

EFFECTIVENESS OF FUND ALLOCATION AND SPENDING FOR THE NATIONAL RURAL HEALTH MISSION IN UTTARAKHAND, INDIA

Block and Facility Report

March 2014

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Effectiveness of Fund Allocation and Spending for the National Rural Health Mission in Uttarakhand, India

Block And Facility Report

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EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM) has been very effective in making more funds available for delivering essential healthcare services to India's rural population. As per the NRHM mandate, at least 70 percent of funds should be spent at the block level and below. To understand the effectiveness of NRHM financing in terms of allocation, disbursement, and utilisation, the Policy Unit of the National Institute of Health and Family Welfare (NIHFW), the USAID-funded Health Policy Project (HPP), the National Health Systems Resource Centre (NHSRC), and the Government of the State of Uttarakhand conducted this study jointly. The study was designed to understand the barriers in the flow of NRHM funds from state to district, and sub-district levels of the public health system in Uttarakhand State.

The present study was designed and executed in two phases. In the first phase, a state- and district-wise analysis of fund allocation and spending was carried out using secondary sources: financial records of the NRHM funds obtained from all 13 districts of the state of Uttarakhand. The Phase 1 analysis found that the amount of NRHM funds allocated by the state to the districts varied widely on a per-capita basis. Average utilisation of NRHM funds increased over time, especially in the NRHM Additionalities funding pool, indicating that districts have developed capacities to spend more of the funds available to them. However, total utilisation of the RCH Flexipool and NRHM Additionalities in 2011–12 was only 75 percent.

The Phase 2 analysis described in this report was carried out to understand planning, allocation, utilisation, and performance below the district level. It complemented the issues analysed in Phase 1 study. For the Phase 2 analysis, three districts of Uttarakhand State were selected for in-depth analysis based on good, moderate, and poor performance in delivering health services: Nainital, Champawat, and Haridwar. For this analysis, service delivery performance and financial records were collected at the district, block, community health centre (CHC), primary health centre (PHC), and health sub-centre (SC) levels. At all these levels, interviews were conducted with relevant health officials to provide contextual information on the use of NRHM funds.

Phase 2 Study Findings

Planning and Budgeting: The study found evidence of highly centralised, top-down planning, despite NRHM's intent for a bottom-up approach. Under a bottom-up approach, inputs from village plans are taken to prepare block plans; block plans provide inputs for district plans, which in turn provide the basis for state plans. The demands of different levels of facilities must be reflected in the respective plans. The whole planning process requires consultations at various levels of health systems. However, the qualitative data collected under this study suggest that there is a lack of consultative process among these levels during the planning phase. The analysis also revealed that the District Health Action Plans (DHAPs) are not the primary basis for allocating funds to the districts. This may suggest that neither the planning input from lower levels is obtained nor are the resource demands of lower-level facilities adequately met. In terms of community involvement, interview participants suggested that the Rogi Kalyan Samiti (RKS), a patient welfare committee at the health-facility level, is an important part of planning and budgeting, however its function could be improved through more frequent meetings and active participation.

Fund Allocation and Disbursement: An important finding is that fund allocation by the centre to districts is often not done according to district requests. Although e-banking has made fund transfers easier for some facilities, there were problems with fund receipt, such as major delays in receiving funds from higher levels and complications that the accredited social health activists (ASHAs) face in opening

bank accounts. The PHCs and auxiliary nurse midwives (ANMs) also reported problems related to their signing authority for receiving funds.

Fund Utilisation: The study found that below the district level funds are not fully utilised. At CHCs, the RCH Flexipool account funds have lower utilisation rates than NRHM Additionalities and Routine Immunisation accounts; an average of only 72 percent of RCH funds was spent in 2012–13. The most common barriers to fund utilisation are a lack of facility-based resources (particularly human resources), delayed fund receipt, and misallocation of funds. To monitor utilisation, facilities reported submitting statements of expenditures (SOEs) to the block and receiving guidelines from higher levels. However, a lack of formal monitoring mechanisms and problems with the current system, such as incomplete guidelines, were reported.

Expenditure Effectiveness: There is some evidence that expenditures were efficient in the sense that resource use was connected with performance. The Janani Suraksha Yojana (JSY) and Routine Immunisation (RI) expenditure was positively correlated to the number of births and measles and Bacillus Calmette Guerin (BCG) vaccinations provided at CHCs. CHCs that spent more JSY and RI funds delivered more babies at their facilities and administered more vaccinations than those who spent less. However, this relationship was not as strong for family planning funds and other programme outputs. Wide ranges observed in unit expenditures for services also suggest that there is room for improvement at higher-cost facilities.

Recommendations

Based on the results of Phase 2, it is recommended that the following actions be taken to improve planning, fund disbursement, fund utilisation, and spending efficiency below the district level.

Prioritise Bottom-Up Planning to Ensure Facilities' Resource Demands are Met: The state should hold regular consultative meetings with districts, which in turn should consult block-level facilities to receive inputs on health plans and encourage bottom-up planning. The state should review why DHAP requests are not being met, and how the DHAP process can be improved.

Scale Up Community Involvement In Planning: Members of village health, nutrition, and sanitation committees (VHNSC) and RKS should be recruited based on their availability and commitment to helping communities realise their health needs. RKS and VHNSC meetings should be held more frequently. It is also recommended that best practices be exchanged between community organisations. RKS and VHNSC that are performing well can set the standard and strengthen low-performing community organisations.

Ensure Timely Release of Funds to Facilities: CHCs and PHCs should increasingly rely on e-banking rather than cheques, and health workers need to have guaranteed access to bank accounts. Signing-authority policies for lower levels should be streamlined to make it easier for ANMs and PHCs to receive funds. Health action plans, SOEs, and Utilisation Certificates (UCs) should be submitted on time so that higher levels can allocate and disburse funds accordingly. Increased communication across levels and training of staff involved in fund management are needed to ensure timeliness.

Increase Facilities' Capacity to Spend Funds: The district and facilities need to improve the performance of existing manpower, such as District Programme Managers (DPMs), who are underutilised. Facilities should also prioritise filling vacant staff positions. Other resources related to the healthcare infrastructure (e.g., roads, service delivery systems, electricity, etc.) must be improved for facilities to carry out their functions. Guidelines on fund utilisation should be made more accessible and easier to follow.

Improve Spending Efficiency by Learning from Cost-Efficient (I.E., Low-Cost, High-Performing) Facilities: Additional studies should analyse facilities with relatively low expenditure and high programmatic output to address problems with high-cost, low-performing facilities. Blocks should lead this initiative, as they have the ability to mentor lower-level facilities.

Formalise and Strengthen Monitoring Processes: Strengthen the block programme management unit by hiring an accounts manager who will be responsible for streamlining the accounting systems. In addition to the requirement of submitting SOEs and UCs, field visits and review meetings should be held, to ensure that facilities adhere to NRHM guidelines. Formal mechanisms, such as briefings, will allow better communication across levels. Facilities require increased funding and other resources to perform these monitoring functions, and increased community involvement can help strengthen monitoring.

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BHAP	Block Health Action Plan
CHC	community health centre
DAM	District Accounts Manager
DHAP	District Health Action Plan
DPM	District Programme Manager
FP	family planning
FY	fiscal year
HPP	Health Policy Project
IUD	intrauterine device
MOIC	Medical Officer In-charge
NHSRC	National Health System Resource Centre
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
PHC	primary health centre
PIP	Programme Implementation Plan
RCH	reproductive and child health
RI	Routine Immunisation
RKS	Rogi Kalyan Samiti
ROP	Records of Proceedings (for each state)
SC	sub-centre
UC	Utilisation Certificate
UKHFWS	Uttarakhand Health and Family Welfare Society
USAID	U.S. Agency for International Development
VHNSC	Village Health, Nutrition, and Sanitation Committee

1. INTRODUCTION

In recognition of the importance of primary healthcare, India launched the National Rural Health Mission (NRHM) in 2005 to improve the access to healthcare and quality of life for people in rural areas. NRHM seeks to provide health services to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building, and human resource management. NRHM aims to increase functional, administrative, and financial resources and autonomy of the field units. Its key goals relate to India's Eleventh Plan targets for infant and maternal mortality rates, total fertility rate, and nutrition among children, women, and girls. There is a particular emphasis on improving service delivery related to childbirth and prenatal care. In 2013, NRHM and the National Urban Health Mission (NUHM) merged to form the National Health Mission.

NRHM's work resulted in more national funds being made available for rural health. The Twelfth Five-Year Plan proposes increasing health funding to 2.5 percent of gross domestic product (GDP), and health spending under NRHM will also see a commensurate increase (MOHFW, 2011a). To make the best use of these funds, states must develop absorptive capacities and multiple levels (central/state/district/block and facility levels) must have accountable, efficient, and effective fund management systems in place.

By design, the NRHM is a devolved system, and it mandates that at least 70 percent of funds be spent at the block level and below. The amount of funding available to blocks and health facilities is determined at higher levels. Therefore, to understand the effectiveness of NRHM financing, it is necessary to look at the state, across districts, and at the lower levels of the system.

Among the eight Empowered Action Group (EAG) states, Uttarakhand has the lowest infant mortality rate (IMR), under-5 mortality rate (U5MR), and maternal mortality rate (MMR). The state has made significant progress on these indicators, including an impressive drop in MMR from 188 deaths per 100,000 live births in 2010/11 to 162 in 2011/12 (VSD, 2012). Uttarakhand has set ambitious goals for further improving maternal and child health. The state is committed to reducing MMR from the current level of 162 to 80 by 2017. Similarly, it aims to reduce IMR to 17 infant deaths per 1,000 live births from its current level of 41 over the same time period (DMHFW, 2013). Achieving these targets will require greater effectiveness in the implementation of reproductive, maternal, and child health programmes. Greater effectiveness in NRHM financing would contribute significantly to this goal.

In response to the need for more effective NRHM financing, the Policy Unit of the National Institute of Health and Family Welfare (NIHFW), the National Health Systems Resource Centre (NHSRC), and the USAID-funded Health Policy Project (HPP) partnered to examine the allocation and spending of NRHM funds in Uttarakhand.

1.1 Study Objectives

Uttarakhand is a High Focus State with well-functioning NRHM systems, so lessons learned from this state can serve as guide for other states seeking to make similar progress. The study aimed to understand the effectiveness of health financing under the NRHM in Uttarakhand at the district level and below, by analysing the allocation, utilisation, and impact of funds targeted to health facilities, especially for family planning.

A key shift under the NRHM has been the reduction in resource underinvestment as the overwhelming barrier to achieving health outcomes at the primary healthcare level. While more resources are still needed, the major increases in outlay, release, allocation, utilisation, and delivery mean that the capacities to better allocate funding to the decentralised level and for the level to better absorb funding are the main enablers of better outcomes. Due to differing local health needs, it is important for district planners to allocate funds according to needs and for facility-level decisionmakers to use funds appropriately, including untied funds.

This study sought to understand the barriers in fund flow and was designed in two phases. In Phase 1, a district-wise analysis of fund allocation and spending was carried out using secondary sources of data obtained from all 13 districts of Uttarakhand. On the basis of the findings from Phase 1, a further analysis of fund flow from the district to blocks and facilities was performed during Phase 2.

- **Phase 1** identified trends in the allocation and expenditure of NRHM funds across districts and investigated whether such funding was effective. The results of Phase 1 are available in the document *Effectiveness of Fund Allocation and Spending for the National Rural Health Mission in Uttarakhand, India: State and District Report*.
- **Phase 2** included field visits to health facilities and interviews with key respondents at the district, block, and facility levels to investigate use of NRHM funds. Phase 2 aimed at understanding the key drivers of spending trends observed in Phase 1 and to dig more deeply into the implementation barriers that could inhibit progress toward Uttarakhand's health goals.

Phase 2 Research Objectives

This analysis focused on the effectiveness of health financing processes at the block and facility levels under the NRHM in Uttarakhand. The allocation, utilisation, and impact of funds provided to health facilities, especially for family planning, were analysed. There were four primary objectives:

Objective 1: Describe NRHM fund planning as practiced in Uttarakhand and its relationship to actual allocations received.

Objective 2: Describe funding allocation mechanisms and trends from districts to blocks.

Objective 3: Describe fund utilisation by health centres and identify barriers.

Objective 4: Describe the relationship between health centre expenditures and programme outputs.

Together, these objectives comprise a beginning-to-end picture of fund planning, allocation, and expenditure. This allows for identification of key areas for improvement at all points in the fund disbursement and expenditure process.

1.2 Background

Health Financing under NRHM

At the national level, NRHM is led by a Mission Steering Group (MSG) headed by the Union Minister of Health and Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health and Family Welfare. At the state level, the NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. Activities under the Mission are carried out through the State Health Society (SHS), which was formed by integrating all the societies created for the implementation of various disease control programmes.

