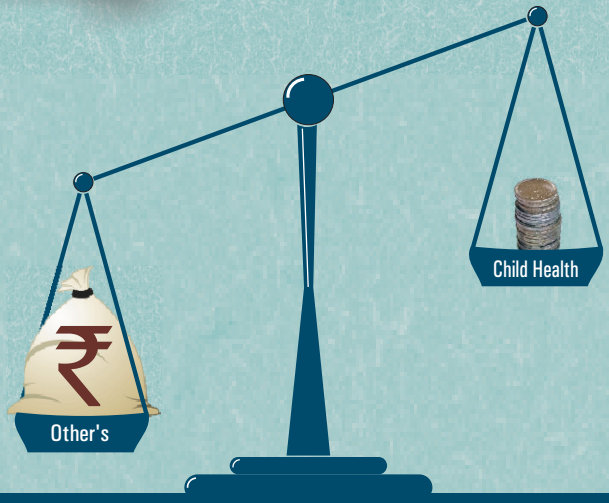
Probing Child Health Situation in Madhya Pradesh

Budget Analysis for Child Health in Madhya Pradesh

(2007-08 to 2010-11).



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Final Report Writing and Editing : **Pallavi K. Mali**

Support : **Seema Jain, Jitendra Shrivastava, Deepa Pohankar, Apara Vijaywargiya, Sachin Jain, Rolly Shivhare**

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Vikas Samvad
E-7/226, Opp. Dhanvantri Complex,
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Phone- 91 755 4252789 / Email- vikassamvad@gmail.com / Website- www.mediaforrights.org
&
Sanket Centre for Budget Studies
E- 7/698, Arera Colony, Bhopal -462016 Madhya Pradesh
Phone- 0755- 2468050 / Email- bhopal@sanketmail.com

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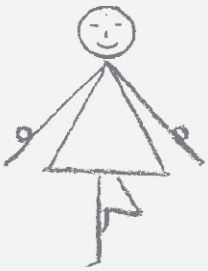

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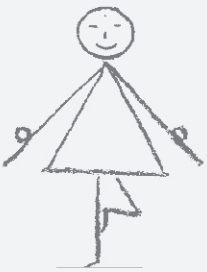

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Executive Summary

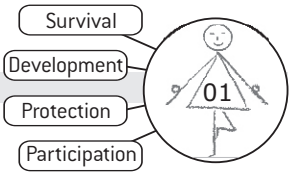
The worrisome situation of child health (0-6 years) in Madhya Pradesh needs immediate attention owing to dismal performance on various child related outcome indicators. In such a situation, state investment on child health is most desirable social investment. But against the backdrop of poor health of children, state's expenditure on child health including expenditure from own offers and from central pool under NRHM/RCH-II is not very encouraging. Analysis of state budget reveals that on an average state is spending 15.94 percent of the total state budget (ava for 2001-02 to 2008-09) per annum on children. However the spending on child health does not even constitute one percent of total budget for children. NRHM/ RCH-II is especially designed to bring considerable improvements in the maternal and child health indicators in rural areas. However, even under NRHM/RCH-II, the average spending on child health component is 4.6 percent during 2007-08 to 2010-11.

The in-depth analysis of the Budget for Children for various components of child health in the state (through State budget as well as including NRHM/RCH-II) reveals following hard-hitting facts about spending on Child health in Madhya Pradesh:

- Total spending on child health and development comes to 1.6% by adding NRHM component and total state budget together. This miniscule spending indicates negligence in state priority resulting into appalling outcomes reflected through related indicators.
- Since last four years, Govt. of MP is spending only 14 paise per day on health of 0-6 years children.
- For nutrition and other child welfare schemes also the situation is not satisfactory as only Rs. 2.88 are being spent per child per day. According to Central Govt. norms it should be Rs. 4 /day for nutrition only.
- During 2007-08 State Govt. alloted 50% of health budget under NRHM for procurement of life saving drugs & essential equipments for neonates & children under 5 years. Rs. 5.46 crore were alloted for the purpose and only 0.3% of this amount could be spent.
- For implementing child health programmes in tribal belts of the state, the provision of merely Rs. 8.75 crore and Rs. 18.20 crore has been made in 2007-08 and 2008-09 respectively under tribal RCH. However, it is miserable fact that no budget provisions was made for it during 2009-10 and a miniscule allocation in 2010-11.
- Urban children are also exposed to vulnerable health conditions but urban RCH constitute a very miserable proportion of total child health budget under NRHM/RCH-II and shows steady decline from 2007-08 till 2010-11.

- During the three consecutive financial years from 2007-08 to 2009-10, infrastructure and maintenance was found to be most prioritized component both in terms of allocation and expenditure with year on year increase.
- The actual expenditure on the procurement of medicines remains negligible.
- In-spite of huge gaps in human resource in health sector, no allocations were made during 2007-08 to 2009-10 to appoint medical and para-medical staff specialized in child health care like paediatrician, trained nurses for new born care units etc.
- The overall analysis of the allocation and expenditure on child health interventions in terms of physical achievements of set targets demonstrate that though on an average more then 75% of the allocated budget under NRHM/RCH-II has been utilized but the average achievements for physical targets remains less then 20% between 2007-08 to 2009-10.

The state is the primary duty-bearer and accountable for the realization of all rights of children. The realization of good governance for children is not possible without appropriate budget allocations and expenditure for child health interventions. Thus the analysis of child health budget in a state like Madhya Pradesh (with alarming conditions of child health) helps to reflect the need for policy priorities, efficiency of governance structure/institutions and effective decentralization for delivering child health services and of course the appropriate budget (including state budget and NRHM) for various components of child health.



1. Introduction

India is committed to the cause of children with provisions for development, care and protection in our constitution which emphasizes on the children's right to highest attainable standards of health. The Government of India has also ratified the Convention on the Rights of the Child on 12 November 1992 which further revalidates the rights guaranteed to children by the Constitution of India. National and State legislation are reviewed to bring it in line with provisions of the Convention and places responsibility on the state to combat malnutrition and childhood illnesses. The fourth goal of UN Millennium Development Goals (MDG-4) also aims to reduce Child Mortality by two-thirds between 1990 and 2015. The corresponding indicators are Under-five Mortality Rate, Infant Mortality Rate (IMR) and proportion of children under five who are immunized against six fatal diseases.

Child Health and Survival is a key to reflection of socio-economic development of any society or a state. Although India has made significant progress in improving maternal and child health indicators, the children in Madhya Pradesh on the other hand are still struggling hard to survive and develop into capable citizens. High proportion of new born and infant mortality along with chronic malnutrition has become a synonymous of child health situation in Madhya Pradesh. Future of the children is at stake owing to dismal performance of the state on various child related outcome indicators when compared to other state, national and international standards. Very particularly this holds true in case of child health and child development.

India's progress report on the UN MDGs, 2005 identifies following that will factors help reducing the prevalence of infant & child mortality are;

- Adequate maternal & new born care.
- Promotion of Safe Institutional deliveries.
- Prevent neonatal diseases.
- Access to quality healthcare.
- Decrease malnutrition.
- Birth Weight.
- Reducing the neonatal mortality rate.

With the objectives to improve the nutritional and health status of children in the age-group 0-6 years and to break the vicious cycle of malnutrition, morbidity and mortality in India the Integrated Child Development Services (ICDS) Scheme was launched in 1975. Number of child health interventions were initiated thereafter across the country. Madhya Pradesh has unlikely to be at par with state's poor performance on various child health indicators like IMR, U5MR, high prevalence of anaemia and chronic hunger among children. According to census 2011, the population of Madhya Pradesh is 72.5 million and child population of MP constitutes 14.5% to its total population. The sex ratio[1] of Madhya Pradesh has shown corrective improvement from 919 during 2001 to 930/1000 in 2011.However child sex ratio (0-6) is 912 per thousand boys which indicates decline of 20 points during the same period which is a critical.

[1]Provisional Data, Census of India , 2011, Government of India

Recent survey conducted by the National Institute of Nutrition, Hyderabad shows a slight decline of 8.23 percent in the existing malnutrition levels as compared to NFHS-3. This means that still more than seven lakh children continue to be grossly underfed in the state.

Alarming Facts on Child Health

- At present 51.77 percent children in Madhya Pradesh are malnourished out of which 8.34 percent comes under the category of severely malnourished[2].
- MP ranks second with 74.1 percent children being anaemic under five years of age*.
- State ranks second with under five mortality rate at 89per 1000 child population**.
- Infant Mortality Rate is also highest in Madhya Pradesh with 62 per thousand live birth***.

The concern of child health in Madhya Pradesh has been well corroborated from the findings of various empirical studies, reports and surveys. Thus, probing into the situation of child health is urgent and important because of considerable size of child population in the state. **Children[3] (0-6 years) in Madhya Pradesh, constitute about 14.5 percent of total population according to Census 2011 that comes around 10.54 million in numbers indicating a decline of 3.1 percent in males and 3.6 percent in females, over Census 2001.**

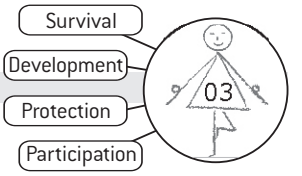
State's investment on child health is most desirable social investment for a prosperous and sustainable society. But against the backdrop of poor health of children, state's expenditure on child health is not encouraging too. Analysis of state budget reveals that on an average state is spending Rs. 4095 crores **i.e 15.94 percent of the total state budget (ava for 2001-02 to 2008-09) per annum on children[4].** Among different sector of child budget, the proportionate constitution of child health (0.72%) and child development (8.18%) is very minuscule.

Madhya Pradesh is positioned at lower ends in terms of per child expenditure (ava for the period 2004-05 to 2008-09) among the states like UP, HP, AP, Orissa, West Bengal and Assam. **The state is spending Rs 404 on child development and merely Rs 15.02 on child health on every child every year** as revealed by the study titled "Budget for Children in Madhya Pradesh", 2010 by Sanket Centre for Budget Studies, Bhopal[5].

2. Ground Realities of Child Health in M.P. : Annual Health Survey

Latest released data of Annual heath survey; 2010-11[6] depicts the shocking results in context of Infant Mortality Rate (IMR), Child Mortality Rate (CMR/U5MR) and Neo Natal Mortality Rate (NMR). In all EAG

[2]Survey conducted by the National Institute of Nutrition, Hyderabad in 2011
[3]Individuals in the age group 0-18 are defined as Children in consonance with UNCRC and Juvenile Justice Act, 2000
[4]Budget for Children in Madhya Pradesh", 2010 by Sanket Centre for Budget Studies, Bhopal.
[5]This spending, however, does not include the spending on NRHM and RCH that bypasses the state budget.
[6]AHS has been implemented by the Office of Registrar General, India in all the 284 districts (as per 2001 Census) in 8 Empowered Action Group States (Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan) and Assam for a three year period during XI Five Year Plan period.
*NRHS-3 **Annual Health Survey 2010-11 ***Annual Health Survey 2010-11



(Empowered Action Group) states Madhya Pradesh holds either first or second position among all. The situation of Madhya Pradesh is very grim. Also in list of **top 100 districts in order of IMR, Madhya Pradesh contributed 30 districts in this list.** In Madhya Pradesh, Panna ranks highest in Infant Mortality Rate (93), under five Mortality Rate (140) and also in Neonatal Mortality Rate (66).