Funds are released by the central government (centre) to the states through two separate channels: the State Finance Departments and the different SHSs. Funds routed through the State Finance Departments are released quarterly, depending on the norms prescribed for various activities under these schemes based on the infrastructure available in the states. Funds are provided to SHSs based on the Government of India's approval of state Programme Implementation Plans (PIPs). The states must reflect their requirements in a consolidated PIP, with sections for individual programmes under seven parts: a) Reproductive and Child Health (RCH), b) Additionalities under NRHM, c) Immunisation, d) Revised National Tuberculosis Control Programme (RNTCP), e) National Vector-Borne Disease Control Programme (NVBDCP), f) Other National Disease Control Programmes (NDCPs), and g) Intersectoral Issues.

The Eleventh Plan Period (2007–12) specified that states are to contribute 15 percent of the funds required (MOHFW, 2011a). At the state and district levels, a Financial Management Group under the respective Programme Management Support Unit is responsible for centralised processing of fund releases, accounting for the expenditure reported by the subordinate units, monitoring of Utilisation Certificates (UCs), and audit arrangements. The groups are also responsible for collecting, compiling, and submitting Statements of Expenditure (SOEs), Financial Management Reports (FMRs), UCs, and audit reports from District Health Societies to SHSs and from SHSs to the Government of India.

Implementation Structure under NRHM at the State and District Levels

At the state level, the Mission functions under the overall guidance of the State Health Mission, which is led by the Chief Minister of the State. The functions under the Mission are carried out through the State Health and Family Welfare Society.

Along the lines of the State Health Mission, every district has a District Health Mission led by the Chairperson, Zila Parishad. To support the District Health Mission, each district has an integrated District Health Society (DHS). The DHS is responsible for planning and managing *all* health and family welfare programmes in the district. The DHS planning considers both treasury and non-treasury sources of funds.

The Governing Body of the DHS ensures intersectoral convergence and integrated planning. It is meant to provide a platform for the three arms of governance (ZP, Urban Local Bodies, district health administration, and District Programme Managers of NRHM sectors) to convene to delineate roles and responsibilities and make decisions on health issues.

The Chief Medical Officer (CMO) receives support from a District Project Manager (DPM), who plays a key role in operationalising the DHS secretariat and arranging managerial and supportive assistance to the district health administration. A District Account Manager (DAM) manages the accounts and is responsible for all fund management at the district level.

Financial Structure under NRHM at the District and Block Levels

NRHM is an umbrella programme with various categories of funds. Funds available under NRHM include RCH Flexipool, NRHM Additionalities, RI, and National Disease Control Programmes. RCH Flexipool funds are used for reproductive and child health programming, which includes maternal health, child health, family planning, JSY, RCH camps, and compensation for sterilisation. NRHM Additionalities are for essential activities related to health system improvements that are not funded from any other head. Three sub-heads under NRHM Additionalities include AMG, untied funds and seed money (see Table A-1 for sub-head allocation amounts). Routine Immunisation funds are used for the reduction of vaccine-preventable diseases, such as Diphtheria, Pertussis, Tetanus, Measles, severe form of Childhood Tuberculosis, and Hepatitis B. Funds are used for the procurement of vaccines and syringes and to cover the costs associated with the cold chain and programme operations. Funding under the National Disease Control Programme is intended for activities related to achieving the Millennium Development Goals (MDGs) and reducing the spread of disease.

The funds received by the states are disbursed to the District Health Societies in accordance with the amounts required in the DHAPs. The districts disburse funds to the blocks, which further disburse funds to various implementing units (CHCs/PHCs/SCs/VHSNCs) for programme implementation. Approximately 10 percent of the total funds are to be spent at the state level, 20 percent at the district level, and 70 percent at the block level and below, as most implementation activities take place at the lower level units.

The implementation of programme activities and actual use of funds starts at the block level. The Block Accountant and Block Programme Manager support the Block Medical Officer. The Block Accounts Manager (BAM) is responsible for disbursing funds to implementing units under block jurisdiction, and monitoring fund use and reporting below the block level. The BAM is also responsible for maintaining accounting records at the block level and reporting fund utilisation to the District Accounts Manager.

At the CHC and PHC levels, the facility accountants manage accounting and reporting activities. The ANMs and ASHAs are responsible for fund management and reporting for SCs and Village Health, Sanitation, and Nutrition Committees, respectively.

Financial Reporting and Monitoring

NRHM has various sub-programmes under its umbrella with multi-layered supervisory and implementing units. Due to decentralisation, large portions of NRHM funding and expenditure are undertaken at sub-district levels.

Most of the financial reports submitted by states to the centre consolidate information from the districts. Sub-district units must submit regular expenditure reports to the district, which inform the districts' reports to the state. Accuracy and timely submission of reports at each level are imperative.

1.3 Results of Phase 1 Analysis

The Phase 1 analysis found that the amount of NRHM funds allocated by the state to the districts varies widely on a per-capita basis. At the high end, the districts of Pithoragarh and Chamoli were allocated ₹209 and ₹205 per person, respectively, in fiscal year (FY) 2011–12. This is almost four times as much as the districts that receive the least per person. In the same year, Udham Singh Nagar was allocated ₹60 per person by the state, and Haridwar was allocated just ₹54, despite the fact that Udham Singh Nagar and Haridwar have some of the poorest health indicators in Uttarakhand.

Regarding fund utilisation, the Phase 1 analysis found that average use of NRHM funds has increased over time, especially in the NRHM Additionalities funding pool. Utilisation of funds available from the NRHM Additionalities pool was 53 percent in 2008–09 and 45 percent in 2009–10. This contrasts sharply with 85 percent utilisation in 2010–11 and 77 percent in 2011–12, indicating that districts have developed capacities to spend more of the funds available to them. Utilisation of RCH Flexipool improved from 76 percent in 2008–09 to 82 percent in 2010–11, but then decreased to 74 percent in 2011–12. As a result, total utilisation of the RCH Flexipool and NRHM Additionalities in 2011–12 was only 75 percent. Around 25 percent of the allocated funds remained unspent at the end of FY2011–12. At the district level, utilisation is a complex problem that is based on the cumulative performance of individual health facilities. Therefore, district-level utilisation must be understood through additional analyses at the facility level.

Previous studies of NRHM fund flow in other states allow for cross-state comparison. A 2012 study of utilisation in Karnataka found that “better-off districts” received higher per-capita funding than others (Gayithri, 2012), suggesting that Uttarakhand is not the only state with a need for more appropriate fund allocations. Utilisation in districts in Karnataka typically exceeded 100 percent for both the RCH Flexipool and NRHM Additionalities pool in recent years; this analysis does not take into account opening balances from the previous fiscal year. It seems these districts were able to spend their accumulated surpluses from previous years (Gayithri, 2012), while districts in Uttarakhand continue to underspend.

Based on the findings of Phase 1, the following is recommended in Uttarakhand:

Allocations to districts should be tied to health needs and spending patterns. Uttarakhand districts with large population sizes generally receive more NRHM funds than districts with small population sizes, but NRHM allocations per capita vary widely by district and are very poorly correlated to health status, therefore missing an opportunity to target funds on the basis of health needs. After allowing for higher costs in hilly districts, enhanced funding in larger districts with poorer health indicators may be needed to make greater gains in overall health. Districts should also be prioritised according to their spending patterns.

District utilisation rates should be improved. Districts in Uttarakhand spend approximately three-quarters of the total funds available to them. There is an opportunity to increase spending rates and achieve greater scale and cost efficiency. District health officials can provide necessary assistance in strengthening their spending patterns by identifying and overcoming barriers.

Districts should better target allocated funds to budget sub-headings within the overall RCH and NRHM Additionalities funding pools. Health prospects across a particular district could be improved if district planners consciously align *within-district* health expenditures to a district’s health needs. District planners must actively target available funds to high-priority health issues and to priority facilities.

1.4 Phase 2 Methodology

Data Sources

The second phase of the study was based on secondary data collected from the sampled districts at different levels of healthcare services. Financial records from community health centres (CHCs) for fiscal years 2010–11, 2011–12, and 2012–13 provided the basis for allocation and expenditure analyses. Documents included the statement of expenditures (SOE) for each major budget heading: RCH Flexipool, NRHM Additionalities, and Routine Immunisation (see Box 1.1 for more on SOEs). In addition, two sub-headings under RCH Flexipool—Janani Suraksha Yojana (JSY) and Family Planning—and Routine Immunisation were singled out for performance analysis. Facility performance data for 2011–12 and 2012–13 were obtained through the Uttarakhand health management information system (HMIS). Other primary documentation collected included RKS meeting notes, auditor reports, and financial performance reports.

Secondary data analysis was supplemented with semi-structured interviews with key informants at health facilities. Interviews consisted of detailed questions about the barriers to receipt and expenditure of funds. In each of the three districts, interviews were conducted at the district hospital (DH), two CHCs, four primary health centres (PHCs), and eight SCs. Respondents included the DPM, DAM, and Chief Medical Superintendent of the DH at the district level; Medical Officers In-charge (MOICs) at CHCs and PHCs; and Auxiliary Nurse Midwives (ANMs) at the SCs. Interviews were conducted in Hindi and transcribed into English by the interviewers for analysis.

Sampling Design

Of 13 districts in Uttarakhand, three were purposively selected for detailed analysis based on the results of the Phase 1 analysis. These three districts, Nainital, Champawat and Haridwar, account for 31 percent of the state's population. They also represent the state-wide variations in NRHM funding and health performance:

1. Nainital – High-performing district
2. Champawat – Moderately performing district
3. Haridwar – Low-performing district

Nainital is considered high performing due to its relatively low crude birth rate and IMR and average NRHM funding per capita. Champawat has average rates in terms of funding per capita and health indicators, meaning that it is a moderately performing district. Haridwar is a low-performing district because it receives relatively low funding per capita and has a high IMR and crude birth rate.

Box 1.1

SOEs track monthly expenditures by budget heading for the FY. They include the following information:

- Opening balance from previous FY
- Grant received for the current FY
- Reallocation amounts across budget heads or line items
- Monthly expenditure
- Cumulative expenditure for current FY
- Refund (if any)
- Closing balance

The type and number of health facilities in each district is shown in Table 1.1.

Table 1.1 Number of Health Facilities in Each District

District Name	Level of healthcare provision			
	DH	CHC	PHC	SC
Champawat	1	2	11	110
Nainital	2	4	19	136
Haridwar	2	6	25	155

Source: PIP, 2013-14

A representative sample of the various levels expected in healthcare provision within each district (1 DH, 2 CHCs, 4 PHCs, and 8 SCs) was selected on the basis of past year's performance, in consultation with district officials. Table 1.1 shows the sample size at various levels across all three districts. Annex Table A-2 includes a detailed list of respondents.

Table 1.2 Sample Distribution

Levels	Number	Respondents
District/ DH	3	CMO/Dy CMO, DPM, DAM, MS DH
Block/ CHC	6	MS CHC, BPM, BAM
PHC	12	MOIC/Pharmacist
SC	24	ANM

Data Collection Tools

To identify the barriers in fund flow at different levels, structured interview guides were developed in consultation with NHSRC, NIHFW, and HPP. The guides were tailored to respondents' positions to maximise the relevance of the questions. Guides were created for each of the following positions:

1. Chief Medical Officer (CMO)/Deputy Chief Medical Officer (Dy CMO)
2. District Programme Manager (DPM)
3. District Accounts Manager (DAM)
4. Medical Superintendent District Hospital (MS DH)
5. Medical Superintendent Community Health Centre (MS CHC)
6. Block Accounts Manager (BAM)
7. Medical Officer in Charge Primary Health Centre (MOIC PHC)
8. Auxiliary Nurse Midwife (ANM)

Physical and financial reports, such as SOEs, were collected on site during the interviews. The data were collected from October 20 to November 17, 2013, in the selected districts by a team of researchers from NIHFW, NHSRC, and HPP. The interviews were recorded, transcribed, and analysed (see Annex).

1.5 Phase 2 Study Limitations

There are a few limitations to the Phase 2 study. The primary limitation is that NRHM fund utilisation rates are only reported for CHCs and some PHCs due to the unavailability of financial records in several facilities. Furthermore, there may be limitations to the quality of the financial and health performance data collected due to incomplete records. The researchers contacted the data source for confirmation and an explanation for any questionable reports. In instances where data could not be validated, the research team used its best judgement in the reporting of financial and health performance data.

1.6 Report Outline

This report is organised according to the primary research questions. *Chapter 2: Fund Planning and Allocation Under NRHM* examines the NRHM fund planning process and draws on key interviews to understand the extent to which Uttarakhand districts follow the published norms and guidelines. *Chapter 3: Fund Flow and Disbursement* explains the fund allocation process and summarises recent trends in disbursement. *Chapter 4: Utilisation Patterns* then analyses facility expenditures as a percentage of total funds available and draws on interviews to understand barriers to full utilisation. *Chapter 5: Expenditure Efficiency and Effectiveness* compares expenditures under key NRHM sub-headings with facility performance to understand how spending translates into health outputs. The report concludes with *Chapter 6: Summary and Recommendations*.