In India, Madhya Pradesh ranks highest in Infant mortality rate (67), following Orissa (65), Uttar Pradesh (63) and Assam (61) and Bihar (61) respectively. In Madhya Pradesh female infant mortality rate is higher in 32 districts than male infant mortality rate.

Top five states with highest U5MR are Uttar Pradesh with U5MR of 94 per 1000 live births, followed by Madhya Pradesh (89), then comes Orissa (87), Rajasthan (79) and Uttarakhand (70). Among the EAG states, in Madhya Pradesh 42% district (19 districts) falls in range 81-100 of U5MR and 29% (13 districts) district falls in range of 61-80. In NMR also Madhya Pradesh fallow Uttar Pradesh with 50 NMR and stands second with a NMR of 44.

The infant and child mortality rate of Madhya Pradesh is not only very high in comparison with the other states of India but the situation is extremely alarming even at the international level. The child mortality indicators of Madhya Pradesh are being compared with Sub-Saharan countries.

Comparative Status of Child Health Indicators of Madhya Pradesh

Child Health Indicators	Madhya Pradesh (Total)	M.P. (Rural)	M.P. (Urban)	Child Mortality Indicators of M.P. even worst in comparison with the countries like
IMR	67	72	50	Bangladesh (41), Ghana (47), Zimbabwe (56), Myanmar (57), Botswana (43), and other Saharan countries, and it is equal to Ethiopia.
Under 5 mortality Rate	89	99	62	Cambodia (88), Pakistan (87), Kenya (84), Ghana (69), Botswana (57), and Bangladesh (53) and almost equal to Zimbabwe (90)
Neo Natal mortality	44	49	32	Bhutan (33), Angola (42), Bangladesh (30), Burundi (42) and Ethiopia (36) and almost equal to Chad and Chile (45)

Source: Annual Health Survey, 2010

The MDG goals mainly focuses upon on women & child development because they are the most vulnerable sections of any community in the world and aimed to be achieved by 2015. But in the present circumstances, it is quite challenging to decline the child mortality indicators to achieve the targets of Millennium Development Goal in a period just four years. If we look at the performance in the four years

period between 2007 to 2010, IMR is declining at the rate of 1.75 points. If Madhya Pradesh wants to achieve the target set by MDG, it will have to reduce 7.8 points per year, otherwise with the present speed it will take 22 year to achieve this minimal target.

The health outcomes of SC/ST populations and girls/women are worse. Estimates suggest that MP is unlikely to meet the targeted reductions in maternal and child mortality without focused and renewed efforts; the prevalence child malnutrition is high in comparison with the rest of India.

To achieve the goals of MDG and to reduce the IMR there is a need for specific intervention and their better implementation at grass root level. Government of Madhya Pradesh is running various schemes to improve the situation of state in child and maternal health. But the progress rate is very slow. To reach the goal of MDG. The reason behind this is the lack of adequate co-ordination among of responsible department and various flaws in service delivery mechanism like, we don't have sufficient Aaganwadi centres in each and every village. Health services are not only inadequate but also suffer from quality gaps. Rural health institutions like CHC/ PHC/ SHCs are not functional with adequate supply of infrastructure and services. No effective measures are being adopted for monitoring of health and nutritional services.

3. Medical Causes of Child Deaths in Madhya Pradesh[7]

Recently NHSRC releases the analysis of Annual Health Survey data 2010-11.This data shares the situation of maternal health as well as child health. NHSRC analyze the district wise data of NRHM from the time period of April 2010 to 2011.

Mortality Age Group	Total deaths	Deaths within 24 hours of Birth[8]	Causes of death known	Causes of not known
Neonatal Deaths	18182	4918	5234	8030 (61%)
Infant Deaths	23586	4918	6640	12028 (64%)
1 Year to 5 years	5756	-	1398	4358 (76%)
6 to 14 years	6947	-	4069	2878 (41%)

If we compare the Infant Mortality Rate of SRS bulletin with NRHM data[9] we found shocking figures, **according to SRS bulletin 2011 the IMR of Madhya Pradesh is 67 but according to NRHM data analysis the IMR of Madhya Pradesh is 15.** It shows the poor recording of deaths of Infants by the government. The drastic difference between both the figures shows that big numbers of deaths have not been reported and the deaths which reported in most of cases causes of deaths are not either reported or not known.

[7] National Health System Resource Center (NHSRC)
[8] There is no explanation given for causes of deaths within 24 hours of birth, and after excluding deaths within 24 hours rest number of deaths divided into causes known and unknown.
[9] NHSRC data from April 2010 to March 2011

Causes of Neonatal Mortalities

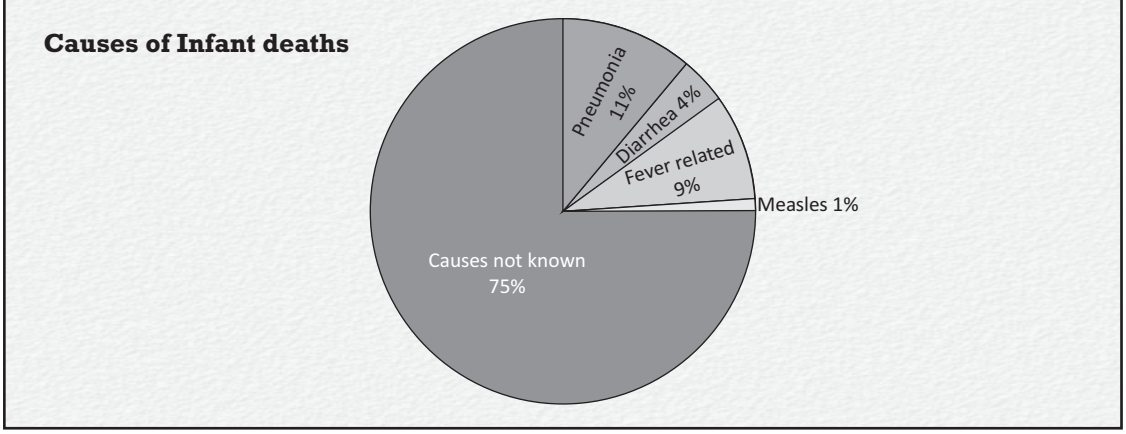
If we analyze the causes of neonatal deaths (Neonatal includes up to 4 weeks of children) we found that according to NHSRC, total 18,182 neonatal deaths were reported out of which 4918 deaths were reported within 24 hours of birth but there is no explanation of the causes of these deaths. Except deaths within 24 hours of birth, 13,624 deaths have been reported from the age group of up to 1 weeks of birth to 4 weeks of birth in Madhya Pradesh between April 2010 to March 2011 due to sepsis, asphyxia, low birth weight and unknown reasons. **Around 61% neonates died in Madhya Pradesh due to unknown cause.** The second highest reason for deaths of neonates is low Birth weight(21%).

Causes of Infants - Child Mortality

According to NHSRC from the time period of April 2010 to March 2011, 11,160 infant and child deaths are reported. The causes of deaths are Pneumonia, Diarrhea, fever related, Measles and Others (Causes not Known). This data show that highest 8,356 it means **75% infants died due to unknown causes and the second highest reason of deaths in infants are Pneumonia which is 11% following fever related causes which is 9%.** If we analyze the situation of deaths of children in over all MP, we found that out of all 50 districts the percent of infant deaths due to unknown causes is more than 50% in 44 districts.

Causes of Death Infant-child deaths

Pneumonia	Diarrhea Others	Fever Related	Measles	Causes not Known		
				Total	Percentage	Total
1,256	443	1,050	55	8,356	75%	11,160



The child mortality statistics are staggering. The analysis of the causes of child death indicates that in more than 50% of the neonatal to child mortality cases, the causes of death are not known. But according to some doctors **the unknown cause of deaths of children are acceptable maximum up to 10% not more than that. In Madhya Pradesh the situation is not so appreciable,** where out of 50 districts, 28 districts scores more than 50% deaths due to unknown causes.

Leading causes of death in under-five children are pneumonia, diarrhoea, malaria and health problems during the first month of life like sepsis, asphyxia and low birth weight. Such deaths are mostly preventable deaths **with increased access to simple, affordable and timely intervention of health care services.** But State fails to prevent these child deaths due to inadequate emergency medical services, poor continuity of treatment and care, and delay in seeking care because of lack of much requisite health and nutritional care to the children. **Strengthening health systems to provide such interventions to all children will save many young lives.**

The serious issue in human resource management is the huge gaps in critical health manpower particularly availability of doctors in government institutions, in rural areas, that provide healthcare to the poorer segments of population. A large number of vacant posts of gynaecologist and child specialist for maternal and child health cares are reported at the primary level in government hospitals. The situation at the secondary and tertiary level is somewhat better, as doctors generally reside in urban areas.

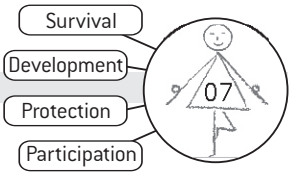
- Children below 6 years constitute 14.1% of the total population of Madhya Pradesh with the total child population of 1.05 crores.
- In Madhya Pradesh, 572 post of child specialist are sanctioned but out of them 250 post i.e. around 43.7% are lying vacant. More disgusting fact is that almost 80% of the gynaecologist & 53% pediatrician are posted in urban areas either at district hospitals and civil hospitals and merely 20% gynaecologist and 47% pediatrician are posted at rural health institutions.
- The vacant post of paediatricians demonstrates that only 1 child specialist is available for about 33,000 children below 6 years. For the children below 12 years there is a single child specialist for about 66,000 children.

Status of positioning of Maternal & Child Health Care Specialist in M.P.*			
Specialist	**Sanctioned Post**	**Appointed**	**Vacant Post**
Gynaecologist	632	293	339 (53.6%)
Paediatrician	572	322	250 (43.7%)
Anaesthetist	308	160	148 (48.0%)

4. Highlights by CAG Report on NRHM for M.P.[10]

- The National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, viz. eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices.

[10] CAG Report No. 8 of 2009-10 on National Rural Health Mission (NRHM)
*mp.gov.in/health/doctorspostinginformation - July August 2011



- The DHM (District Health Mission) had not been constituted in any district of Madhya Pradesh along with Andhra Pradesh, Bihar, Delhi, Jharkhand, Mizoram and Uttar Pradesh. This meant that decentralized planning, as envisaged in the Mission, was yet to be achieved in these States. It is necessary to ensure the formation of DHS/DHM in all districts and conduct their meetings at regular intervals to fulfill the aim of decentralized planning for future health initiatives.
- Under the Mission, annual DHAP were to be prepared on the basis of preparatory studies, mapping of services and household and facility surveys conducted at village, block and district level, which would act as the baseline for the Mission against which progress would be measured. The Mission targeted to complete 50 percent of household and facility surveys by 2007 and 100 percent by 2008. In seven States/UTs (including Madhya Pradesh) facility survey had not been conducted for any health centre.
- In six States, viz. Madhya Pradesh, Andhra Pradesh, Gujarat, Karnataka, Maharashtra, and Tripura, the perspective plan for the State was prepared without the finalization of perspective plans for districts. By means of preparing a perspective plan for each district, the DHS and the SHS, under the NRHM guidelines, had to identify the gaps in the health care facilities, areas of intervention, probable investment required.
- As per NRHM framework, during the 11th Five Year Plan (2007-12), States were to contribute 15 % of the funds requirement of the Mission. The 18 States/UTs (including Madhya Pradesh) did not contribute at all to the NRHM from their own budget during 2007-08. Since 2008-09, the States were directed to transfer the 15 % State share to the State Health Societies from the State funds.
- To attain the desired outcomes and build up management capacity at each level, the NRHM provided funds for management costs up to 6 percent of the total annual plan approved for a State/district. An analysis of expenditure on the management of the NRHM during 2005-08, showed that nine States/UTs had spent more than the prescribed funds on management expenditure. For Madhya Pradesh the management expenditure goes up to 10.29 percent in 2005-06 and it had turn down to 7.75 percent 2006-07 which was still higher to allocations.
- SHS of Madhya Pradesh, Bihar, and Karnataka did not furnish information on expenditure on IEC activities. Moreover, interest accrued on unspent balances had not been accounted for. Irregularities were also observed in expenditure on IEC. During 2006-07, SHS released Rs. 889.00 lakh to the IEC Bureau in Madhya Pradesh. The IEC Bureau, however, had shown the receipt of Rs. 697.08 lakh and the remaining amount could not be reconciled. Madhya Pradesh also did not furnish information on VHNDs and/or school health check-ups.
- All organizations were required to prepare codified purchase manuals, containing detailed purchase procedures, guidelines and also proper delegation of powers, so as to ensure systematic and uniform approach in decision-making relating to procurements. However, in 26 States/UTs, including Madhya Pradesh, SHSs had no documented written procedures and practices on procurement.

- A positive impact of the Mission was that two months' buffer stock of medicines was available in nine states/UT (Madhya Pradesh, Maharashtra, Uttar Pradesh, Punjab, Chhattisgarh, Chandigarh, Delhi, Himachal Pradesh and Lakshadweep).
- Among sample units, none of Sub Centres in Madhya Pradesh had two ANMs and the deployment of MPWs was also inadequate. In M.P, 66 percent sample SHC does not have MPW.

5. Pro-active Governance for Child Rights and Child Budget Analysis

The situation analysis of child health in Madhya Pradesh clearly indicates that children in the state are at the verge of death with alarming rate of infant and under five mortality. In- spite of being so vulnerable, children never demands for its rights because they are too small to understand even about their basic needs, and needs special care and protection.

Children are remarked as **'Future Citizens'** of any nation but children's entitlement to being citizens should not depend on their future contributions to society. All children are born with civil, political, social and economic rights which enable them to practice their citizenship – at least to some extent. The state is the primary duty bearer and accountable for the realization of all rights of children.

Therefore, there is an imperative need of proactive governance on the part of the state to build enabling environment for securing the best interest of the children. Good governance for children is about creating systems and mechanisms that benefit children. Children and governance is essentially about the recognition of children as citizens in their own right, therefore as rights holders. Fundamental to this recognition is State action by formulating legislation, policies and programmes and also implementing them through the executive, legislature and judiciary.

Large number of policies and programs have been designed and implemented every year both by the central and state government. To ensure that these programme and policies are proved to be effective tool for the realization of child rights, needs to have accountable systems with appropriate budgetary allocations and expenditures.

Child budget analysis is an important tool to monitor Government's performance in realizing the rights of children. Our previous attempt of child budget analysis showed that the budgets apportion very little for children and the miniscule amount of money earmark is insufficient for this huge demographic group that comprises over 40 per cent of the population[11]. A large proportion of money allocated for child intervention schemes remains unspent. To understand the constraints in effective utilization of budgetary resources, we need to look at it through the prism of outlays, outputs and outcomes.

6. Rationale for the study

It is therefore, pertinent to look at the critical issue of status of child health in the state more holistically covering various developmental perspectives. Analysis also include reflection on child health in terms of policy priority, efficiency of governance structure/institutions and effective decentralization for delivering

[11] Census of India , 2001, Government of India

child health services and of course the budget (including state budget and NRHM) for various components of child health. Here we have focus on expenditure in terms of quality of expenditure in the form of adequacy and effective utilization of funds for right cause.

7. Reflection of child health in terms of policy priority

This section attempts to identify the policy priorities of the State Govt and crucial aspects mentioned in the NRHM and RCH related to child health. This enabled us to understand the focussed and subsidiary areas.

7.1. State Govt Initiatives

Despite the poor health outcome indicators for children; there is no specific child health related policy at the state level. However, the State Population Policy does mention about significant reduction in IMR, MMR and TFR for giving momentum to population stabilization efforts.

Among the State Government run schemes, "Dhanwantari Vikaskhand Yojana" (Health Dept) aims at reducing IMR and MMR by focussing and promoting institutional deliveries in 50 blocks identified on pilot basis.

Besides, Health dept, Women and Child Development Dept plays vital role in as far as child development is concerned. It is nodal dept for implementing important programme like ICDS for curbing malnourishment in the state. Rather, ICDS is the only scheme catering developmental needs of children in 0-6 year age. Among other efforts, WCD dept, was implementing Bal Sanjivani Abhiyan a campign to identify malnourished children below five years age and their medication. The scheme winded-up in 2010 to begin new initiative called "Atal Bal Arogya Evam Poshan Mission".

Amid the NGO stir and media highlights about incidences of severe malnutrition; the State Govt has came out with integrated strategy known as Atal Bal Mission. Overall objective of this 70 point resolution is to render an enabling mechanism for prevention and reduction of malnutrition and under five mortality rates in the children of the State through coordinated and concerted efforts by the key stakeholders.

7.2. NRHM

GoI, started ambitious health programme 'National Rural Health Mission (2005-2012)' against the backdrop of need for basic health care delivery system in the country. The goal of the mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. The important health determinants covered under mission include segments of nutrition, sanitation, hygiene and safe drinking water.

The State of Madhya Pradesh also subscribe to the vision adopted by the National Rural Health Mission to improve overall health situation of the state. Besides, worst performing districts on weak health indicators and poor health infrastructure were selected to be focussed on priority basis. They are Dindori, Damoh, Sidhi, Badwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur where health conditions needs revamping on urgent basis.

7.3. RCH - II

Launched in October 1997, the Reproductive and Child Health Programme is an umbrella programme that looks forward to integrate and strengthen the services /interventions under Child Survival and Safe Motherhood Programme. The larger objective of RCH is to achieve population stabilization in the country by enhancing the quality of reproductive life of the population.

The second phase of RCH commenced from 1st April, 2005. The key objective of the RCH-II programme is to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes as envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India.

The programme goal of RCH-II seeks to improve the health status of all women and children through improved access and quality of Reproductive and Child Health services with focused attention to the most vulnerable sections of the society. Key components of RCH also include Child Health in general and Urban RCH and Tribal RCH in particular.

8. Child Health Interventions in Madhya Pradesh

8.1 Child Health Interventions under NRHM -RCH

The Reproductive and Child Health programme (RCH) II under the National Rural Health Mission (NRHM) comprehensively integrates interventions that improve child health and addresses factors contributing to Infant and under-five mortality. Reduction of infant and child mortality has been an important tenet of the NRHM.

The Department of Public Health and Family Welfare, Madhya Pradesh is also implementing several important programmes and schemes under RCH-NRHM to address the issue of high infant and child mortality in the country. Notable amongst these are the:

8.1 (a) Programme for Universal Immunization

- **Universal Immunization :** Under the Universal immunization programme (UIP), children are being immunized against six serious but preventable has been a cornerstone of the child health care programme under the public health system. But unfortunately in Madhya Pradesh, children (age 12-23 months) the most productive future assets are not even fully immunized against preventable diseases. As per the DLHS-3 report only 36.2% children in the state & in rural areas only 31.4% children are fully immunized. The latest Coverage Evolution Survey (CES 2009) by UNICEF indicates some improvements with 42.9 percent children are fully immunized.

  Implementing 'Alternate Vaccine Delivery System', wherein village-wise micro-plans are prepared and vaccines are transported to specific immunization site on Village Health and Nutrition Day, mentioning the names of respective vaccinator and supervisor. In an attempt necessary cold chain is maintained to retain the vaccine potency.

Innovated 'Defaulter Tracking System' is followed at Sub Health Centre for proper tracking of children coming for particular immunization session.

8.1 (b) Programme for Prevention and Treatment of Childhood Diseases

- **Integrated Management of Neonatal and Childhood Illness (IMNCI) :** Integrated Management of Neonatal & childhood illness is a Child Health Intervention to be implemented as part of NRHM/RCH-II to bring down neonatal, infant & child mortality rate. The IMNCI clinical guidelines target all the children under 5 years of age — the age group that bears the highest burden of deaths from common childhood diseases. The strategy encompasses a range of interventions to prevent and manage the commonest major childhood illnesses which cause death i.e. neonatal illnesses, Acute Respiratory Infections, Diarrhoea, Measles, Malaria and Malnutrition. It focuses on preventive, promotive and curative aspects, i.e. it gives a holistic outlook to the programme. The objectives is to implement IMNCI package at the level of household and SHCs (through ANMs), PHCs (through medical officers, nurse and LHVs), to provide a comprehensive newborn and child health services to address major neonatal and child hood illnesses.

  IMNCI program started in M.P. in 2003 in Shivpuri district with the financial and technical support of UNICEF and then later on other districts were included in different phases. Till today the IMNCI has been implemented in 18 districts in the state. IMNCI is a skilled based training programme. Till Dec'2010, 81 % MOs, 88% ANMs/MPWs, 71% AWWs and 90 Health supervisors have been trained in IMNCI.

  Along with this, Pre Service IMNCI has also been accepted has an important strategy to scale up IMNCI by GOI. It is also being included in the curriculum of Medical colleges and Nursing colleges of the country. This will help in providing the much required trained (IMNCI) manpower in the public and the private sector.

- **Control of ARI and Diarrhoea Management :** To control of deaths due to acute respiratory infections (ARI), healthcare workers have been trained to recognize signs and symptoms of pneumonia and Cotrimoxazole, an antibiotic used for treatment, is supplied throughout the country to all the health care units for distribution to patients.

  Education, IEC, and use of ORS are advocated for the early treatment of diarrrhoea and to prevent deaths due to this disease.

8.1 (c) Programme for Newborn Care

- **Navjaat Shishu Suraksha Karyakram (NSSK) :** Newborn care and resuscitation (NSSK) is an important starting-point for any neonatal programme and its objective is to reduce neonatal mortality significantly in the country. Under this program the training is being imparted to Medical officers, Staff nurses and ANMs at CHC/FRUs and 24x7 PHCs where deliveries are taking place.

- **Sick Newborn Care and Resuscitation through SNCU :** Sick Newborn Care Units (SNCU) are a special newborn unit meant primarily to reduce the case fatality among sick children born within the

hospital or outside, including home deliveries within first 28 days of life. It is a very positive step towards the child survival as neonatal mortality accounts for over 60% of Infant mortality and around 40% or fewer than under five mortality. SNCU is a three tiered system of primary level-I at the block level, secondary level-II at district and tertiary level–III care at medical collage with inter linkages.