2. NRHM FUND PLANNING AND ALLOCATION

Representatives from the centre, states, districts, blocks, facilities, and villages work in tandem to establish NRHM programme targets and funding allocations every year. This chapter explains the ideal planning and allocation processes under NRHM and analyses adherence to these planning norms at and below the district level. Actual allocations are compared with fund requests to evaluate the planning process.

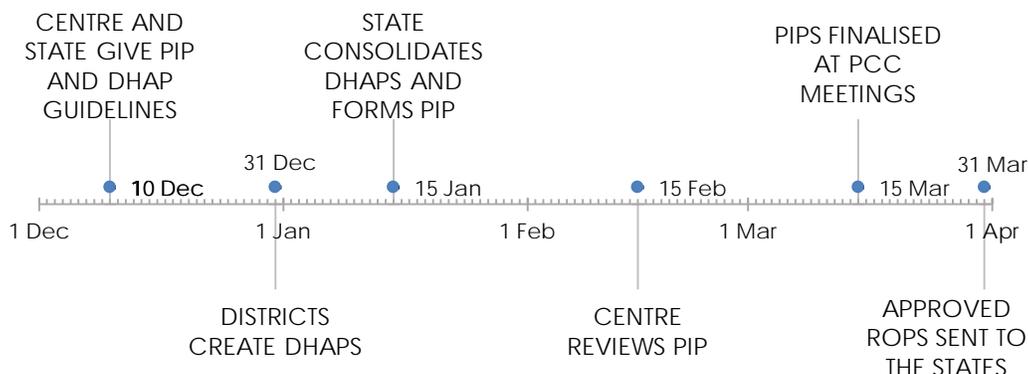
2.1 Ideal Planning Process under NRHM

The formal planning process begins at the block level, which prepares the Block Health Action Plan (BHAP) based on the input of implementing units (i.e., CHCs, PHCs, and SCs). BHAPs are based on community needs, which are summarised in village health action plans. BHAPs detail the physical performance targets and budgetary estimates for each NRHM budget head, and cover all NRHM programme activities for the fiscal year from April to March.

Completed BHAPs are sent to the district and aggregated to form an Integrated District Health Action Plan (DHAP). The DHAP provides an annual budget for the district and details the resources needed at sub-district levels for programme implementation, including costs for infrastructure maintenance, staffing, and procurement. The District Health Societies (DHSs) are also required to prepare long-term NRHM perspective plans.

DHAPs and perspective plans are compiled at the state level three months before the start of the fiscal year. (For a timeline of the formal budgeting process, see Figure 2.1.) The state uses the DHAPs to prepare a realistic, implementable, and need-based state PIP. PIPs estimate the fund requirements for NRHM programme activities for the subsequent fiscal year, and are reviewed by the centre during the two months preceding the start of a new fiscal year. Once PIPs are approved, the centre issues the Records of Proceedings (ROPs). ROPs show the amounts allocated to states for each NRHM budget head and begin the disbursement process.

Figure 2.1 Annual Planning and Budgeting Process Timeline



Source: MOHFW, 2011b.

Decentralised Planning: Planning and budgeting under NRHM were envisioned to be bottom-up processes, with lower levels in the system having significant influence over setting their own targets and budgets. In particular, NRHM is focused on building capacity for planning and monitoring at the village level. To ensure accurate representation of the implementing units, NRHM established planning teams and committees at each level of the healthcare system. Districts and blocks also have health management systems in place to respond to local management needs and challenges.

Community Involvement: NRHM has institutional arrangements for community involvement in planning, management, and monitoring. As mentioned above, community-based planning and monitoring committees are established at the state, district, block/CHC, PHC, and village levels.

District health planning is viewed as an iterative and two-way process, where the district planning teams provide the overall planning framework and financial parameters, along with training for the block and village planning teams. Below the district level, planning committees determine their communities' health needs, assist in the creation of health plans and programmes, and monitor programme activities. Specific responsibilities include conducting household surveys and hiring ASHAs.

Before NRHM was launched, Hospital Management Committees were present in the CHCs and DHs under the name of Chikitsa Prabandhan Samaiti (CPS). In Uttarakhand, CPSs have been renamed as Rogi Kalyan Samitis (RKS) and serve district hospitals, CHCs, and PHCs. RKS is comprised of various community leaders (e.g., government officials, NGO representatives) to manage these facilities. RKS meetings are required at least once every three months.

Village Health, Sanitation, and Nutrition Committees (VHSNCs) are established in every village where there is an ASHA. VHSNCs are comprised of community members such as ANMs and teachers, and are tasked with formulating village health action plans. VHSNCs are required to meet once a month and are given an untied grant of 10,000 rupees annually (MOHFW, n.d.).

2.2 Is There Evidence for Bottom-Up Planning?

Respondents indicated that there is a lack of decentralised planning and decision-making power tends to be concentrated at the higher levels, such as the district and blocks.

Lack of communication: The qualitative data revealed that there is a lack of communication between levels of the healthcare system during the budgeting and planning process. Districts and blocks are expected to consult with lower levels when preparing plans and budget documents, but this does not occur in reality. Although BHAPs are based on inputs received from lower levels, there are no consultative meetings below the block level to discuss and receive feedback for these plans. It was reported that block officials send their BHAPs to the district after they receive input from ANMs, indicating that facilities are not given a chance to review the BHAP before it is finalised. The same pattern is seen at the district level, as there are no consultations with lower levels before sending the DHAP to the state.

Limited input from lower levels: Qualitative interviews also revealed that lower levels have limited input in funding allocation. For instance, about half of the ANMs reported that they receive their targets and allocations directly from the CHC, bypassing the PHC and SC entirely. Similarly, four out of nine PHC officials said they do not know the criteria for fund allocation or say their funding is fixed rather than demand-based, suggesting they have very little input on planning and budgeting.

2.3 Is There Evidence of Community Participation in Planning?

Community participation at the grassroots level was found to be severely lacking. VHSNCs are in place, but their role is limited to fund receipt and disbursement. Most ANMs (15 out of 24) said they do not get support from VHNSCs. Panchayati Raj Institutions (PRIs) do not hold formal meetings to prepare health plans for the villages or give inputs to the block. This inadequate involvement by PRI members creates problems in planning and service delivery. For example, many ANMs in Haridwar district reported great difficulties in accessing funds that are directly deposited in the PRI accounts.

Assessment of RKS: District-level officials, CHCs and PHCs recognised RKS as an important part of planning and monitoring (see Table 2.1). A majority of CHC (83%) and PHC (78%) officials were appreciative of RKS' overall role in planning. Half of CHC officials reported that RKS was helpful for understanding the needs of the community, while many PHC and district officials were satisfied with RKS' help in maintaining facilities. Most PHC officials (56%) also reported that RKS helped monitor their budgets.

When prompted to discuss any advantages or drawbacks associated with RKS, respondents often expressed mixed feelings. Although respondents indicated multiple benefits of RKS, most of those interviewed at the district level (57%) and CHCs (67%) complained of members being absent from or uninvolved during RKS meetings. Some CHC officials suggested that RKS members should come from the health department because officials from other departments do not show interest in RKS and postpone meetings, causing significant delays in workplan approvals.

Table 2.1: Advantages and Problems Associated With RKS

	District (n=7)		CHCs (n=6)		PHCs (n=9)	
	Count	Percent	Count	Percent	Count	Percent
Advantages of RKS						
Maintenance of facilities	3	43%	1	17%	4	44%
Monitors budget	2	29%	1	17%	5	56%
Improves service delivery	2	29%	0	0%	0	0%
Members actively involved	2	29%	2	33%	2	22%
Understand community needs	1	14%	3	50%	0	0%
Generally helpful in planning	1	14%	5	83%	7	78%
Problems with RKS function						
Aloof/absent members	4	57%	4	67%	1	11%
Infrequent meetings	2	29%	1	17%	0	0%
Lengthy process (delays)	1	14%	2	33%	0	0%
No or limited impact	1	14%	2	33%	2	22%

2.4 What Is the Relationship Between Planning and Actual Allocation?

As discussed in Section 2.2, planning under NRHM tends to be highly centralised. However, districts do seek inputs from facilities in preparing DHAPs. To assess whether these requests translate into actual demand-based allocation, the amounts proposed in DHAPs were compared with the amounts approved by the state in ROPs.

Table 2.2 shows that there is a great deal of variation in the amounts proposed under DHAPS and the amounts approved in ROPs. This suggests that requests at and below the district level may not be taken into consideration during fund allocation. Haridwar, the most underfunded district sampled, consistently requested more than it received, particularly for RCH Flexipool funding.

Table 2.2: DHAPs Requests vs. District Allocation by NRHM Budget Head

% Amount proposed in DHAP that was approved in ROP	Year	
	2011-12	2012-13
Haridwar		
RCH Flexipool	54%	56%
NRHM Additionalities	55%	84%
Routine Immunisation	66%	193%
Nainital		
RCH Flexipool	42%	69%
NRHM Additionalities	78%	153%
Routine Immunisation	37%	200%
Champawat		
RCH Flexipool	83%	127%
NRHM Additionalities	114%	99%
Routine Immunisation	76%	172%

Gaps in Funding Requests and Allocation: In 2011-12, Haridwar and Nainital districts received less funding than requested for all NRHM budget heads. Only 37 percent of RI funds requested in Nainital were approved that year. Champawat's allocations were more in line with its requests, but funding for RCH Flexipool and RI still did not meet the district's requests and NRHM Additionalities funding exceeded the amount requested.

In the following year (2012-13), the centre tried to compensate for the mismatch in requests and approvals experienced in 2011-12. In Haridwar, districts marginally increased the amount requested for each budget head from 2011-12 to 2012-13. The centre, however, nearly doubled the allocation amount under NRHM Additionalities and RI to more closely match the requests made in the previous year. While this resulted in an improvement in NRHM Additionalities funding allocation, Haridwar received about twice as many funds as requested for RI.

In Nainital, the district decreased its funding requests for each budget head from 2011-12 to 2012-13. The centre slightly increased allocations for RCH and NRHM Additionalities but more than doubled the

allocation for RI. These efforts resulted in the centre allocating more funds to the district than the district requested for RI and NRHM Additionalities.

In Champawat, fund requests remained virtually unchanged while the centre increased allocations for RCH Flexipool and RI and decreased funds for NRHM Additionalities. The amounts requested and approved were almost equal for NRHM Additionalities, but the centre approved more than was requested for RCH Flexipool and RI. (See Annex Table A.3 for an expanded table.)

Potential Explanations for Funding Gap: One possible reason for the mismatch between DHAP requests and actual allocations is that fund disbursement is a flexible mechanism. Funds are generally disbursed according to the demand generated by the facilities throughout the year. As a result, the centre and state may not feel compelled to allocate according to DHAPs because facilities can still receive additional funding through written requests during the fiscal year. However, problems can arise when district allocations exceed the amounts requested as facilities within the district must have the absorptive capacity to utilise those funds.

2.5 Conclusion

There are problems with the implementation of decentralised planning under NRHM. In particular, the study found:

There is insufficient communication across levels. Blocks and districts ask for input and documentation from lower levels, but they do not hold consultations to allow for more discussion and feedback. According to the NRHM guidelines, districts and blocks should hold more regular meetings with lower levels to receive feedback and encourage demand-based planning.

Community-based planning is lacking. Establishing community-based planning and monitoring was expected to be a slow process due to the limited capacity of communities. However, efforts must be made to accelerate this initiative to improve NRHM planning. Community committees are seen as beneficial by many facilities due to their contributions to planning, budget monitoring, and other vital activities, but capacities are limited and there is a lack of interest in meetings.

District funding requests are unrelated to actual allocation. The gap between funding requests and allocations suggests that planning is inefficient. When the centre allocates a different amount than is requested by the district, the input and demands generated by lower-level facilities are being ignored. In all three districts sampled, RI allocations by the state significantly surpassed the amounts requested by the districts in FY2012–13. It is recommended that centres allocate according to DHAPs. Districts should also meet with the centre to discuss why actual allocations may differ from amounts requested and how the DHAP process can be improved.

3. FUND FLOW AND DISBURSEMENT

This chapter examines how NRHM funds are disbursed to each level of the healthcare system. Issues surrounding fund transfer, including timeliness of receipt, e-banking, and the fund flow structure are reviewed. Trends in fund allocation across the CHCs are also analysed to examine variability by year and facility.

3.1 Ideal NRHM Fund Flow Process

Fund Flow Hierarchy: Figure 3.1 shows the NRHM fund distribution process from the centre to the implementing units. The GOI distributes funds to the SHS based on the approved state PIPs and issued ROPs. Each SHS then releases funds to the District DHS based on the approved DHAPs, after adjusting for unspent balances from previous years.