Till Dec'2010, SNCUs level-II were operational in 22 districts hospitals of Madhya Pradesh whereas 6 were under construction. So far, about 39,609 newborn were admitted for specialized treatment in SNCUs. In 2010-11 (till Dec'2011) alone 19904 were treated under SNCU. It is expected that when SNCUs will be scaled up to entire state, it would save about 63,000 newborn every year and thus decreasing the IMR of Madhya Pradesh by 30% [12].

Along with this, SNCU level-I for primary newborn care are also being established in 17 CEmONC centres and 620 Newborn corners has been set-up in delivery centres at the block level[13].

8.1 (d) Programme for the treatment of SAM Children

- **Nutritional Rehabilitation Centre (NRC) :** For the management of the severely malnourished children (SAM) 234[14] Nutritional Rehabilitation Centres have been established under the Bal Sakti Yojana. NRCs are facility-based units managed by the state health department under National Rural Health Mission (NRHM) for the care of children who suffer from SAM.

8.1 (e) Programme on Child Feeding Practises

- **Infant and Young Child Feeding Practices :** Given the high prevalence rates of malnutrition in children, emphasis is being under IYCF accorded to promotion of exclusive breastfeeding up to the age of six months and breastfeeding along with appropriate practices related to the introduction of complementary feeding from 6 months to 2 years or more (weaning). These include three in one IYCF counselling skills training, Radio publicity, periodic release of informative magazine, cinema slides, mother's meetings and counselling, distribution of IEC material to AWCs, organizing competitions in various institutions and many other methods.

- **Baby Friendly Hospital Initiative (BFHI) :** The Baby-Friendly Hospital Initiative is an effort to ensure that all maternities whether free standing or in a hospital, become centers of breastfeeding support. A maternity facility can be designated 'baby-friendly' when it does not accept free or low-cost breast milk substitutes, feeding bottles or teats, and has implemented 10 specific steps to support successful breastfeeding.

8.1 (f) Programme for Management of Micronutrient Deficiencies

- **Bal Suraksha Mah :** Bal Suraksha Mah is a bi-annual program for Vitamin A supplementation with deworming of children. To decreasing the prevalence of micronutrient deficiencies relating to Vitamin A deficiency to levels below 0.5%, the specified dose of Vitamin A is being given at six

[12] Sub Group Meeting, PIP 2010-11, Department of Public Health & Family Welfare, M.P.
[13] Annual Report 2010-11, Department of Public Health & Family Welfare, Govt. of M.P.
[14] Annual Report 2010-11, Department of Public Health & Family Welfare, Govt. of M.P.

monthly intervals up to five years of age. All cases of severe malnutrition to be given one additional dose of Vitamin A.

- **Provision of Iron Supplementation :** To manage the widespread prevalence of anemia among infants and children under 5 years of age policy has been revised for iron supplementation in liquid formulation in doses of 20mg elemental iron and 100mcg folic acid per day per child for 100 days in a year.

8.2 Other Interventions

State's response to address malnutrition and child mortality is mainly looked after by Women and Child Development Department and is described in the following section.

- **Universalization of ICDS :** Strong efforts have been made by ICDS programme to set up AWCs and mini AWC in all villages and small pockets to improve the accessibility practically to most of the habitations ensuring that each village, majra and tola should have AWC. As on today there are 78929 AWCs and 12070 mini AWCs are functional in the state, which are as per the GoI norms.
- **Aanganwadi Chalo Abhiyan :** To improve the enrolment of the children and monthly growth monitoring Angawadi Chalo Abhiyan was initiated in 2009 with the objectives of strengthening the delivery of ICDS services and improving the attendance of children at AWCs.
- **Bal Sanjivani Abhiyan :** Madhya Pradesh conducted 12 bi-annual rounds for six years for malnutrition detection along with vitamin A supplementation and immunization termed as Bal Sanjivani Abhiyan. This Abhiyan covered all the children across the state and streamlined the growth monitoring activities. This initiative was started to address the high prevalence of under nutrition among the children 0 years - 5 years of age.
- **Sanjha Chulha :** ICDS addressed the delivery of SNP by initiating a joint supplementary feeding programme called Sanjha Chulha with MDM for AWC's children. Sanjha Chulha is a joint feeding programme aimed at providing two hot cooked meals i.e., breakfast and lunch to children in the age group of 3 years - 6 years prepared with the help of local self help groups. This allowed AWWs and helpers to spend more time with children for preschool education activities and home visits.
- **Take Home Ration :** Recently state has introduces THR for 6 months to 36 months old children. THR is a tasty, nutritious and micro nutrient fortified food which is distributed for six days. The food contains different varieties and all efforts are made to maintain good quality. Increasing timings of AWCs and honorarium of workers- State has increased their share of funds for AWWs and helper's honorarium significantly and has also increased the timing of AWCs from 3 hours to 5 hours. This gives more time for fun filled activities.
- **Mapping current Nutritional Status through NIN :** National Institute of Nutrition is developing a district wise profile on the nutritional status of children under five along with causal analysis. This analysis will be the base line survey for districts.
- **Organization of Mangal Diwas activities :** Mangal Diwas activities have provided a strong platform to women to discuss and learn about issues on every Tuesday. Themes taken up in Mangal Diwas

related to nutrition among children and women. Popular perception among the community about AWCs being a Dalia (porridge) distribution centre has now changed. Though an appraisal of the Mangal Diwas programmes has not been carried out but experience from the field shows that awareness among community about childhood malnutrition has increased and there is a good response to the programme.

- **Project Shaktiman :** A special programme for tribal children was initiated in 2007-08 called Shaktiman with the objective to reduce malnutrition among tribal children. The project covered 19 districts and benefited about 60000 children in 997 villages of 38 Blocks.
- **Implementation of use of new WHO Growth Standards :** Madhya Pradesh is the first State in India to roll out the implementation of new WHO Growth standards across the State. This has helped in mapping the nutritional status of the children and made it easier for the Anganwadi Worker to plot the nutrition standard of children.
- **Jagriti Shivir :** Each district organizes village level women awareness camps in which local women and community members are mobilized and sensitized about government schemes, health and nutrition issues.
- **Home Visits :** Initiatives have been taken to strengthen the home visits particularly, visits to families of moderately and severely malnourished children discharged from NRCs and ANC and PNC of mothers. Home visits are also organized to sensitize young mothers, there mothers-in-law and other members of the community.

9. Rhetoric Vs Reality : Physical target and achievement

Indeed various interventions by the State Government on this crucial front indicate the fact that Govt has taken serious note of the key issue of persistent child mortality and malnutrition in the state. However, it is equally important to gauge the ultimate effectiveness of the programmes in terms of performance on physical targets and achievements and financial outlays and utilization. Furthermore, tracking of field experiences would give appropriate insights on implementation status.

S.N.	Target/interventions	Present Status	Remark
1.	Maternal Mortality Ratio reduced to less than 220 per 1,00,000 live births by 2012	269/100000 for 2004-06 (Source: SRS Bulletin on Maternal Mortality in India, June, 2011)	The said target is highly ambitious to achieve provided state govt is much disciplined in implementation. Provision of trained health staff in case of emergency, increase awareness levels for institutional deliveries, provision of iron and folic acid tablets

2.	Reduction in IMR rate to 60 per 1000 live births by 2012	Total -62, Rural-75/1000 and Urban-48/1000 (Source: SRS Bulletin Jan. 2011, Data for 2010)	The target is in achievable range in the said timeframe with focus on better antenatal and post natal child care facilities, increase access to health facilities, full immunization

10. Budget Analysis for Child Health

Besides, the state budget one also has to consider the share of spending on child health under NRHM and RCH to gauge the spending on child health. Details of NRHM including RCH emerged the following child related components like child health, urban RCH, Tribal RCH. Thus, the component-wise detail of financial performance for past three years is given in the following table:

Child Health Budget through State budget and under NRHM/RCH-II

10.A From State Budget

Table : Expenditure on Child Health and Development in the State Budget and NRHM from 2007-08 (figs in Rs Crore)

Years	Child Development	Child Health	Total	Total State Budget + NRHM (from the year 2007-08)	% of Total State Budget + NRHM (from the year 2007-08)	% of Total budget on child health (excluding ICDS)
2001-02 AC	120	8	128	15315	*0.8%*	*0.05%*
2002-03 AC	217	11	228	17428	*1.3%*	*0.06%*
2003-04 AC	234	19	254	20400	*1.2%*	*0.093%*
2004-05 AC	226	16	242	26288	*0.9%*	*0.06%*
2005-06 AC	258	57	315	28021	*1.1%*	*0.20%*
2006-07 AC	352	43	396	28487	*1.4%*	*0.15%*
2007-08 AC	555	38	593	34032	*1.7%*	*0.11%*
2008-09 AC	700	68	768	38568	*2.0%*	*0.18%*
2009-10 RE	1577	27	1604	50445	*3.2%*	*0.05%*
2010-11 BE	1516	88	1604	66477	*2.4%*	*0.13%*
Budget allocation from the financial year 2007-08 includes the allocation for child health under NRHM as well.						

Source : State Budget Books for various years, GoMP

The table throw light on the fact that expenditure on the critical components of child development and child health together constitute 1.6 percent taking the average of spending in last decade from 2001-02 to 2010-11. This miniscule spending shows rising trend only from 2005-06 onwards with an exceptional rise in 2009-10 and that was mainly due to higher allocations in nutritional component of ICDS falling under child development category.

The analysis of budget allocations shows that a total amount of Rs 128.00 Crore was spent on Child Health and Development-Survival component, which was merely 0.05% of the total state budget in 2001-02. The trend continues till date with marginal increase even after launch of NRHM in 2005-06 at 0.13%.

A significant rise is however observed in child development particularly under ICDS services (Child Development and Growth), which increased from Rs. 120.00 Crore to Rs 1516 Crore for the Year 2010-11, whereas allocations for child health increased from Rs. 8 Crore to Rs. 88 Crore. This point at the fact that the critical issue of child health status in MP further needs higher budgetary allocations and spending.