The DHS manages both fund releases and programme activities for the entire district. The DAM manages the finances under the supervision of the DPM. In addition to releasing funds to lower levels, the DAM is responsible for maintaining account books, budgeting, planning, programme implementation, monitoring blocks' expenditure and reporting, and facilitating annual audits. The DAM disburses the amount stated in the DHAP to the blocks.

The block Chief Medical Officer is the head of the block-level Programme Management Unit and is supported by the Block Programme Manager and Block Accounts Manager. The BAM is responsible for disbursing funds to the implementing units (CHC, PHC, SC, and VHSNC). At the PHC level, accounting and reporting activities are managed by PHC accountants. At the sub-centre level (including VHSNC), funds are managed by ANMs.

Frequency of Disbursement: In general, funds are released in tranches based on the utilisation of previous funds. The funds are normally released in at least two tranches. The district's needs and demand for funds are based on submitted SOEs and written requests to higher levels.

The GOI releases funds to the SHS in the quarter following approval of the state PIP. These transfers are supposed to occur at the start of the fiscal year in May and midway through the fiscal year in October (see Table 3.2 for disbursement guidelines). Within 15 days of receiving funds from the GOI, the SHS transfers funds to the DHS. SHS directly credits the funds to the main account of the DHS. The DHS transfers funds to sub-accounts maintained under each programme. Blocks and implementing units can receive funds based on written demands to higher levels.

Figure 3.1: Fund Flow Diagram

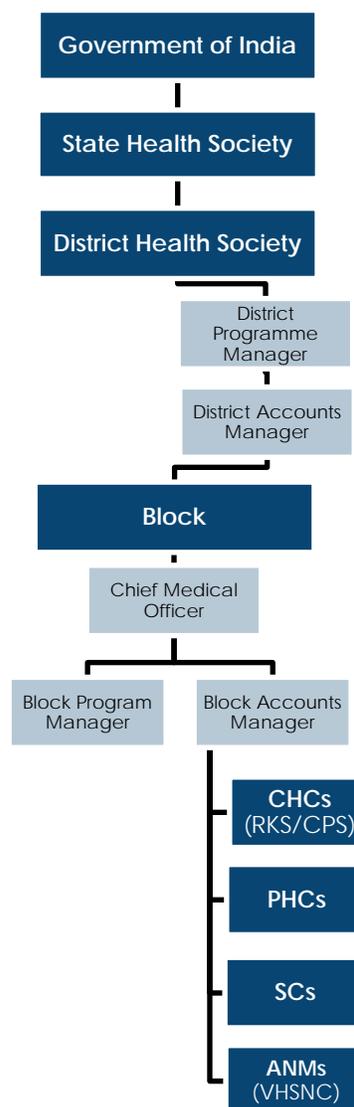


Table 3.1: Guidelines for Frequency of Disbursements

Disbursing Unit	Receiving Unit	Timing
Centre	State	Generally in May and October
State Health Society	District	Within 15 days of receipt of funds from centre
District Health Society	Block	Immediately after receipt of funds from SHS
Block/Supervisory Unit	Implementing units	Immediately after receipt of funds from DHS

Source: Operational Guidelines for Financial Management Issued by MOHFW, 2012

Fund Transfer Mechanisms: In early 2005, the Ministry of Finance piloted an e-banking system in Uttarakhand. The e-banking system became fully operational at the state and district levels in 2008–09. In July 2013, the government implemented a grassroots initiative of Direct Benefit Transfer to JSY beneficiaries and ASHAs. The initiative requires that ASHAs have bank accounts in which they can receive funds. In Haridwar, ASHAs receive payments through electronic transfer.

NRHM guidelines mandate that there should be joint signatories to operate NRHM bank accounts. There are three designated signatories at the DHS. The two main signatories at DHS are Area Chief Medical Officer (ACMO) and Chief Medical Officer (CMO). At the block level, two joint signatories are required to operate the bank account. CHC and PHC accounts are managed by the Medical Officers In-charge (MOIC). Gram Pradhans (village leaders) and ANMs are joint signatories at the SC level for AMG and untied funds.

3.2 Key Challenges in Fund Disbursement Processes

Actual fund flow processes diverge from the ideal NRHM processes. Box 3.1 shows the key challenges respondents identified with the existing fund flow process.

Box 3.1

Fund Flow Hierarchy: The sample facilities in Haridwar and Nainital reported that PHCs often do not have a MOIC in place, indicating that PHCs do not have signing authority to disburse funds to SCs. Consequently, many PHCs and SCs are managed directly by the block CHCs, and the PHCs only provide Outpatient Department (OPD) services at the facilities.

Another problem noted by about half of the ANMs (13 out of 24) is that they face difficulty in receiving funds from the Gram Pradhan. For instance, one of the ANM respondents said she must “visit the Gram Pradhan many times for his signatures. The Gram Pradhan under my catchment area is female but most of the work is done by her husband and often he is not cooperative.”

Key Challenges:

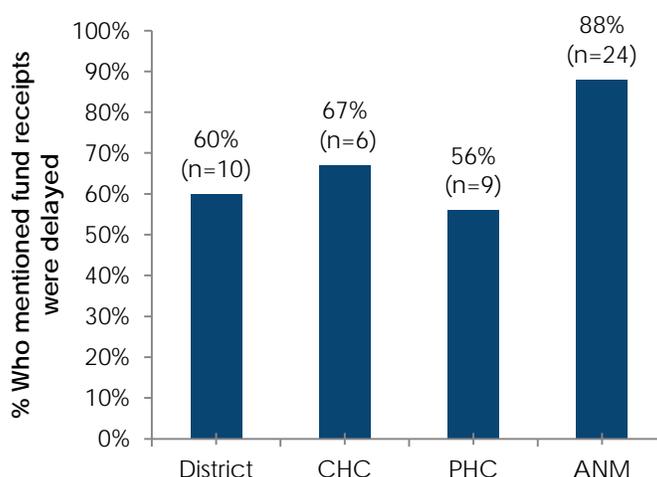
- Problems with signing authority
- Delayed fund receipt
- ASHAs face difficulty in opening bank accounts

Banking System: Due to the widespread use of e-banking in the state, there is little difficulty in the physical transfer of funds. However, not all facilities, particularly at the lower levels, send or receive funds through e-transfer. Two CHCs reported that they disburse funds through cheques rather than e-transfer and two PHCs and three ANMs said they primarily receive funds through cheques.

The recent initiative to create bank accounts for ASHAs allows for more control over fund flow and utilisation at the lowest implementation levels, but it can be problematic for ASHAs with low socioeconomic status. For instance, one of the respondents in Haridwar reported that, “They [ASHAs] do not have address proofs which is mandatory for opening of a bank account. We do face a lot of problems to give funds to such beneficiaries.” It was also reported in Champawat that regional banks often do not approve the account numbers given by beneficiaries.

Timeliness of Fund Receipt: The majority of respondents at each level reported funding delays (Figure 3.2). ANMs are most likely to experience funding delays, partially because they are one of the last units to receive funds. Four ANMs in Champawat said they received funds as late as February, which is almost the end of the financial year. Another four ANMs in Champawat said they usually do not experience a delay, but did so in 2012–13.

Figure 3.2: Funding Delays Reported through Interviews



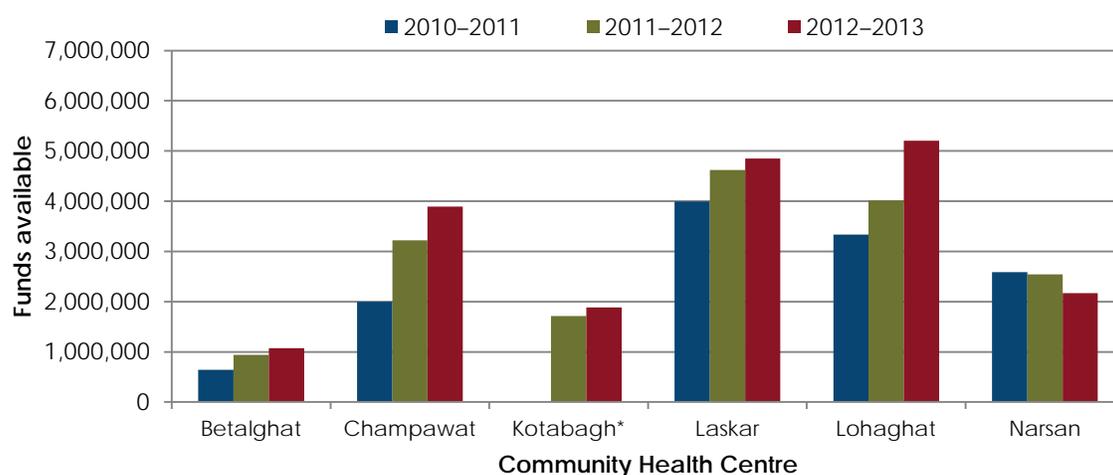
In 2011–12, RCH Flexipool funds were received by the district on June 12, which is almost 2.5 months after the start of the fiscal year. This delay was a result of lengthy approval processes at the centre, state, and district levels. During the interim period, facilities continued essential programme activities such as JSY, VHND, Immunisation, FP, and ASHA meetings using the previous year’s (2010–11) RCH Flexipool balance. One of the DAMs reported that the state instructed the districts to keep a certain amount from 2010–11 to carry out these interim-period activities.

Only one respondent took personal responsibility if funding is ever delayed. This person was at the district level, suggesting that individuals at lower levels may feel like they have no control over the disbursement process. The others surveyed generally blamed higher levels for delays. For example, two respondents in Champawat and three PHC officials in Nainital claimed the delays are a result of the state not receiving funds from the centre in time.

3.3 How Do NRHM Fund Allocations Vary by Year and Facility?

RCH Flexipool Funds Available: Figure 3.3 shows the trends in RCH Flexipool fund allocations for each of the six CHCs. There is some variability in funds available (defined as the grant received plus the opening balance) across years and facilities at the CHC level. For instance, in 2012–13, RCH funds available were almost five times higher for CHC Lohaghat than CHC Betalghat. For all three years, CHC Betalghat received the least amount of money under RCH Flexipool. RCH funding has increased every year for all CHCs except CHC Narsan, which experienced a 16 percent decrease in RCH funds available from 2010–11 to 2012–13. RCH funding almost doubled for CHC Champawat during this time. The research team was unable to follow up with CHCs Champawat and Narsan for to get an explanation as to why funding changed.

Figure 3.3: RCH Flexipool Funds Available (in Rs.) by CHC

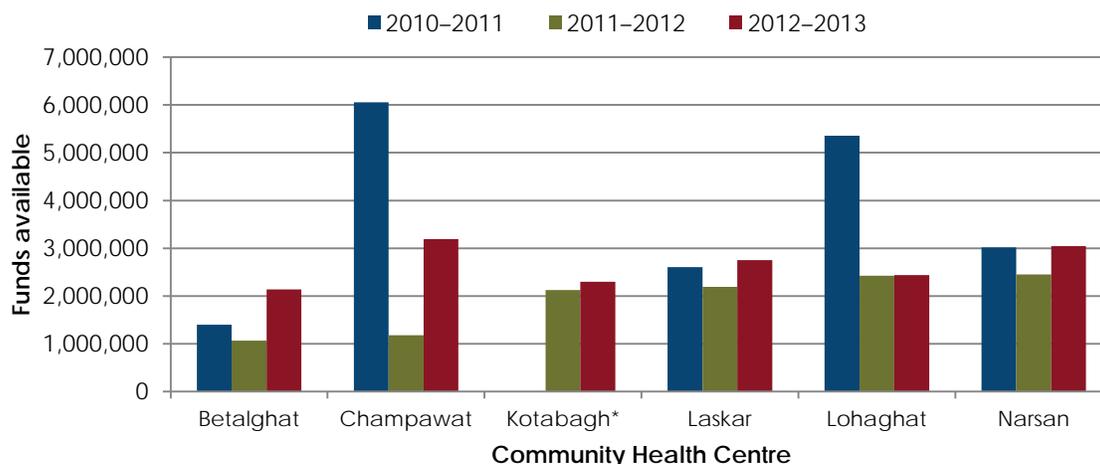


* 2010–11 data not available for CHC Kotabagh.

NRHM Additionalities Funds Available: Figure 3.4 shows the funds available to CHCs under NRHM Additionalities. Unlike the funding for RCH Flexipool, the range in NRHM Additionalities allocations across CHCs was not very large in 2012–13. This is likely due to the standardised provisioning of NRHM Additionalities.

However, similar to RCH funds, CHC Betalghat consistently received the least amount of NRHM Additionalities funding across the three years. NRHM Additionalities funding decreased for all six CHCs from 2010–11 to 2011–12. Funding dropped precipitously during this time for both CHCs in Champawat and Lohaghat (by 47% in CHC Champawat and by 54% in CHC Lohaghat). However, funding increased for all CHCs from 2011–12 to 2012–13.

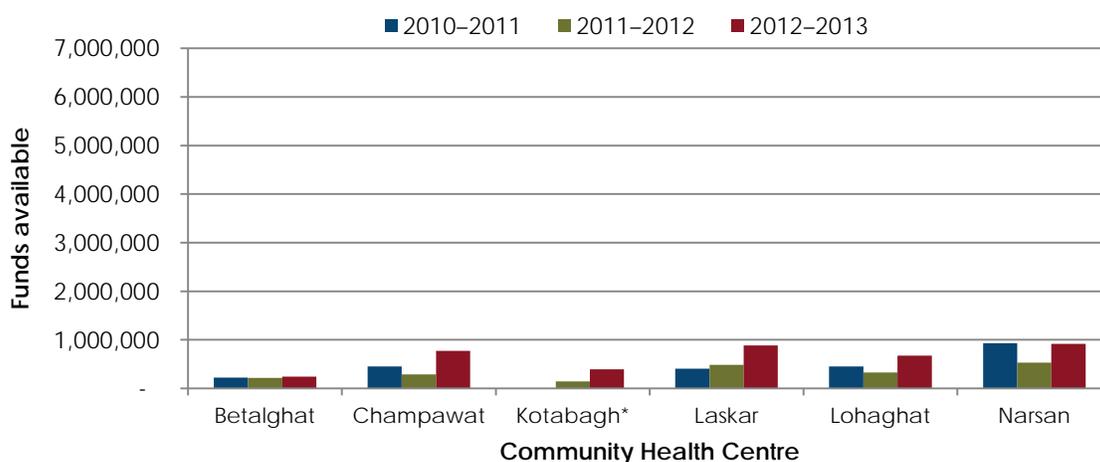
Figure 3.4: NRHM Additionalities Funds Available (in Rs.) by CHC



* 2010-11 data not available for CHC Kotabagh.

RI Funds Available: Figure 3.5 shows the funds available to CHCs under RI. Amounts under RI are much smaller than those under RCH Flexipool and NRHM Additionalities, but RI still represents a significant portion of NRHM funding. In 2012-13, CHC Narsan received more than four times the amount of RI funding than CHC Betalghat received, a possible reflection of differences in block population sizes. While RI funds available decreased from 2010-11 to 2011-12 for most CHCs, all six experienced increases in RI funding from 2011-12 to 2012-13. This increase was particularly dramatic for CHCs Champawat, Kotabagh, and Lohaghat, which experienced more than a twofold increase in RI funding.

Figure 3.5: Routine Immunisation Funds Available (in Rs.) by CHC



* 2010-11 data not available for CHC Kotabagh.

3.5 Conclusion

Similar to findings in the previous chapter on NRHM planning processes, NRHM fund disbursement procedures in Champawat, Nainital, and Haridwar tend to diverge from governmental norms and guidelines.

Delays and banking are key challenges in fund disbursement. Although the adoption of e-banking allows for the easy transfer of funds, some ASHAs are unable to open bank accounts and most facilities reported significant delays in receiving NRHM funds. Furthermore, PHCs and ANMs reported signing authority complications that resulted in difficulties receiving funds.

NRHM fund allocations are volatile. Trends in actual disbursements reveal that funding can shift significantly year-to-year, particularly for RI. Funds received varied widely by facility for RCH and RI, which is likely a result of these funds being allocated based on factors other than facility type. CHCs Betalghat and Kotabagh consistently received the smallest amounts of funding for all three budget heads analysed. This is likely a result of these two blocks (Betalghat and Kotabagh) having the smallest population size of all six blocks sampled (MODWS, 2009).

4. NRHM FUND UTILISATION

The NRHM mandates that 70 percent of resources be spent at the block level and below, and 20 percent spent at the district level. Only a small portion of funds is held at any level above the district. Against its mandate, the NRHM managed to spend 68 percent of its funds at the block and lower levels in its first four years. Twenty-five percent of all funds went into flexible mechanisms such as untied grants, annual maintenance grants to primary healthcare institutions, and to community initiatives (MOHFW, 2009).

Utilisation from two major funding pools maintained by NRHM—Mission Flexible and RCH Flexible—has improved over time nationally. The utilisation rates in 2009–10 were 61 percent for RCH Flexible and 70 percent for Mission Flexible, up from 48 percent and 22 percent, respectively, in 2006–07. Data for 2010–11 suggest utilisation rates have gone above 100 percent (MOHFW, 2011). This indicates increased absorptive capacity of the state health systems. Other studies at the state level show similar patterns. For example, an examination of utilisation of NRHM Additionalities funds in Karnataka revealed that utilisation rates increased from 2008–09 to 2010–11 and that utilisation rates were higher in larger facilities (KSHSRCB and CBPS, 2012).

An important requisite for an effective health financing system is that funds be used to provide health services and further the programme mission. Therefore, it is important to understand how efficiently and effectively health facilities can spend the funds available to them. Both qualitative and quantitative methods were used to explore fund utilisation performance by health facilities and potential barriers to full utilisation of funds.

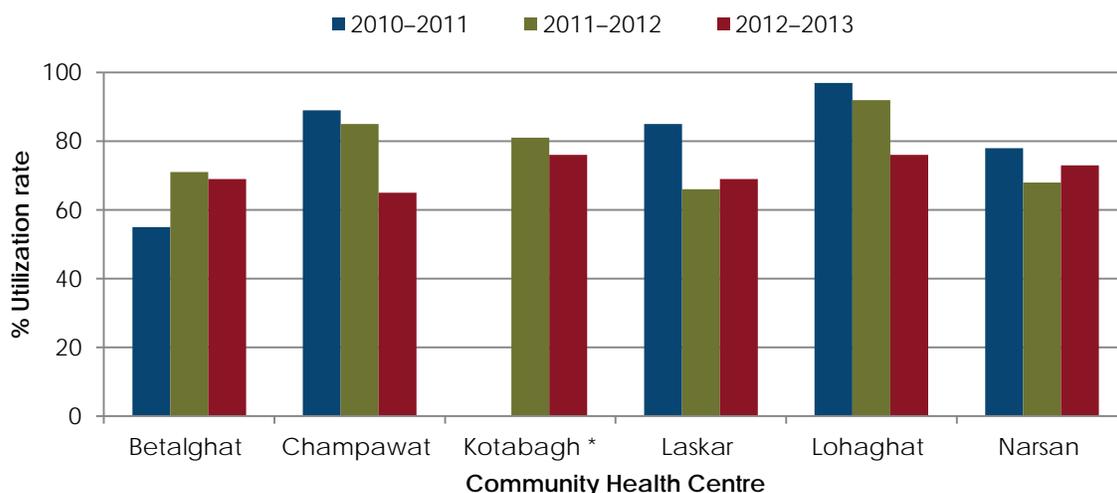
4.2 Fund Utilisation by Budget Heading

This section analyses NRHM fund utilisation across three fiscal years for all six CHCs sampled. NRHM fund utilisation is examined in five PHCs for FY2012–13, as well.¹ The ANMs reported their ability to spend NRHM funds through interview questions.

CHC RCH Flexipool Utilisation: In many ways, RCH Flexipool programmes form the backbone of the NRHM, so the expenditure of this heading is crucial for the success of NRHM's mission. However, this analysis found that the performance of CHCs can be volatile, and they routinely spend less than 80 percent of the funds available to them (see Figure 4.1 and Annex Table A-4). Across the six facilities sampled, average utilisation of the RCH Flexipool was 72 percent in FY2012–13, a decrease from 81 percent in 2010–11 and 77 percent in 2011–12.

¹ Incomplete financial data in most facilities limited the analysis to one fiscal year and five PHCs. No fund utilisation data are available for PHCs in Haridwar due to indirect receipt of funds.

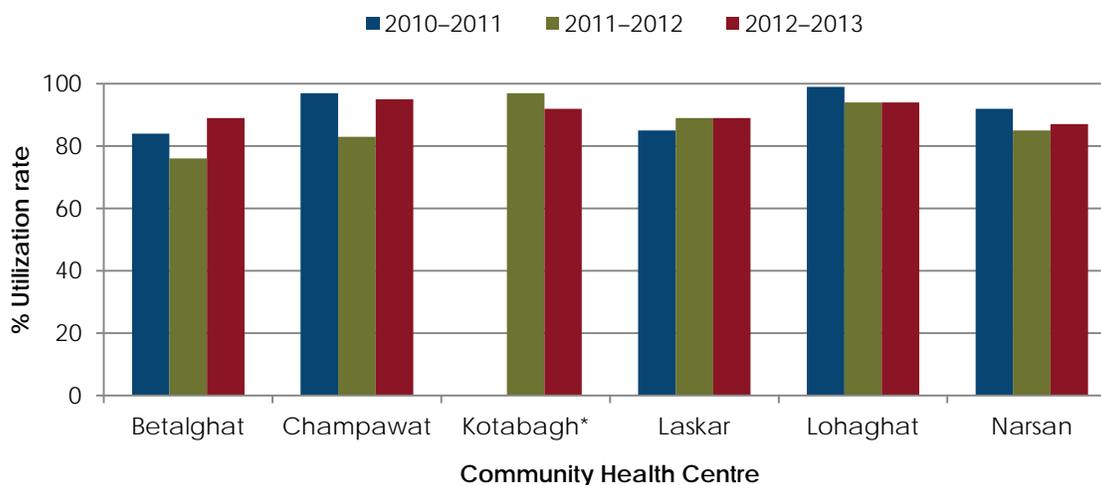
Figure 4.1: RCH Flexipool Utilisation by CHC as a Percentage of Total Available Funds



*Utilisation data for CHC Kotabagh in 2010-11 are unavailable.

CHC NRHM Additionalities Utilisation: Overall, utilisation rates for the NRHM Additionalities fund were greater than the RCH Flexipool utilisation rates. In 2012-13, the six CHCs averaged 91 percent utilisation, and in the three years of analysis, no CHC used less than 76 percent of available funds for any year (see Figure 4.2 and Annex Table A-5).

Figure 4.2: NRHM Additionalities Utilisation by CHC as a Percentage of Total Available Funds

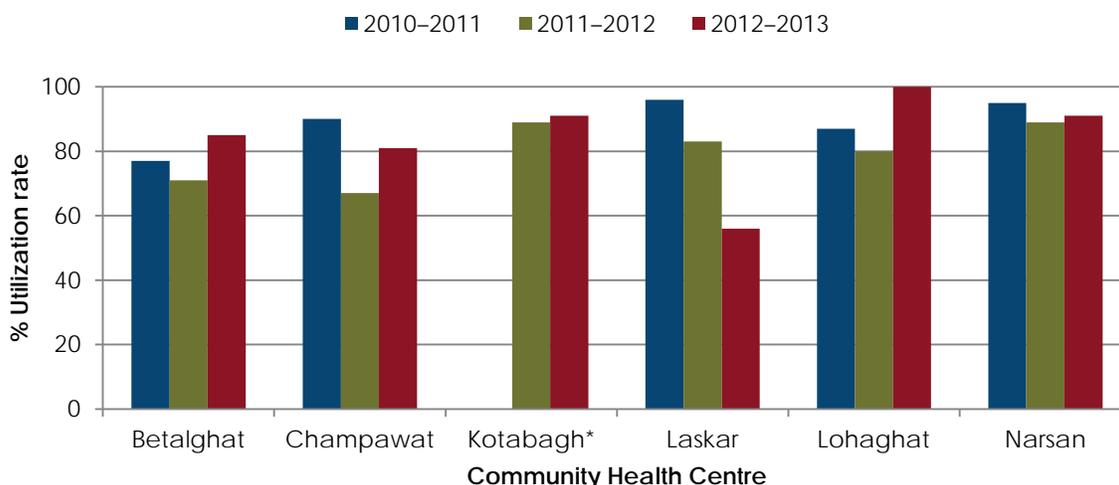


* Utilisation data for CHC Kotabagh in 2010-11 are unavailable.

CHC Routine Immunisation Utilisation: Immunisation plays an important role in the prevention of childhood mortality and is a high priority for the NRHM. In 2010-11, 2011-12, and 2012-13, the CHCs averaged 89 percent, 80 percent, and 84 percent utilisation, respectively (see Figure 4.3 and Annex Table A-6). However, these averages mask differences across years and between facilities. For example, in 2012-13, Laskar CHC spent just 56 percent of funds, despite spending 83 percent in the prior year and 96 percent two years ago. Likewise, Champawat CHC fell to 67 percent utilisation in 2011-12, after spending 90 percent in 2010-11. The following year it rebounded to 81 percent. CHC Lohaghat also

increased its RI utilisation from 80 percent in 2011–12 to 100 percent in 2012–13, demonstrating that large gains are possible from year to year.