10.B Child Health component in NRHM and RCH

Table : Child Health Components in NRHM (figs. in Rs Crore)

Component	2007-08			2008-09			2009-10			2010-11			2011-12
	Allotted Budget Plan	**Exp**	**%**	**Allotted Budget Plan**	**Exp**	**%**	**Allotted Budget Plan**	**Exp**	**%**	**Allotted Budget Plan**	**Exp**	**%**	**Allotted Budget Plan**
1. Child Health	10.79	4.39	40.7	16.7	16.34	97.8	12.19	17.35	142.3	17.63	23.64	134.1	13.22
2. Urban RCH	2.88	1.53	53.3	2.55	1.77	69.4	1.8	1.41	78.7	1.53	0.66	43.1	1.94
3. Tribal RCH	8.75	9.6	109.8	18.2	16.88	92.8	0	0	0	0.24	0.12	50.0	0
Sub Total (1+2+3)	22.42	15.52	69.3	37.45	34.99	93.4	13.99	18.76	134.1	19.4	24.42	125.9	15.16
Total NRHM Budget	472.8	440.6	93.2	609.5	479.49	78.7	692.5	503.1	72.6	733.51	632.39	86.2	708.17
% of Child health (including Urban and Tribal RCH) in NRHM budget	4.7	3.5		6.1	7.3		2.0	3.7		2.6	3.9		2.1

Source : Audited statement obtained from NRHM, Bhopal

Analysis of child heath budget component under NRHM/ RCH-II has been done for a period from 2007-08 to 2010-11. The programmes and activities under NRHM/RCH-II has been implemented in Madhya Pradesh since 2005-06 but due to huge inconsistency observed in the budgetary statistics during the initial two years, it was difficult to segregate the child health components from total NRHM/RCH-II budget. In terms of allocation 2007-08 and 2008-09 were promising with 4.7 and 6.1 percent of total NRHM and RCH budget going to child health component. In later years from 2008-09, on one hand where allocation shows great dip, the expenditure on the other hand exceeds allotted plan budget. In yet another, interesting fact, it was observed that in 2007-08 and 2008-09, Tribal RCH component was given a due attention in terms of allocations, which in the later years are either silent of shows miniscule presence. Urban RCH on the other hand shows steady decline from 2007-08 till 2010-11.

10.C Total Expenditure on Child Health in Madhya Pradesh (State Health Budget + NRHM/RCH)

Proportion of Actual Expenditure on Child Health and Development including both through State Budget and under NRHM (in Rs. Crore)							Figures in Rs.
Year	Budget for Child Development and Survival– ICDS through State Budget	Child Health budget (Under NRHM/RCH-II and Child Health allocation in State Health Budget)	Total Expenditure on Child Health and Child Development	Total State Budget	%expenditure on child health, survival and development of Total Expenditure in M.P.	Budget Allocation per Child per year in MP-Child Health (10.54) Million under the age of 6 years)	Budget Allocation per Child per year in MP-Child Health and development -survival (10.54 Million under the age of 6 years)
	(A)	(B)	C (A+B)	D	C*100/D		
2007-08	555	38	593	34032	1.7%	36	562
2008-09	700	68	768	38568	2.0%	64	664
2009-10	1577	27	1604	50445	3.2%	25	1496
2010-11	1516	88	1604	66477	2.4%	83	1496
Average allocation per child for their health and development-survival in last 4 years -						52 (0.14 per day)	1054.50 (2.88 per day)

Budget is one of the key indicator of state's commitment towards its people; including children. The analysis of budget for last 4 years – from 2007-08 to 2010-11, established the fact that reduction undernutrition and child mortality is still a far sighted dream; because during these years Government of Madhya Pradesh has spending on an average Rs. 0.14 per child per day or Rs 52 per year only (if children under the age of 6 years are to be covered under child health services).

Keeping in mind the fact that more than 6 million children under the age of 6 years are undernourished in the state; we also analysed the allocations for Integrated Child Development Services – Child Development Programs. As per the decisions of Government of India, in terms of allocation norms per child per day for supplementary nutrition – am amount of Rs. 4 per child per day must be allocated; but in MP it comes to only Rs. 2.88 average (which includes all other expenditures in this) in last 4 years. The question is – the problem of food and nutrition insecurity children will resolved by spending Rs. 2.88 per day for a child?

Overall the state government is spending less than 2.5% of its total budget for the 15% of its total population to cover their health and nutrition-care requirements; which entail primary and critical attention.

11. Key Analysis

A critical analysis of physical progress of various interventions planned against achievements under child health budget of NRHM/RCH-II reveals very startling picture. These interventions may be further

categorized into interventions where no initiative has been undertaken, interventions without consistency, interventions with various degrees of achievement etc in past three years from 2007-08 to 2010-11. Along with this analysis of child health budget under NRHM/RCH-II helps to calculate cost analysis per beneficiary and quality of expenditure in terms of adequacy and effective utilization.

11.A.1 Overview of Child Health Budget Analysis under NRHM

- Child health and child survival is one of the most imperative aspects of NRHM/ RCH-II, however, the proportion of planned allocation for child health (including Urban and Tribal RCH) is observed to be quite low under NRHM budget (see table 10.B). Under NRHM it was about 4.3 percent (Rs. 22.41 crore) in 2007-08 which increased to 6.1 percent (Rs. 37.46 crore in 2008-09) of total allocation. However, a disappointing allocation of merely 2 percent (Rs. 13.99 crore) was made during 2009-10. Lack of appropriate financial allocations contribute to poor outcomes in terms of child health indicators against the set targets.
- The downfall in the child health budget (including Urban and Tribal RCH) was observed in 2009-10 because of the fact that in that year 'Immunization', one of the major components of child health budget was segregated from it. Allocation for Immunization includes the budget for cold chain maintenance, training of health workers, alternate vaccine delivery system, mobility support, construction of disposal pits, procurement of consumables, for monitoring and quarterly review etc. In 2009-10, a separate budget provision for Rs. 19.46 crore was made for achieving the goals of universal immunization, out of which Rs. 15.81 crore (about 81%) was utilized. In previous two years to 2009-10 no separate allocation was being made for immunization purpose. However, even if we include allocations for Immunization in the total budget for child health, urban RCH and tribal RCH, then also the budget allocations for 2009-10 falls short by 10.69 percent in comparison to budget allotment for 2008-09 (Rs. 37.45 crore).
- Between 2007-08 to 2009-10, a total budget of about Rs 39.68 crore was allocated for child health (excluding Urban & Tribal RCH) under NRHM/RCH II. Average expenditure against the total allocation on child health comes to around 96 percent.
- Analysis of the child health budget (excluding Urban & Tribal RCH) under NRHM for the period of 3 years (between 2007-08 to 2009-10) depicts that allocation was highest during 2008-09 with total allocation of Rs. 16.70 crore. It portraits a favourable indication towards child health component under NRHM as in that year the budget on child health increased by about 64.6 percent as compared to previous year. However, the trend do not continued too long as in next year i.e. in 2009-10, health budget showed a downfall of about 27 percent with the total allocation of merely Rs. 12.19 crore.
- The annual expenditure pattern depicts a very unbalanced picture during the period of 3 years. Under-utilization of the allocated child health budget is clearly visible in 2007-08 as about 60 percent of the allocated budget remains unutilized; however, a vibrant over-utilization of 142 percent is illustrated during 2009-10. While in 2009-10, Rs. 17.35 crore had been utilized against

the total allocation of Rs. 12.19 crore. In 2008-09, almost 97 percent of the allocated budget has been utilized depicting a more optimum utilization of the financial allocations.

- Child health indicators in tribal areas of Madhya Pradesh present very bleak picture for the observation of child rights. With the objective to improvise tribal reproductive child health indicators, Tribal RCH component was added to NRHM. For implementing child health programmes in tribal belts of the state, the provision of Rs. 8.75 crore and Rs. 18.20 crore were made in 2007-08 and 2008-09 respectively under tribal RCH. However, it is a miserable fact that no budget provisions were made for the same it during 2009-10.
- Though NRHM basically concentrates on the health needs of the rural areas but it also endeavour to improve health situation of the urban poor population residing in the urban slums through its Urban RCH. However, child health budget allocations for Urban RCH constitute a very miserable proportion of total child health budget under NRHM/RCH. Analys is of urban RCH budget for 2007-08 to 2009-10, it was found that allocation was lowest during 2008-09, that forms merely 6.81 percent of child health budget while for other 2 years it comes to around 12 percent.

11.A.2 Allocations Vs Expenditure under Various Heads in Child Health Budget

- In all the three consecutive financial years between 2007-10, infrastructure and maintenance was seem to be given high priority both in terms of allocation and expenditure and it goes on increasing on yearly basis. Lack of child appropriate health Infrastructures is the most basic constraint to ascertain child health services in rural Madhya Pradesh.
- Qualitative trainings and orientation workshops boost-up the scope for successful implementation of the programmes at different levels. Under NRHM also a significant importance was given to orientation workshops and capacity building training programmes during 2007-08 and 2008-09 with almost 30 percent planned allotment. The proportion of expenditure on the workshops and trainings at different levels to the total expenditure on child health was about 29 percent in 2007-08 which declined to 23 percent in 2008-09. However, in monetary terms, the expenditure for training and workshops increased from Rs.1.28 crore to Rs. 3.91 crore. In 2009-10, the expenditure on this head further rise as more and more districts were brought under programs like IMNCI and SNCU, which required a pool of more trained and oriented professionals and field workers.
- Another key point highlight in the child health budget under NRHM for the year 2007-08 is that total quantum of Rs. 5.46 crore was budgeted for purchasing medicines and equipment to ensure the survival of children but expenditure was very dismal with merely 0.3 percent of the total expenditure. While in 2008-09 and 2009-10, less than 1 percent was planned and utilized under this head.
- Gaps in human resources in one of the major hurdle in efficient delivery of health care services for children. In- spite of this, no endeavour was made to fill the gap by making appropriate budgetary provisions and allocations. Human resource development remains most neglected overhead; no allocations were made during these 3 years to appoint medical and para-medical staff specialized in

child health care like paediatrician, trained nurses for new born care units etc. Between 2007-08 and 2009-10, only a miserable amount of Rs. 2.43 lakhs was spent for developing human resource for child health.

11.B Component-wise analysis of Child Health Budget under NRHM

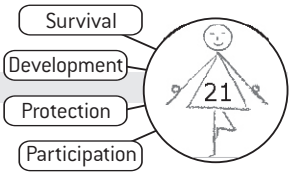
The major focus of NRHM is to provide all promotive, preventive and curative services needed by the people in an integrated fashion, so that services are provided through a single window. For accomplishment of these the state needs to have adequate human resources equipped with desired knowledge and skills regarding quality health care delivery services.

Orientation Workshops and Capacity Building Training Programs for Child Health under NRHM

Trained manpower is essential to provide quality services. Considering the importance of orientation workshops and capacity building training in implementation of NRHM activities and in achieving the NRHM goal, the utmost importance is given to the workshops, capacity building trainings programs, training of trainers and follow-up trainings of health care professionals under NRHM in the state. It includes workshops at the state, district and even at the block level for Medical Officers, para-medical staff, for the field level workers that also includes ToT and follow-up training programs along with the logistic support required.

Achievements

- At a very first instant, the overall physical and financial achievements for capacity building training programmes and orientation workshops under child health component of NRHM in 2007-08 seems to be overwhelmingly successful with more than 153 percent completion rate. It included workshops at the state, district and even at the block level for Medical Officers, para-medical staff and for the field level workers. During the year 2007-08, 325 such training and workshops were planned but 498 batches of workshops, trainings, ToT and follow-ups were actually been assumed.
- In 2008-09 and 2009-10, added priorities has been given to the block level training programmes which are significant for the proper implementation of the child health programs/activities at the grassroots, which were missing in 2007-08.
- Diarrhoea is one of the prominent causes of infant and child mortality in Madhya Pradesh. Realizing the importance of capacity building training of the paramedical and field staff for the management of diarrheal diseases, a series of workshops and training was been planned from state to block level during 2008-09. Achievement for diarrhoea management workshops in 2008-09 was about 41 percent at the district level and 33.5 percent at the block level and were conducted within the specific budget limits.
- The year 2009-10 was devoted to the district and block level workshops on 'Bal Poshan Mah' with the objective to decline micronutrient deficiencies in young children. Out the planned 100 and 626 workshops at district and state level respectively, 82 percent workshops at district level and 56 percent workshop at the state level was carried out successfully.