Figure 4.3: Routine Immunisation Utilisation by CHC as a Percentage of Total Available Funds

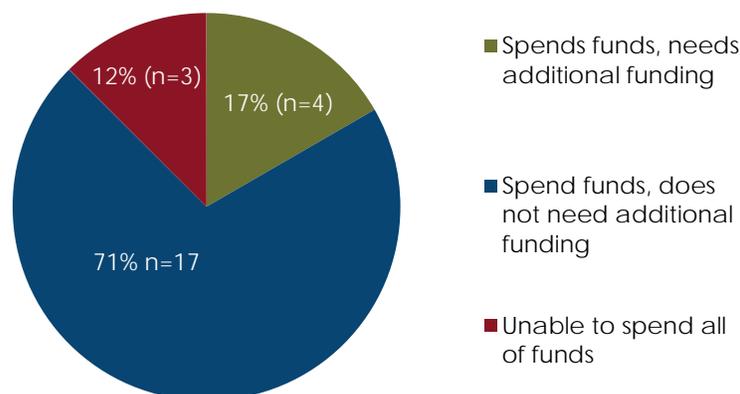


* Utilisation data for CHC Kotabagh in 2010–11 are unavailable.

PHC NRHM Fund Utilisation: Regarding utilisation of RCH Flexipool funds at PHCs, PHCs in Nainital performed better than those in Champawat. The average utilisation rate in 2012–13 in three Nainital PHCs was 73 percent compared to 37 percent in two PHCs in Champawat. In 2012–13, PHCs in Nainital and Champawat had higher utilisation rates for NRHM Additionalities than for RCH Flexipool. On average, PHCs spent 89 percent of their NRHM Additionalities funds.

SC/ANM Fund Utilisation: Based on interviews with ANMs, most (71%) reported being able to spend the entire amount allocated to them in the past year (2012–13) and did not need additional funding to carry out their activities (see Figure 4.4). Of the three ANMs who spent all of their funds and needed more, two specified that they would like additional AMG funding. Only three ANMs (12%) said they were unable to spend their allocations. Although most ANMs said they do not need more funds, two in Champawat volunteered that they would like more supplies, as it is easier to track and use supplies than money.

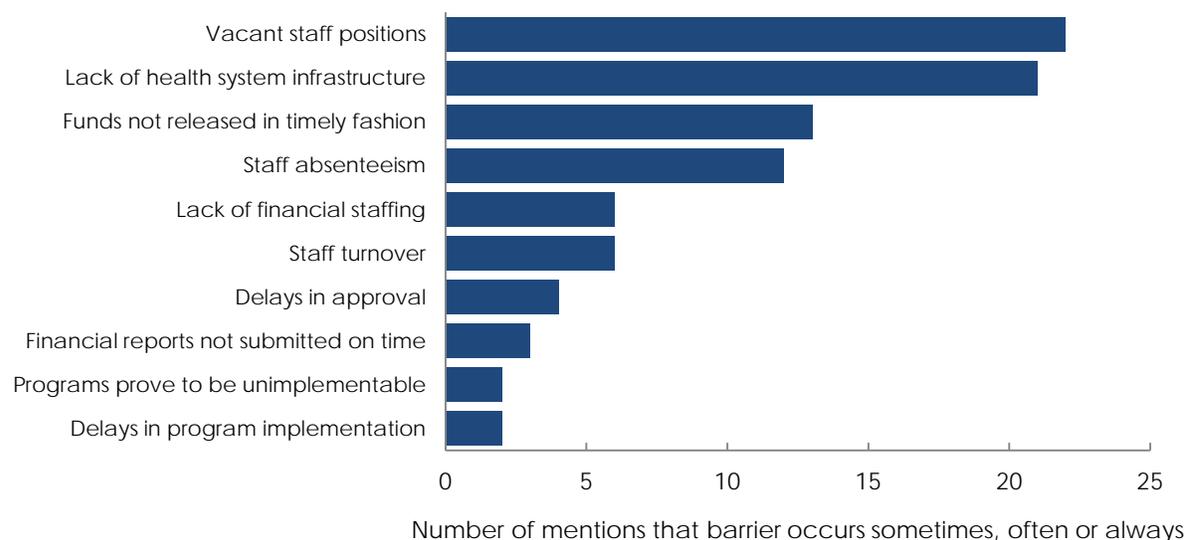
Figure 4.4: Auxiliary Nurse Midwife Ability to Spend Funds



4.3 What Are the Barriers to Fund Utilisation?

To understand barriers to fund utilisation, stakeholders were interviewed about their perceived barriers to spending. The most common identified barriers were vacant staff positions and lack of health infrastructure (Figure 4.5). Delayed fund releases and staff absenteeism were also considered significant barriers to fund utilisation. Programmes being difficult to implement or delayed were not viewed as major barriers to spending.

Figure 4.5: Reported Barriers to Spending (number of mentions)



Source: Interviews with all respondents in sample (n=39).

Lack of Infrastructure and Human Resources: Vacant staff positions were mentioned as the top barrier, most likely due to the high percentage of unfilled staff positions in the state. More than 50 percent of specialist positions are still vacant in Uttarakhand (UKHFWS, 2010–2011). Facilities do not have sufficient staff to provide services, resulting in underperformance and underutilisation of funds at the CHCs, PHCs, and SCs. In particular, CHC staff interviewed felt overloaded due to the lack of service provision at lower levels and high caseloads at CHCs.

Staff absenteeism (12 mentions), lack of financial staffing (6) and staff turnover (6) were also seen as significant barriers to spending. After vacant staff positions, staff turnover and staff absenteeism were the most frequently experienced barriers to spending for CHCs and PHCs, respectively.

Table 4.2 shows the percentage of staff vacancies at CHCs ranges from 22.5 percent at CHC Lohaghat to 62.2 percent at CHC Champawat. CHC Lohaghat may have had consistently higher fund utilisation rates than the other CHCs because it had fewer vacant staff positions.

Table 4.2: Staff Vacancies by CHC

CHC	% of sanctioned staff posts that are vacant	Average NRHM fund utilisation rate (FY2012-2013)
Champawat	62.2%	80%
Betalghat	41.7%	81%
Narsan	38.7%	84%
Laskar	36.8%	71%
Kotabagh	33.3%	86%
Lohaghat	22.5%	90%

In addition to the paucity of human resources, the health system's infrastructure was cited as a top barrier to spending. The healthcare infrastructure refers to the physical upkeep of health systems and facilities, along with the procurement of equipment and supplies. This was viewed as the biggest barrier to spending among ANMs and facilities in Nainital. For example, many sub-centres were unable to perform deliveries due to the unavailability of water and electricity, and ANMs reported having to travel long distances to collect vaccines from the CHC and to reach villages.

Delayed Fund Receipt: As reported in Chapter 3, most facilities experienced significant delays in receiving funds. For instance, SCs generally received their first fund instalment in September–October, approximately six months late. ANMs were most likely to experience funding delays, and they viewed these delays as the second biggest barrier to spending (after health system infrastructure).

Delayed funds present a number of problems for facilities. While waiting for their allocations, facilities reported having to interrupt programme implementation, delay payment to ASHAs, or borrow from other sub-heads. Five ANMs also spent money out-of-pocket to continue NRHM activities. Even after funds are disbursed, CHCs pressure PHCs and SCs to utilise the entire allocation by the end of the fiscal year in March, giving facilities little time to spend the funds.

Problems with Guidelines and Utilising Certain Funding Pools: Respondents in Haridwar and Nainital indicated problems in utilising certain types of funds they received. For instance, a CHC official in Haridwar said that untied and AMG funds are problematic because they are fixed for all CHCs, irrespective of the capacity and functionality of the CHC. Another CHC official in Nainital reported that the CHC needs more AMG funds and less seed money.

Respondents indicated that the guidelines for sub-heads under NRHM Additionalities were unclear. ANMs faced problems during annual audits because some items purchased through AMG were supposed to be purchased using untied funds. To avoid confusion, a few ANMs suggested that the two sub-heads be merged.

4.4 Are There Effective Systems to Monitor Fund Utilisation?

Higher levels (i.e., blocks, districts, and states) need to monitor facilities' fund utilisation and should understand their capacities and needs to improve utilisation rates. For instance, higher levels cannot adjust their allocations or tell facilities to take corrective actions without monitoring. Although respondents reported that a number of mechanisms exist, such as field visits, meetings, audits and financial reporting, many officials experience problems in implementing these processes and would like NRHM to increase monitoring capacity (see Table 4.3).

Table 4.3: Strengths and Weaknesses of Monitoring Mechanisms

Strengths	District level (n=10)		CHCs (n=6)		PHCs (n=9)		ANMs (n=24)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Guidelines for utilisation and disbursement are available	8	80%	6	100%	7	78%	0	0%
Review meetings are held regularly	5	50%	1	17%	3	33%	5	21%
Sends SOEs and other reports to higher level	4	40%	6	100%	8	89%	15	63%
Receives SOEs and other documentation	3	30%	0	0%	2	22%	6	25%
Field visits are made	2	20%	6	100%	7	78%	1	4%
Weaknesses								
No formal monitoring mechanism	6	60%	1	17%	2	22%	0	0%
Lack of resources (time/staff/training/transportation)	6	60%	3	50%	1	11%	1	4%
Incomplete or lack of guidelines for utilisation and disbursement	3	30%	2	33%	2	22%	1	4%
Lack of review meetings or visits	2	20%	1	17%	1	11%	0	0%
Problems with audits	2	20%	1	17%	0	0%	1	4%
Problems receiving SOEs and other documentation	3	30%	2	33%	0	0%	13	54%

Monitoring Mechanisms: Six of ten district officials interviewed reported a lack of formal monitoring mechanisms for physical performance and fund utilisation, and many respondents indicated a shortfall in funding for monitoring. Half of CHC officials and 60 percent of district officials said lack of time, staff, training and/or transportation hindered their capacity to monitor. For example, DAMs in Haridwar and Nainital reported that fund utilisation is not monitored at the district level because of the lack of manpower for monitoring activities. The DPM in Nainital also stated that there are problems due to the separation of DPM and DAM positions. Programme activities and budgeting go hand-in-hand, so separating these roles has disrupted coordination and monitoring.

Submitting Financial Documentation: Although formal mechanisms may not be in place, SOEs are sent to the blocks, districts, and state on a monthly basis for the purpose of monitoring fund utilisation. All six CHCs and seven of nine PHCs reported sending SOEs and other required documents to higher levels in a timely manner. However, none of the CHCs and just two PHCs mentioned receiving SOEs from lower levels, and about a third of district officials and CHCs had problems receiving such documentation. About half of ANMs (54%) experienced problems receiving necessary documents and support from VHNSC.

Field Visits and Review Meetings: Some facilities made field visits and held review meetings to supplement the submission of SOEs. Half of districts and a third of PHCs said review meetings were held regularly. All CHC and most PHC officials (78%) conducted field visits. However, two district officials, a CHC and a PHC, said they would like to have more review meetings and field visits.

Guidelines: While a majority of respondents reported receiving guidelines for fund utilisation and disbursement, many also said guidelines are lacking or incomplete. Although all six CHCs received guidelines, a third found them incomplete or difficult to follow. Incomplete guidelines could be a reason some facilities experienced problems during auditing. Although auditing problems were not common, two district officials, one CHC official, and one ANM, reported difficulties with auditing.

4.5 Conclusion

Fund utilisation rates vary by budget head and do not seem to be improving. Fund utilisation rates at CHCs were lower for RCH Flexipool than for NRHM Additionalities or RI. This presents a problem because RCH Flexipool funds are critical to achieving the NRHM mission of expanding access to healthcare, particularly for women and children. For all three budget heads, utilisation rates were volatile across years and facilities, indicating that utilisation performance is not improving. However, lessons can be learned from facilities that consistently have higher utilisation rates, such as CHC Lohaghat.

Lack of human resources and infrastructure are the main barriers to fund utilisation. The most frequently reported barriers to utilisation were vacant staff positions and a lack of healthcare infrastructure. Delayed fund receipt and misallocation of funds were also perceived as problems in properly utilising NRHM funds.

There are fund monitoring systems in place, but they could be improved. Facilities have various mechanisms in place to monitor fund utilisation and address some of these barriers, including guidelines, SOE submissions, field visits and review meetings. However, some respondents said that there were no formal monitoring mechanisms and that there were problems with the current monitoring system, such as incomplete guidelines, a lack of resources, and problems in sending and receiving financial documentation.

5. ALIGNMENT OF EXPENDITURE WITH PERFORMANCE

Utilisation rates can be used to evaluate fund allocation efficiency and facilities' absorption capacity, but they are not the best measure for spending efficiency and effectiveness. For instance, facilities with high utilisation rates may have low programme outputs and high unit expenditure. To evaluate expenditure efficiency and effectiveness, this chapter examines the relationship between NRHM spending and programme outputs by CHC for three budget heads: JSY, Routine Immunisation, and Family Planning.²

CHCs that spend more than other facilities might be expected to have a greater volume of output. The findings show that greater expenditure is generally linked to greater programme outputs. A closer examination of unit expenditure reveals which facilities are outperforming the others for a lower cost.

5.1 JSY

Janani Suraksha Yojana (JSY) is a programme under NRHM that aims to reduce maternal and new-born mortality by providing financial incentives to mothers who deliver in a health facility. Therefore, a facility's JSY expenditure should be closely related to the number of deliveries at that facility.

Relationship between Spending and Number of Deliveries: JSY expenditure varies greatly by facility. For instance, JSY expenditure in CHC Laskar was nearly 12 times the amount spent in CHC Betalghat in 2012–13. CHC Betalghat spent the least amount of JSY funds in both years, while CHCs Lohaghat and Laskar were consistently the biggest JSY spenders. The number of deliveries at the facilities ranged from 238 in CHC Betalghat to 1,283 in CHC Narsan in 2012–13. CHC Narsan experienced more than a fourfold increase in deliveries from 2011–12 to 2012–13.

Table 5.1: JSY Expenditure and Number of Deliveries at Facility

CHC	2011–12		2012–13	
	JSY Expenditure (Rs.)	No. of deliveries at facility	JSY Expenditure (Rs.)	No. of deliveries at facility
Laskar	1,640,450	920	1,913,496	1,096
Lohaghat	1,901,950	1,140	1,908,150	1,183
Champawat	1,121,877	1,193	1,010,475	1,265
Narsan	665,800	280	683,846	1,283
Kotabagh	603,798	294	676,100	387
Betalghat	191,650	348	163,250	238

JSY expenditure is strongly positively correlated to the number of deliveries at CHCs. CHCs that spent more JSY funds had more deliveries at their facilities than those that spent less. There was a higher correlation between JSY expenditure and the number of deliveries in 2011–12 than in 2012–13.

² The study assumes that HMIS figures on programme outputs for the block are accurate and comprehensive.

Although there is a relationship between JSY fund expenditure and the number of deliveries conducted at the facility, CHCs that spent the most on JSY were not necessarily the highest performing facilities. For instance, CHC Narsan was the highest performing facility in 2012–13, but the fourth highest spender of JSY funds in 2012–13.

Spending Efficiency by Unit Expenditure: Expenditure per delivery varies widely by facility (see Table 5.1). In 2011–12, CHC Narsan spent over four times more RCH funds per birth than CHC Betalghat. The gap in unit expenditures was smaller in 2012–13, but CHC Kotabagh still spent more than three times the amount CHC Narsan spent per delivery.

Table 5.2: Rank order of Facilities by JSY Expenditure per Delivery

2011–12		2012–13	
CHC	Unit expenditures (Rs.)	CHC	Unit expenditures (Rs.)
Narsan	2,378	Kotabagh	1,747
Kotabagh	2,054	Laskar	1,746
Laskar	1,783	Lohaghat	1,613
Lohaghat	1,668	Champawat	799
Champawat	940	Betalghat	686
Betalghat	551	Narsan	533

Unit expenditure decreased for all facilities from 2011–12 to 2012–13, except for CHC Betalghat, which experienced a 25 percent increase in JSY expenditure per delivery. Although CHC Betalghat’s unit expenditure increased, it was still one of the most cost-efficient³ facilities in 2012–13. Many CHCs experienced a decrease in unit expenditure due to increases in the number of deliveries conducted at the facilities. For example, CHC Narsan went from being the least cost-efficient CHC to the most cost-efficient CHC during this time due to a substantial increase in the number of deliveries performed at the facility from 2011–12 to 2012–13.

³ Cost-efficient is defined here as having relatively lower unit expenditure than the other facilities.

Box 5.1

5.2 Routine Immunisation

RI funds are used to purchase vaccines and syringes and to cover the costs of cold chain maintenance and programme operations. As facilities spend more RI funds, the number of measles and Bacillus Calmette Guerin (BCG) vaccinations administered is expected to increase. Although measles and BCG vaccinations are just a subset of the vaccinations funded under the RI budget heading (see Box 5.1), they are representative of a facilities' vaccination output and are directly connected to RI. Therefore, the number of measles and BCG vaccinations conducted at each CHC is an important indicator for analysing RI expenditure efficiency.

RI vaccines:

- BCG
- DPT
- Measles
- Hepatitis B
- JE vaccination (select high burden states)
- Hib containing Pentavalent vaccine (DPT+HepB+Hib, in select states)

Relationship between Spending and Number of Measles and BCG Vaccinations: In both years (2011–12 and 2012–13), CHC Betalghat spent the least on RI, while CHC Narsan spent the most. The range in expenditure was quite large, as CHC Narsan spent nearly three times as much as CHC Betalghat during this time. All six CHCs increased their RI expenditure from 2011–12 to 2012–13. CHC Champawat increased expenditure the most (threefold), followed by CHCs Lohaghat and Kotabagh. CHC Laskar experienced the least amount of growth in RI expenditure (23%).

The number of measles and BCG vaccinations administered at a facility varied greatly by CHC. For instance, CHC Narsan provided 6.6 times as many vaccinations as CHC Betalghat in 2012–13. There was relatively little change in the number of vaccinations provided by the facilities in 2012–13 compared to 2011–12.

Table 5.3: RI Expenditure and Number of Measles and BCG Vaccinations

CHC	2011–12		2012–13	
	RI Expenditure (Rs.)	No. of measles and BCG vaccinations	RI Expenditure (Rs.)	No. of measles and BCG vaccinations
Narsan	472,150	6,902	828,925	7,453
Lohaghat	262,270	1,940	679,876	1,969
Champawat	194,200	3,891	625,185	3,595
Laskar	401,200	7,701	495,275	6,932
Kotabagh	130,530	1,932	360,366	2,040
Betalghat	154,750	1,351	296,098	1,123

RI expenditure was strongly positively correlated with the number of BCG and measles vaccinations in 2011–12, but less so in 2012–13. This is mainly a result of the number of vaccinations staying relatively constant while expenditure increased significantly in most facilities from 2011–12 to 2012–13.

The number of measles and BCG vaccinations provided by the two highest-expenditure facilities (CHCs Narsan and Lohaghat) varied greatly in 2012–13. Even though CHC Narsan spent about 21 percent more RI funds than CHC Lohaghat, CHC Narsan provided 3.8 times as many measles and BCG vaccinations than CHC Lohaghat. As a result, CHC Narsan is consistently a high-spending and high-performing facility. At the other end of the spectrum, CHC Betalghat is a low-spending and low-performing facility in both years.

Spending Efficiency by Unit Expenditure: The unit expenditure per vaccination for measles and BCG is indicative of the overall RI spending efficiency. For both years, CHCs Lohaghat and Betalghat were the least cost-efficient facilities among the six CHCs. The gap between the most cost-efficient and least cost-efficient facility increased from 2011–12 to 2012–13. In 2011–12, CHC Lohaghat’s RI expenditure per vaccination was 2.7 times greater than CHC Champawat. In 2012–13, CHC Lohaghat’s expenditure per vaccination for measles and BCG was 4.9 times greater than CHC Laskar, the most cost-efficient facility that year.

Table 5.4: Rank Order of Facilities by RI Expenditure per Measles/BCG Vaccination

2011–12		2012–13	
CHC	Unit expenditure (Rs.)	CHC	Unit expenditure (Rs.)
Lohaghat	135	Lohaghat	345
Betalghat	115	Betalghat	264
Narsan	68	Kotabagh	177
Kotabagh	68	Champawat	174
Lashkar	52	Narsan	111
Champawat	50	Lashkar	71

Every facility experienced a significant increase in unit expenditure from 2011–12 to 2012–13, indicating that facilities were spending more rupees per vaccination delivered. Per-unit expenditure more than tripled for CHC Champawat and more than doubled for CHCs Lohaghat, Kotabagh, and Betalghat during this time. Per-unit expenditure increased by 37 percent in CHC Laskar from 2011–12 to 2012–13, the least amount of growth in unit expenditure among the CHCs. Additional research is needed to explain why the number of measles vaccinations conducted at the facilities did not increase as RI expenditure increased. Possible explanations include inadequate planning, as the three districts sampled were allocated significantly more RI funds than were requested in 2012–13.

5.3 Family Planning

Line items under family planning are mostly related to sterilisation and intrauterine device (IUD) distribution. As a result, it is expected that family planning expenditure will be linked to the number of IUD insertions and sterilisations performed at a facility. Although family planning funds are used for other activities as well, the number of IUD insertions and sterilisations is indicative of FP programme output at facilities.

Relationship between Spending and Number of Sterilisations and IUDs: Family planning expenditure ranged from 101,750 rupees to 263,690 rupees in 2012–13. A similar range was evident in 2011–12. CHC Laskar was the highest-spending facility in both years, and spent about 2.5 times as much as the lowest-spending facility. Family planning expenditure decreased slightly in every facility from 2011–12 to 2012–13, except CHC Betalghat.

For each facility, the number of IUD insertions greatly exceeded the number of sterilisations conducted each year. These performance indicators were combined for analysis. The total number of sterilisations and IUD services varied greatly by facility and the gap between facilities grew from 2011–12 to 2012–13. For instance, CHC Narsan, the highest-performing facility, completed 5.3 times more sterilisations and IUD insertions in 2011–12 than CHC Betalghat, the lowest-performing facility. By 2012–13, CHC Narsan performed 13.2 times as many sterilisations and IUD insertions as CHC Betalghat. This was due

to a combination of CHC Narsan increasing its output and CHC Betalghat decreasing its output during this time.

Table 5.5: Family Planning Expenditure and Number of Family Planning Services (Sterilisations and IUD insertions)

CHC	2011–12		2012–13	
	FP Expenditure (Rs.)	No. of FP services	FP Expenditure (Rs.)	No. of FP services
Laskar	291,230	1,448	263,690	1,026
Lohaghat	242,740	685	239,020	680
Kotabagh	215,950	642	184,800	684
Champawat	169,390	1,186	169,220	1,090
Betalghat	116,470	422	125,200	252
Narsan	130,750	2,249	101,750	3,327

There was not a consistent relationship between facilities' family planning expenditure and the number of sterilisations performed and IUDs inserted. However, CHC Narsan was an outlier for both years, as the number of family planning services conducted greatly exceeded the numbers for other facilities. When CHC Narsan was removed from the analysis, there was a positive correlation between family planning expenditure and performance for the remaining facilities in both years. This means that as the facilities spent more on family planning, the number of sterilisations conducted and IUD insertions increased.

Spending Efficiency by Unit Expenditure: The unit FP expenditure per sterilisation and IUD insertion serves as an important indicator for FP spending efficiency as IUD insertions and sterilisations are the most common outputs for family planning. Even though not all family planning outputs are accounted for, this analysis conceptually shows facilities' spending efficiency. Table 5.3 illustrates the range in unit expenditure by CHC. Some variations in unit expenditure could be explained by the difference in price between sterilisations and IUD insertions. For example, while CHC Laskar performed 17 times more IUD insertions than sterilisations in 2012–13, CHC Betalghat only performed 1.7 times as many. This may partially explain why CHC Betalghat had higher unit expenditure for family planning services than CHC Laskar.

Still, there were significant differences in unit expenditures across facilities. In 2011–12, the least cost-efficient facility spent six times as much per family planning service than the most cost-efficient facility. This disparity grew in 2012–13, when the least cost-efficient facility spent 16 times as much as the most cost-efficient facility per family planning service.

Table 5.6: Rank Order of CHCs by Family Planning Expenditure per Family Planning Service

2011–12		2012–13	
CHC	Unit expenditure (Rs.)	CHC	Unit expenditure (Rs.)
Lohaghat	354	Betalghat	497
Kotabagh	336	Lohaghat	352
Betalghat	276	Kotabagh	270
Laskar	201	Laskar	257
Champawat	143	Champawat	155
Narsan	58	Narsan	31

CHC Narsan was the most cost-efficient facility in both years and actually improved its efficiency in 2012–13 by decreasing its family planning unit expenditure by 47 percent. CHCs Champawat and Laskar were also relatively cost efficient in both years, although both facilities experienced an increase in unit expenditure from 2011–12 to 2012–13. CHC Betalghat went from being the fourth most cost-efficient facility to the least cost-efficient facility due to an 80 percent increase in unit expenditure.

5.4 Conclusion

The relationship between expenditure and programmatic output and the unit expenditure per output is indicative of how well facilities are performing relative to others.

Spending is related to programmatic output. This study found that the relationship between increased expenditure and better programmatic performance was evident for JSY and RI. As facilities spent more of these funds, the number of births and BCG and measles vaccinations conducted at the facility increased. However, family planning expenditure and the number of family planning services provided at the facility were only related when the most cost-efficient CHC was removed from the analysis.