Gaps

- The total budgetary outlay for training, workshops and follow-up on child health under NRHM has gone up from 310 million in 2007-08 to 39.1 crore in 2008-09. However budgetary provisions were cut down seriously to just 48 crore in 2009-10.
- The proportion of overall expenditure on the workshops and trainings to the total expenditure on child health shows a declining trend from about 29 percent of total expenditure on child health in 2007-08 to 23 percent in 2008-09 and further to merely 1.60 percent in 2009-10.
- The overall physical achievements for the training and workshops against planned physical achievement also depicted declining trend to a very great extend between 2007-08 and 2009-10. The achievement comes down to 80 percent in 2008-09 from 153 percent in 2007-08 and then further rise to about 65 percent in the financial year 2009-10. But budget utilization pattern shows upward trends as against the physical trends in 2008-09. About 74 percent of the allotted budget was utilized in 2008-09 against 41.2 percent budget utilization in 2007-08. A decline was observed in 2009-10 where budget utilization stood at about 57 percent. Thus physical and financial achievements for training/workshops do not coincide with the planned achievements and allocations which is a serious concern.
- State level workshops and ToT are vital to prepare master trainers who in turn train the officials and staff at the district and block level. Merely one state level workshop planned in 3 consecutive years for this purpose and executed during 2008-09 but without any budget utilization. Similarly no Training of trainers (ToT) had organized between 2008-09 to 2009-10.
- No efforts were planned and executed to fill the previous gaps. For example, in 2008-09, 313 block level workshops on diarrhoea managements (@ 1 workshop per block) were planned but in reality it was organized only in 105 blocks during the given year. It should have to continued in next year for the proper management of diarrhoeal diseases in the coming years. Similar gaps were also identified for state level workshops, district level workshops, follow-ups, training of MOs/labour room staff, ToT etc. But it was to see that unfortunate new workshops were planned in next year without making efforts to fill the previous gaps.
- Although huge targets were been set for some activities like ToT, orientation of master trainers, workshops on diarrhoea management, training of ASHAs, facilitation technique trainings etc but no concomitant, budgetary provisions were made for the same. It resulted in poor physical outcomes against the set targets.

Critical Issues

- In 2007-08 and 2008-09, achievement is over 231 and 152 percent respectively only in single head i.e. training for field level workers, while in all other sub heads under training & workshops the gap is clearly visible. For example, 10 district level workshops were planned but merely 3 of them had actually taken up during the year. Similarly none of the 52 batches planned for the re-orientation training of about 1800 medical officers in the state on management of severally malnourished

children had been assumed. No training for field level workers planned in 2009-10. It indicates that achievements for training and workshops at different levels for different categories of professionals and staff were quite disproportionate against the activities planned.

- From the overall physical achievements of 2007-08, if we segregate the achievements in terms of training of field level workers, the achievements for training and workshop shows a very steep decline from 153.2 percent to just 43.7 percent. Similar feature is indicated in 2008-09 also which collapsed to about 52 percent, if the achievement of field workers training has been separated from overall training achievements. In 2009-10, training of Medical Officers and Staff Nurses on operating essential new born care equipments (Radiant Warmer and Phototherapy unit etc) constitutes a major proportion of the overall achievement for that year. Thus physical achievements for training/workshops in these three years were basically based on the over achievement in particular training programme and not on the successful execution of different training/workshops parallelly.
- Contrary to the overall physical achievements of 2007-08, the budget utilization seems to be quite poor in the same financial year. During 2007-08, merely 41.27 percent of the allotted budget was utilized. It might be due to the very fact that the excess number of training for field level worker were taken up from the unutilized budget of the previous year i.e. 2006-07. While in 2008-09 and 2009-10 overall budget utilization of about 74 percent and 57 percent was quite balanced comparing to the overall physical achievements.
- Disproportionate financial outlays are resulting in inconsistent outcomes. Logistic support only to 5 medical collages for IMNCI training had been planned during 2007-08 with the budgetary outlay of Rs. 5 lakh. However, actually logistic support has been provided to 34 medical institutions which could have included district hospitals in total budget utilization of Rs. 848814. However, the critical point to be noticed here is that separate targets have been set logistic support under IMNCI at the district level in both 2007-08 and 2008-09 without making budgetary provisions for the same. That probably has compelled to endorse for making logistic support to district hospital for IMNCI under the planned head of 'logistic support to 5 medical collages for IMNCI training'. In 2009-10, no logistic support has been given under IMNCI.
- The financial allocations towards follow-up training for supervisors on the one hand signifies wrong estimation in budget allocation while on the other side it depicts a massive over utilization of the budgets. In 2007-08 and 2008-09, 22 and 24 batches of the follow-up training for supervisors were planned with the total budgetary outlay of Rs. 17.68 lakhs and Rs. 12.96 lakhs respectively. Each batch of supervisor's follow-up training results in the training of 24 supervisors. Although the number of follow-up training planned has increased in 08-09 but financial allocations has reduced considerably. In 2007-08, out of 22 batches planned but merely 7 follow-up sessions were being organized with the total expenditure Rs. 18.24 lakhs which means that each follow-up cost around Rs. 2.60 lakhs against the outlay of about Rs. 80,000 only indicating massive wastage of limited resources. While in 2008-09, 23 of 24 planned follow-up were organised and each follow-up cost

around Rs. 80,000 while allocation were reduced to merely Rs. 54,000 depicting poor estimation of financial needs. The remaining batches of Supervisors might be left out of the follow-up training due to budgetary constraints.

- While on the other hand, a reverse portrait of under utilization has been depicted under the training of district level trainers. 15 batches (each batch having 24 participants) have been planned and 14 of them had been organized during the year. This indicates that physical achievement goes up to 93 percent. For each batch a total budgetary outlay was of Rs. 185300 was made, however, it is amazing that all the 14 batches training gets over with merely 16.5 percent budget utilization. It might poses a question mark on the quality of training of district trainers which may further results in poor training of block level and field level workers.

Infrastructure & Maintenance

Safeguarding and improving the health status of individuals, families and communities in rural areas were accorded higher priority under NRHM. The fundamental importance of health infrastructure in rural health cannot be underestimated. And in this context, efforts were undertaken to expand the health infrastructure for enhancing rural health delivery system and to improve the scope and quality of health care. However, Madhya Pradesh faces a huge gap in terms of health infrastructures such as PHCs, SHCs etc. In order to improve the geographic and coverage, access to care, huge financial resources need to be made available to the health sector, existing infrastructure need to be renovated and expanded and should be made equipped for the staff and patient's need including necessary maintenance, repair renovation work.

The first priority of the Mission is therefore to put the enabling public health infrastructure in place at the district level. It also focuses on promoting much needed investment and improvement in tertiary care in the district hospitals. NRHM also prioritize funding for addressing inter-district disparities in terms of health infrastructure.

Achievements

- Analysis for the 3 years indicates that infrastructure development and maintenance was most prioritized section. Initially in 2007-08, planned allocation for infrastructure and maintenance was about 17.03 percent of total planned budget under child health budget for NRHM. It was at second position in the priority list after the provisions for medicines and equipments. But then the proportion increased manifolds and as a result more then 90 percent of the total child health budget was being allocated for the same for the year 2009-10.

Gaps

- The proportionate expenditure on child specific infrastructure and maintenance work to the total actual expenditure also increased substantially from 57.5 percent in 2007-08 to 94.5 percent in 2009-10. But if one observe the actual expenditure on infrastructure and maintenance in contrast to the budget planned in that year for the same overhead, we notice a huge over expenditure which on the one hand indicates towards incorrect estimation of actual cost or may be due to increase in the cost of supplies.

Expenditure in infrastructure development for children can be better scrutinized by reviewing the allocations and expenditure for construction and maintenance of child friendly infrastructures like IMNCI, SNCU, NRC etc. the field level.

- **IMNCI**

- IMNCI is a very comprehensive programme for the prevention and treatment of childhood illnesses but still require much focus for developing the requisite infrastructure to cater the services under IMNCI smoothly. No budgetary provisions has been made during 2007-08 and 2008-09 and then in 2009-10. Budget allocation of Rs. 20 lakhs was been made to support 5 medical collages for pre-IMNCI services, which is just 2.2 percent of the total allocations for infrastructure development and maintenance under NRHM child health.

- Physical targets remain unachieved in lack of the requisite financial resources. For example, targets were set for the establishment of IMNCI cell at the Directorate in 07-08 and Pre-service IMNCI activities in 5 Medical Colleges in 09-10 did not turn out in reality as no financial allocations were made for the same.

- The only physical achievement against the set target under IMNCI was observed was related to pre-service IMNCI activities in one Medical College in 07-08, with the budget utilization of Rs. 2.62 lakhs although no allocation was made for the same.

- **SNCU**

- The state priorities for the development and maintenance of infrastructure of SNCU were not much reflected under NRHM child health budget during 2007-08 as no fund were allocated for the same. However, the planned budget for the year 2008-09, highlight positive outlook for developing infrastructure for new born care, where fund of about Rs. 5.30 crore was allocated for strengthening and maintenance of SNCU/PICU. It was about 53 percent of the total allocations for child health infrastructure of Rs. 10.02 crores in 2008-09. In 2009-10, no attention was given for the development and strengthening of SNCUs but it only concentrates on the repair and maintenance of existing SNCUs/PICUs with the utilization of total fund of Rs. 1.97 crore.

- In 2007-08, physical targets were set for the strengthening of level-2 SNCUs at the district hospitals of Guna and Shivpuri district with the financial and technical support of UNICEF. It was also planned for the upgradation of level-3 SNCUs in two medical colleges. Achievements was double as four level-2 SNCUs were developed during that year but upgradation of level-3 could be completed in 2007-08 or afterwards.

- In 2008-09, strengthening of level-2 SNCUs in 10 district hospitals was planned with the total budget allocation of 4.50 crores. Successful initiatives resulted into strengthening of level-2 SNCUs in 7 district hospitals with just 31 percent budget utilization. Along with this maintenance, repair work was also planned for 20 level-1 SNCUs and 2 level-2 SNCUs.

- Over-achievements in the maintenance of level-2 SNCUs in about 33 SNCUs against the planned

work in 13 level-2 SNCUs was observed. However, the fact to be noticed here is that only 13 SNCUs with level-2 facilities were in existence till 2009-10, now the point to be raised here is that which are the other institutions in which this maintenance expenditure actually incurred.

- **Baby Friendly Hospital Initiatives**

  - With the objective to promote baby friendly environment within the public health institutions, a very innovative initiative to develop baby friendly hospitals was planned in 2007-08 for all the 48 districts hospitals and 5 government medical colleges in the state. The unit cost of Rs. 5000 was calculated for it resulting in total allocation of Rs. 2.65 lakhs. Only 16 district hospitals out of 53 planned were being converted to baby friendly hospitals with average expenditure of about Rs. 5805 per hospital. Thus, 30 percent physical achievements were visualized with 35 percent utilization of allocated budget.

- **NRC**

  - In 2007-08, more focused attention was given to the establishment of NRCs and making them operational for the survival of malnourished children. In that year about 98.5 percent of the total investment of child health infrastructure was allotted for the strengthening of services for malnourished children at NRCs. Similarly, in 2008-09 and 09-10, near about 47.1 and 77.7 percent of child health budget for infrastructure and maintenance were allotted for development and maintenance of NRCs in Madhya Pradesh.

  - In-spite of huge allotments for NRCs development, budget proved to be deficit as expenditure elevated in huge proportion in comparison to allotments. For example, on an average expenditure was almost 172 percent high compared to total allotment for development and maintenance of NRCs.

  - During the periods of 3 years, construction of one building for NRC was also completed during 2008-09 with the budget utilization of Rs. 10.97 lakhs, although it was not a planned expenditure for that year.

  - Physical achievements indicate the establishment of 438 NRCs. However, the total number of NRCs at present comes to around 234 till 2010.

- **Human Resource**

Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources. The human resource plays vital role in the delivery of health care. The existence and quality of services to promote health, prevent illness or to cure and rehabilitate depend on the knowledge, skills and motivation of human resources in health sector. According to WHO, "The health system requires getting the right number of service providers with the right skills to the right place at the right time"[15]. Apart from doctors other diverse human resource, like physicians, AYUSH practitioners, dentists, nurses,

[15]WHO Human Resource for Health (http://www.who.int/hrh/en.)

midwives, pharmacists, technicians, and community health workers recruited as per need. The public health system in Madhya Pradesh suffers from shortages, imbalances, imbalance distribution, poor work environment, low productivity of personnel, vacant posts, loss of personnel to private sector, and migration to urban areas or overseas.

Given the current problem of un availability of both medical as well as paramedical staff in the rural areas, the NRHM seeks to try a range of innovations and experiments to improve the position. These include incentives for compulsory rural posting of doctors, skill upgradation of the existing Medical Officers, ANMs and other Para Medical staff, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions. Thus, it is very important to analyze, the investment on human resource development under the child health budget in terms of outcomes.

Achievements

- Three new IMNCI coordinators were appointed for the smooth implementation of activities under IMNCI programme.
- In 2008-09, the target was set for the engagement of 60 staff nurse along with 20 support staff members for level-1 SNCU. The physical achievements were at 26 percent and 30 percent respectively for staff nurse and support staff.

Gaps

- It is pathetic that in spite of having such a huge gaps in human resources in health sector at large and specifically for child health services, no budgetary provisions were made for development of human resources under child health budget during a time frame of 3 years. However, an expenditure of about 24 lakhs and 70 lakhs were incurred in 2007-08 and 2008-09 respectively.
- IMNCI and SNCU are the two child health intervention programmes which are meant specifically for the treatment of newborn and childhood illness. Till 2010, 18 districts of Madhya Pradesh have been brought under IMNCI. For the successful implementation and monitoring of IMNCI, provision were made for the appointment of 12 IMNCI Coordinators in 2007-08 and then further provisioning for 13 districts in 2008-09, but only 3 of them could be position till 2009-10.

Critical Issues

- No new targets were set for the year 2009-10 but even the target which were lead down during the previous financial year for the human resource development for child health services had not achieved. Lack of adequate staff directly hampers the proper implementation of programme activities.

Medicines and Equipments

NRHM aims at reduction in Infant Mortality Rate and Maternal Mortality Ratio and improving universal access to public health services. For this timely supply of drugs and essential medical equipments of good

quality which involves procurement as well as logistics management is of critical importance. Under NRHM, it was provided that two months stock for essential medicines/drugs can be maintained in the health centres. To decentralize the procurement activities and build capacity for this purpose, NRHM emphasized upon setting up State Procurement Systems and Distribution Networks for improved supplies and distribution. The GoMP has recently issued its Drug Policy wherein the State plans to institute a system of drug supplies and logistics management on the lines of Tamil Nadu.

Various field study reveals that there is huge shortage of child health specific medicines and equipments in the public health institutions either at district hospital or CHC/PHC at the block level. Scrutinizing this fact, it is imperative to encompass a proportionate investment for the procurement of requisite medicines and medical equipment, so that immediate medical services can be facilitated at different levels to every sick child coming to public health institutions and thereby ensuring the right to health for every child in the state.

Achievements

- No significant achievement were observed in terms for procurement of medicines and equipments under child health budget.

Gaps

- Various provisions were made in 2007-08 and 2008-09 for the procurement of baby wraps, IMNCI drug kit, drugs for diarrhoea and ARIs, Vitamin A bottles and iron syrups and also for essential equipments for new born care. But it is quite distressing that these targets have never been achieved during three consecutive years. For example in 2007-08, it was planned to procure drugs of worth Rs. 18 lakh for the prevention of Diarrhoea and ARIs (ORS, Zinc & cotrimaxzoal etc.) but did not achieved even in next two years.
- The physical achievements were almost negligible in all three years but shows with 39% utilization of the total budget allocated for purchasing of medical equipments and medicines in 2008-09
- In 2007-08, a handsome amount of 5.46 crore, almost 50 percent of the planned budget for child health under NRHM was allocated for under particular head, however, just 1.47 lakhs were utilized actually it posses a question mark on the willingness of the state health society to follow the minimum mandatory provisions for child health in the state of Madhya Pradesh.

Critical Issues

- A very minisule proportion of the total actual expenditure on child health has been incurred on medicines and medical equipments. Roughly 0.34 percent and 0.36 percent of total child health budget was actually spent on procurement of medicines and medical equipments in 2007-08 and 2008-09 respectively. There were no physical and financial plans in 2009-10 for the same.

Information, Education and Communication (IEC)

IEC has been inbuilt component in NRHM as the government has recognized that Information, Education and Communication (IEC) as a support to efficient health care delivery system. The NRHM has been keen to

increase the range and depth of programmes on Health Education / IEC activities which are an integral part of activities under the Mission at every level.

In addition it also works with the departments of education to make health promotion and preventive health an integral part of general education. Intense IEC is being pursued to ensure behavioural changes that relate to better child survival and women's health i.e. exclusive breast feeding, timely initiation of complementary feeding, young child feeding, spacing, age at marriage, education of the girl child etc.

Achievements

- In monetary terms a significant improvement was observed for the provisioning of IEC as it goes up from 28.20 lakhs in 2007-08 to 88.50 lakhs in the next financial year.

Gaps

- The average planned expenditure on IEC, which is a backbone for the successful implementation of any programme seems to be considerable very low in proportion to the total expenditure on child health. In 2007-08 and 2008-09, proportionate budget of merely 2.61 percent and 5.3 percent were planned and in 2009-10, the IEC component was totally neglected under the child health budget of NRHM.
- The actual expenditure incurred on this component shows decline in terms of proportionate expenditure on IEC with about 5.2 percent decline from 2007-08 to 2008-09. No actual expenditure was incurred for the development and dissemination of IEC material to boost up mass awareness about various welfare programme on child health.
- The physical achievements for IEC were lagging far behind the planned targets. For example, the year 2007-08 aimed at the printing of 5000 modules on child health which could not be achieved. Again in 2008-09, target set for the generation and dissemination of 27600 IEC modules and case study formats along with the development of 41 filp books and film on child care. And it is quite daunting fact that only 1001 reporting formats could be printed during 3 given years.

Critical Issues

- Although, the state falls short to achieve physical targets on IEC component but over-utilization of budget allotted for the developing and disseminating IEC material was observed in both 2007-08 and 2008-09. No IEC material were printed in 2007-08; however the budget of Rs. 42.9 lakhs was spent against the allotment of Rs. 28 lakhs. Similarly, in 2008-09, the physical achievement was very dismal at 3.61 percent but contrary to it, almost 85 percent of allotted budget was been exhausted for printing of modules for training, training and printing of case registers.

Monitoring and Documentation

The State would also seek to strengthen monitoring and evaluation system for effective healthcare delivery system to put in place. The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal

monitoring. The State Health Society/Mission also monitors progress periodically, in addition, the state proposes to develope and document best practices so that the programme implementers can benchmark their performances.

Achievements

- The monitoring achievements were visible only for the visits of monitoring by the state and district level monitoring committees. Achievements of the state monitoring committee were about 50 percent and 25 percent respectively for 4 planned visits for 08-09 and 09-10. While at the district level achievement increased from 18.5 percent in 08-09 to 28.7 percent in 09-10.

Gaps

- In 2007-08, two activities have been planned for overall monitoring and supervision; one for monitoring progress against plans, follow-up with training and procurement etc and other for facility assessment of level -1 SNCU. The physical target set for these two activities were 2 and 170 respectively, but that was achieved physically in 2007-08.
- A budgetary provision Rs. 20,000 was been made against 2 planned monitoring visits in 2007-08 but overwhelming over-expenditure of Rs. 7 lakhs were explicit without the desired outcomes.
- Along with this, it was also planned to develop about 4 lakhs reporting formats without making any budgetary provisions for the same in 2008-09 and could not achieved in the end.
- The year 2009-10, planned for the quarterly review of the Bal Sakti Yojana to keep a close watch on quality implementation of the scheme to root out malnutrition from the state. For this a provision of Rs. 12 lakhs was made but review team proved quite ineffective to execute their responsibility in a satisfactory manner. Merely 72 of total 200 planned district quarterly review of Bal Sakti Scheme were taken up during the given year. Similarly the was budgetary provision @ 5 lakhs for documentation of the Bal Sakti Yojana at the field level however it had never been documented in 2009-10.

Referral Support to Sick Children

NRHM designed in such a way that primary health care would be made accessible to all. However, in the case of need for hospitalization to provide specialized treatment, a child needs to be referred to secondary and tertiary health care institutions like CHC or district hospital. Therefore, referral mechanism is designed to ensure that an identified sick infant or child can be swiftly transferred to a higher level of care when needed. Field workers are trained to provide referral support for referring sick child to the health institutions. The primary and secondary health institutions refer serious and complicated cases for further management level. However, in Madhya Pradesh facilities for providing timely referral support to children are quite inadequate and needs to strengthening.

Gaps

For the referral of sick children under IMNCI programme, it was estimated in 2007-08 and 2008-09 that there is need of referring about 5000 sick children every year to BEmONC and CEmONC centres in IMNCI

districts. Referral support to single child at the rate of Rs. 200 and therefore an allotment of Rs. 10 lakhs per year was made. Childhood sickness along with malnutrition is one of the primary causes for high IMR and U5MR in the state but in-spite of that the progress for the referral of sick children was far from satisfactory in the two years. Merely 27 percent sick children from the set targets in IMNCI districts could be referred to get requisite health intervention in time.

Mobility Support to Staff

Monitoring and supervision team under NRHM need to conduct supervisory visits to the health centers at district, block and village level. In order to facilitate their mobility, NRHM provide mobility support by either hiring vehicle on a monthly basis or providing cash reimbursement to compensate expenses for visits. This will not only improve the monitoring and supervision of different health programmes under NRHM but will also help in promptly investigating disease outbreaks and organizing rapid response.

Gaps

- Madhya Pradesh is comparative a larger state spread out in a large geographical area and as such number of public health institutions are located in remote areas with no public transportation system. Keeping these constraints in view, provisions have been made under NRHM for providing mobility support to supervisory and monitoring staff to ensure effective implementation of child health programmes. In all the three given years, mobility support to supervisors @ Rs. 50 per visit has been envisaged for regular follow-up of the programme implementation. 1500, 36,000 and 35000 such supervision visits were planned during 2007-08, 08-09 and 09-10 respectively. Although the physical achievement keeps on increasing every year but achievement (less then 10 percent) was far behind the targets.
- A huge wastage of limited resources was observed during 2007-08, when merely 4 visits consumed more then Rs. 1 lakh, it means each visit on an average cost around Rs. 25000 against the allocation of Rs. 50 only.
- In 2008-09, budget utilization was in close contrast to allocations with an average expenditure of Rs. 50.83 per visit. However, budget utilization turned double in comparison to physical achievements in 2009-10 where each visit on an average cost for Rs. 107. In this merely 3599 visits were worked out against the plan of 35,000 visits.

Others Initiatives under Child Health Budget

- As a special initiatives, budget allocation of Rs. 1 lakh was made for intensive care of an sick new born of BPL families through accredited private hospitals through PPP model. And it appreciable that it has also been taken although the budget allocation goes wrong as it cost around Rs. 1.50 lakhs.
- Other miscellaneous expenditure of around Rs. 54.65 lakhs which includes district specific child health activities was incurred in 2009-10.

Urban RCH

Urban RCH programme aims to improve the health status of the urban poor particularly the slum dwellers and other disadvantage groups by provisioning access to quality Primary Health Care Services along with strengthening the existing capacity of health delivery systems leading to improved health status and quality of life.

The urban poor population in Madhya Pradesh has been increasing rapidly with increased urbanization. The urban poor rarely benefit from the facilities in urban areas and are as deprived as those in the rural areas. Therefore to promote child rights to health and survival, it is imperative to cater child health services in the urban areas particularly in urban slums and underserved areas through programmes like Urban RCH.

Achievements

- Under Urban RCH, the key focus was on deploying resources to fill the existing gaps in human resources. In 2007-08, about 35.39 percent of total allocations were planned for recruitment and hiring of human resources and it increased to almost 49 percent in 2009-10.
- The physical achievement for training were comparatively satisfactory where achievement was above 50 percent in all the three subsequent years.

Gaps

- A continues decline was observed in the total budget allocations for Urban RCH programme. The planned allocation was about Rs. 2.88 crore in 2007-08 showed a decline trend in the subsequent years. It tumbled down Rs. 1.80 crore in 2009-10.
- Although the existing allocations for urban RCH were already short but it is more miserable out of the fact that the department even fails to utilize the allotted fund to ensure service deliveries for children in urban slums and underserved areas. Average utilization for the 3 years was less than 70 percent of the planned allocations.
- In-spite of appropriate financial allocations, the target achievement was also dismal as most of the were post continued to be vacant which seriously hampers the implementation of the programme at the field level.
- The declining trend was observed in the proportionate budget allocation for programme activities. In 2007-08, almost 55 percent of total allocations were for training and implementation of programme activities but in the later years it goes down to 40 percent.
- Under PPP model, it was planned for the establishment of 9, 14 and 7 new urban centres on rental basis but only 17 of them could be physical established during 2007 to 2010. Although the achievement was lagging behind the targets but expenditure over shoot the plan allocations in a very massive proportion between 2008-10.

Tribal RCH

With the objective of reducing barriers to accessing health care in tribal areas, special inclusions for tribal

RCH programme were made under NRHM/ RCH-II. It add-ons for strengthening the service delivery in the public health centres in tribal areas with up-gradation of infra-structure and equipment along with drugs and supplies. Extensive IEC/BCC activities under tribal RCH also influence the health seeking behavior of tribal population.

Achievements

- A positive step by institutionalizing RCH services at the doorstep of tribal households was processed by making provision for mobile dispensaries for rendering quality RCH & FP services in identified tribal Block including provision for medicines etc. Between 2007-09, provisions were made to initiate about 180 mobile dispensaries under tribal RCH program and it comes out successful to a very great extend as 163 of them were made operational.
- Although no targets were fixed for operational execution of at least one CEmONC in each tribal block ensuring service delivery through nearest point. But still efforts were made in these directions and as a result 56 such CEmONC centres in tribal belts were made functional with the total expenditure of about Rs. 53.67 lakhs.

Gaps

- No child health specific activities were planned and achieved under Tribal RCH between 2007-10.
- Under Tribal RCH, no physical and financial plans and allocations were made in 2009-10.

Immunization

According to WHO estimates of 2009, proper immunization saves more than 3 million lives worldwide each year, and it saves millions more from suffering illness and lifelong disability. The vaccination of children against six serious but preventable diseases are cornerstone of the child health care programme under the public health system. But unfortunately in Madhya Pradesh, more then 63 percent children (age 12-23 months) the most productive future assets are not even fully immunized against preventable diseases, as per DLHS-3 report. Complete immunization is the right of every child and must be ensured at any cost. Under NRHM/RCH, separate provisioning is being made for Immunization component so that the immunization targets can be achieved to reduce the achievement gaps of MDGs pertaining to child health.

Achievements

- In 2009-10, apart from allocations for the various child health programmes, separate provisions of Rs. 19.46 crore were made for immunization which was lacking during previous fiscal years.
- Under the immunization programme, more and more focus was made on social mobilization of the community so that they can understand the importance of immunization for the prevention of deadly diseases. In 2009-10, it was proposed for social mobilization of about 5.80 lakh people by the ASHA and link workers and target was achieved up to 73 percent during the given year. And for this almost 37 percent of the immunization budget was being allocated for the same. However, expenditure exceeded by 8.10 percent of actual allocations.

Immunization : Proportion of Total Planned And Total Actual Expenditure on Various Sub-Heads during 2009-10		
Sub-Heads	**Planned Expenditure**	**Actual Expenditure**
Infrastructure and Maintenance	0.92	1.26
Human Resource	2.61	2.51
Information Education & Communication (IEC)	5.39	2.65
Monitoring & Documentation	6.95	4.63
Procurement and Delivery of vaccine & other items for safe immunization	19.48	22.38
Capacity Building Workshops /Training	16.88	9.33
Social Mobilization	36.98	55.51
Other (including micro planning, focus on urban slum/underserved areas etc)	10.77	1.72
Total Immunization Budget (in Rs. Crore)	19.46	15.81

Gaps

- Neither separate physical targets nor specific budget allocations were made for immunization during 2007-09. Immunization is one of the larger programmes under NRHM/RCH-II but in spite of that achievements are not indicated under the child health budget of NRHM.
- Under immunization programme, financial allocations were made for some of the major activities like cold chain maintenance; printing and dissemination of immunization cards, charts etc without actually setting up the physical targets for the same.

12. Recommendations

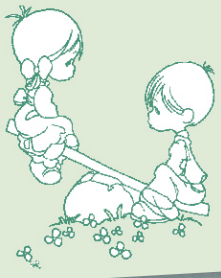
- The door step availability of the essential maternal and child health services must be ensured to reduce IMR and MMR and to boost up timely intervention and referral support.
- The new health centres should be established in the under-served areas to ensure better access of public health services. Health infrastructure at CHCs and PHCs must be made functional and child friendly with all essential infrastructure, equipment and manpower to ensure improvement in quality of child healthcare in rural areas at an affordable cost.
- The overall allocations and spending on child health should increase substantially to ensure universal access to safe childhood. The financing mechanism should reflect a rights-based approach rather than the practice of targeted interventions currently being pursued.
- Fund flow arrangement should be rationalized to ensure effective utilization of funds at various levels.
- There should be reasonable distribution of funds among various components of child health

services. Infrastructure and human resources should be accorded greater priority in fund allocations. IEC strategy and impact assessment should be rationalized with appropriate norms and criteria.

- A rearrangement of the financial mechanism with greater share of states and redoubled emphasis on decentralization may be some of the pointers for a future roadmap on the government's child health interventions in the country.
- Special attention should be given to fill gaps in human resource in health centres at various levels. 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.
- The focus should be on training and upgrading skills of existing staff for promoting child friendly health services, for which training institutes at the state level can be revived and new ones set up. All the medical and para-medical staff needs to be sensitized for pro-active child friendly service deliveries to sick children.
- Every sub-centre and PHC should be equipped with well-functioning ambulance facilities for referral support to the sick newborn and children. Ambulances should be connected with help-lines.
- Child health interventions like IMNCI should be replicated in all the remaining districts of the state with some integrated approach for neonatal and child health care opted in a holistic manner. Also institutions like SNCU and NRC should be established at block levels.
- Focused initiatives are needed to promote community based management of childhood diseases and malnutrition.
- All the essential life saving drugs to prevent child mortality should be made readily available at the health centres at different levels.
- Monitoring framework from grassroots' up to the state level needs to be strengthened so as to ensure periodic impact assessment of various child health programs/ schemes for timely interventions and corrective actions. Village Health and Sanitation Committee (VHSC) needs to strengthen to boost-up community monitoring of the child health services like immunization, referral support system at the village level.
- There is an urgent need for preparing comprehensive database on child health interventions for all the districts and state as a whole for better assessment of child health situation, identifying gaps, and monitoring of performance indicators of child health.

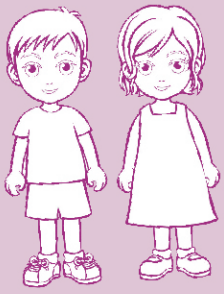
Abbreviations

AC	Actual Budget
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWC	Anaganwadi Centre
AWW	Anganwadi Worker
BE	Budget Estimates
BEmONC	Basic Emergency Obstetric and Newborn Care
BPL	Below Poverty line
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Centre
DFID	UK Department of International Development
DHS	District Health Society
IAP	Indian Academy of Pediatrics
ICDS	Integrated Child Development Services
IEC	Information Education and Communication
IMNCI	Integrated management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standard
IYCF	Infant and Young child Feeding
MDM	Mid- Day Meal
MIS	Management Information System
MMR	Maternal Mortality Rate
NBC	New Born Care
NFHS	National Family Health Survey
NIN	National Institute of Nutrition
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PICU	Paediatric Intensive Care Unit
RE	Revised Estimates
RCH	Reproductive Child Health
RHFWTC	Regional Health and Family Welfare Training Centre
SIHMC	State Institute of Health Management and Communication
SC	Scheduled Caste
SHC	Sub-Health Centre
SHS	State Health Society
SNP	Supplementary Nutrition Programme
SNCU	Sick New Born Care Unit
ST	Scheduled Tribe
TFR	Total Fertility Rate
THR	Take Home Ration
WCD	Women and Child Development
WHO	World Health Organization



"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace."

Kofi Annan



"Creating a world that is truly fit for children does not imply simply the absence of war. It means having the confidence that our children would not die of measles or malaria. It means having access to clean water and proper sanitation. It means having primary schools nearby that educate children, free of charge. It means changing the world with children, ensuring their right to participate, and that their views are heard and considered. It means building a world fit for children, where every child can grow to adulthood in health, peace and dignity."

Carol Bellamy

"If we are ever to have real peace in this world we shall have to begin with the children."

Mahatma Gandhi

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