There are wide ranges in unit expenditure by year and CHC. There was a large range in unit expenditure across facilities. In 2012–13, CHC Narsan had the lowest unit expenditure for JSY and family planning and the second lowest unit expenditure for RI, indicating that it is one of the most cost-efficient CHCs. Although this may be a result of economies of scale due to the block’s relatively larger population size, other factors, such as better financial management and planning, could play a role in CHC Narsan’s lower unit expenditure.

All facilities experienced a significant increase in RI unit expenditure from 2011–12 to 2012–13. FP and JSY unit expenditure also increased in half of the CHCs during this time. These results suggest that spending efficiency may not be improving in facilities.

6. SUMMARY AND RECOMMENDATIONS

6.1 Summary

The NRHM's existence has resulted in increased funds being available for delivering healthcare services to the rural population. To evaluate the effectiveness of NRHM financing, the Policy Unit of NIHF, HPP, and NHSRC carried out a study in Uttarakhand to understand the patterns and barriers in fund flow and utilisation at various levels of the health system.

The study was designed and executed in two phases: Phase 1 looked at fund flow and utilisation at the state and district levels, while Phase 2 examined these patterns below the district level. According to the NRHM mandate, at least 70 percent of funds should be spent at the block level and below, so it is important to understand processes at these lower levels. The key results to Phase 2 are summarised below.

Planning and Budgeting: The study found evidence of highly centralised, top-down planning, despite NRHM's intent for a bottom-up approach. Under a bottom-up approach, districts and blocks are expected to consult with lower levels of the system when preparing planning and budget documents for NRHM funding. However, the qualitative data collected suggest there is a lack of consultative process between these levels during the planning phase. The analysis also revealed that the DHAPs are not the primary basis for allocating the funds to the districts. This may suggest that neither the planning input from lower levels is obtained nor are the resource demands of lower-level facilities adequately met. In terms of community involvement, respondents interviewed for the study suggested that the RKS is an important part of planning and budgeting, however its function could be improved through more frequent meetings and active participation.

Fund Allocation and Disbursement: An important study finding is that fund allocation by the centre to districts is often not done according to their requests. Although e-banking has made fund transfers easier for some facilities, there were problems with fund receipt, such as major delays in receiving funds from higher levels and ASHAs facing complications in opening bank accounts. The PHCs and ANMs also reported problems with their signing authority for receiving funds.

Fund Utilisation: The study found that funds below the district level are not fully utilised. At CHCs, the RCH Flexipool account funds have lower utilisation rates than NRHM Additionalities and Routine Immunisation accounts; an average of only 72 percent of RCH funds was spent in 2012–13. The most common barriers to fund utilisation are a lack of facility-based resources (particularly human resources), delayed fund receipt, and misallocation of funds. To monitor utilisation, facilities reported submitting SOEs and receiving guidelines. However, a lack of formal monitoring mechanisms and problems with the current system, such as incomplete guidelines, were reported.

Expenditure Effectiveness: There is some evidence that expenditures were effective in the sense that resource use was connected with performance. The JSY and RI expenditure was positively correlated to the number of deliveries and measles and BCG vaccinations administered at CHCs. CHCs that spent more JSY and RI funds had more deliveries at their facilities and provided more vaccinations than those that spent less. However, this relationship was not as strong for family planning funds and other programme output. Wide ranges observed in unit expenditure for services also suggest that there is room for improvement at higher-cost facilities.

6.2 Recommendations

Recommendations from Phase 1: State and District

Analysis of financial data from the NRHM in Uttarakhand under Phase 1 of this study revealed that, while the state has shown impressive improvements in health outcomes in recent years, opportunities exist for accelerated gains if the effectiveness of NRHM financing can be increased.

Allocations to districts should be tied to health needs and spending patterns. Uttarakhand districts with large population sizes generally receive more NRHM funds than districts with small population sizes, but NRHM allocations per capita vary widely by district and are very poorly correlated to health status, thereby missing an opportunity to target funds on the basis of health needs. After allowing for higher costs in hilly districts, enhanced funding in larger districts with poorer health indicators may be needed to make greater gains in overall health. This utilisation analysis suggests that these large districts can perform as well as smaller districts in spending additional funds.

Currently, the state is required to ensure that High-Focus Districts receive at least 30 percent more funds than non-HFDs (MOHFW, 2011c). However, the basis for this requirement is unclear, since NRHM Programme Implementation Plan guidance documents do not define what the additional 30 percent should cover, and no evidence was found that this guideline is strictly followed. The basis for the 30 percent HFD adjustment should be made clear and consistent.

Districts should also be prioritised according to their spending patterns. Uttarakhand should provide assistance in strengthening districts' spending patterns by identifying weaknesses in the district-level systems.

District utilisation rates should be improved. Districts in Uttarakhand spend approximately three-quarters of the total funds available to them. This is relatively efficient compared to other states but should be improved. Based on HPP's analysis, there is an opportunity to increase spending rates and achieve greater scale and cost efficiency. Districts must address the barriers to utilisation below the district level (identified in Phase 2) to improve the efficiency of the NRHM health system.

Districts should better target allocated funds to budget sub-headings within the overall RCH and NRHM Additionalities funding pools. Health prospects across a particular district could be improved if district planners consciously aligned *within-district* health expenditures to a district's health needs. Just as it is critical for the state to allocate NRHM funds to districts in accordance with their needs, it is equally important that the districts subsequently spend those funds in the priority areas of health that need the most improvement.

Recommendations from Phase 2: District and Below

Based on the results Phase 2, the following actions are recommended to improve planning, fund disbursement, fund utilisation, and spending effectiveness below the district level.

Districts and blocks should prioritise bottom-up planning to ensure the demands of lower levels and facilities are met. The study found evidence of top-down planning and disconnections between funding requests and actual allocation. It is recommended that districts and blocks hold regular meetings with lower levels to receive feedback on health action plans and to review current performance, according to the NRHM guidelines. The state should review why DHAP requests are not being met, and how the DHAP process can be improved. Furthermore, facility-level managers should be trained on planning and target setting in poor-performing facilities.

Community involvement in planning needs to be scaled up. Members of VHNSC and RKS should be recruited based on their availability and commitment to helping communities realise their health needs. For instance, CHCs suggested that RKS members should come from the health department because those members tend to be more actively involved. RKS and VHNSC meetings should be more frequent, in accordance with NRHM guidelines. It is also recommended that best practices be exchanged between community organisations. RKS and VHNSCs that are performing well (i.e., those who meet frequently and are actively involved with planning, budgeting, and monitoring) can share their procedures to strengthen low-performing community organisations.

Funds must be released on time to facilities. Facilities frequently experienced NRHM fund delays. Efforts can be made to ensure that funds are released on time to the implementing units. First, CHCs and PHCs should rely on e-banking rather than cheques and health workers must have guaranteed access to bank accounts. Second, signing-authority policies for lower levels should be re-evaluated. ANMs could be the sole signatories for fund receipt, as Gram Pradhans frequently withhold funds. PHCs without an MOIC should be able to designate signing authority to another PHC official. Third, health action plans, SOEs, and UCs should be submitted on time so that higher levels can allocate and disburse funds accordingly. Increased human and financial resources and improvements in planning and community involvement may reduce delays in submitting financial documentation.

Districts and facilities need to improve facilities' capacities to spend funds. The main impediments to fund utilisation are human resource constraints. The district and facilities must improve the performance of existing manpower. For instance, DPMs are underutilised and should conduct more monitoring visits to CHCs, PHCs, and SCs. Facilities should also prioritise filling vacant staff positions through local recruiting. Other resources related to healthcare infrastructure (e.g., roads, service delivery systems, electricity) must be improved for facilities to carry out NRHM programmes. Guidelines on fund utilisation should be made more accessible and easier to follow because many ANMs had difficulty understanding the differences between untied and AMG funds.

Facilities should improve spending efficiency by learning from cost-efficient (i.e., low-expenditure, high-performing) facilities. Additional studies should analyse facilities with relatively low expenditure and high programmatic output to address problems with high-cost, low-performing facilities. The wide variation in unit expenditure suggests that there is room for improvement in facilities with high unit expenditure. Blocks should lead this initiative because they have the ability to mentor lower-level facilities for the proper utilisation and management of NRHM funds.

Monitoring processes need to be formalised and strengthened. Many respondents indicated a need for more formalised monitoring mechanisms. The block programme management units should be strengthened by hiring an accounts manager who will be responsible for streamlining the accounting systems. In addition to the requirement of submitting SOEs and UCs, field visits and review meetings are required to ensure that facilities adhere to NRHM guidelines. Staff involved in fund management should be trained and have formal communication channels with higher levels. All communication should be passed down to lower levels instantly and, if necessary, formal briefings by the state and district to blocks and facilities should be conducted. Facilities need increased funding and other resources to perform these monitoring functions. Increased community involvement can also help strengthen monitoring.

ANNEX

Pilot Testing of Tools

All the study tools were piloted in Dehradun district by the study team members and finalised after incorporating feedback received from pilot testing.

Orientation of the Team for Data Collection

A one-day orientation programme was organised at NIHFW on October 14, 2013, for researchers from NHSRC, NIHFW, and HPP before they went into the field for data collection. The objectives were to ensure common understanding among all the researchers and to modify the tools wherever required.

Table A-1. Provisioning of AMGs, Untied Funds and Seed Money Per Annum

Type of Facility/Recipient	AMG (Rs.)	Untied Funds (Rs.)	Seed Money (Rs.)
District Hospital	N/A	N/A	500,000
Community Health Centre	100,000	50,000	100,000
Public Health Centre	50,000	25,000	100,000
Sub-Centre	10,000	10,000	N/A
VHSC	N/A	10,000*	N/A

*Per 1,500 population. Source: MOHFW, n.d.

Table A-2. Interview Details

Name	Designation	Place of interview	Date of Interview
Dr. Rajesh Shah	Chief MS	Male District Hospital, Nainital	22.10.2013
Dr. Bhabani Pal	Chief MS	Female District Hospital, Haridwar	31.10.2013
Dr. Rajesh Gupta	Chief MS	Male District Hospital, Haridwar	31.10.2013
Ms. Surabhi	DAM	Haridwar	28.10.2013
Mr. Karakotti	DAM	Nainital	22.10.2013
Indi Bhaskar Painuly	DAM	Champawat	14.11.2013
Mr. Amit	DPM	Haridwar	28.10.2013
Gaurav Pandey	DPM	Champawat	14.11.2013
Mr. Madan Mehra	DPM	Nainital	23.10.2013
Dr. B.K. Thakur	DY CMO	Haridwar	28.10.2013
Dr. Alpana Mishra	MOIC	PHC Dhari, Nainital	23.10.2013
Dr. A.K.Sharma	MOIC	CHC Betalghat, Nainital	24.10.2013
Dr. Monoj Kandwal	MOIC	CHC Kotabagh, Nainital	25.10.2013
Dr. Anil Verma	MOIC	CHC Laksar, Haridwar	29.10.2013
Dr. Shahenaz	MOIC	PHC Dhandera, Haridwar	N/A
Dr. NC Tiwarri	MOIC	PHC MOTAHALDI, Nainital	23.10.13
Dr. AK Sinha	MOIC	CHC Narsan, Haridwar	29.10.2013
Dr. UC Joshi	MOIC	PHC Joelikat, Nainital	24.10.13
Dr. Om Prakash	MOIC	PHC Kaladungi, Nainital	25.10.13
Smt. Maya Sah	ANM	SC Lohila, Nainital	24.10.2013
Smt. Sohba	ANM	SC Simalkha, Nainital	24.10.2013
Smt. Rebti	ANM	SC Betalghat, Nainital	24.10.2013
Smt. Radha negi	ANM	SC Tallisethi, Nainital	24.10.2013
Smt. Devki Gunvat	ANM	SC Okhaldhunga, Nainital	25.10.2013
Smt. Janki Arya	ANM	SC Bansi, Nainital	25.10.2013
Smt. Sakuni Aya	ANM	SC Pataliya, Nainital	25.10.2013
Km. Chandra Arya	ANM	SC Ginti Gaon, Nainital	25.10.2013
Smt. Bhagwatti	ANM	SC Rashi, Haridwar	30.10.2013
Smt. trilotama	ANM	SC Rampura, Haridwar	30.10.2013
Smt. Shyam bala	ANM	SC Nirajpur, Haridwar	30.10.2013
Smt. Sudha Rani	ANM	SC Bhaktan Pur, Haridwar	30.10.2013
Naraini Bisht	ANM	SC Sibti, Champawat	14.11.2013
Mamata Goswami	ANM	SC Mohan Pokhri, Champawat	14.11.2013
Manjulata Pant	ANM	SC Dhaun, Champawat	15.11.2013
Basanti Samant	ANM	SC Bhaghana Mehra, Champawat	14.11.2013
Sushila Joshi	ANM	SC Lupra, Champawat	12.11.2013
Shakuntala Chand	ANM	SC Pullhindola/Pulla, Champawat	12.11.2013
Tarawati Mowny	ANM	SC Kemtoli, Champawat	12.11.2013
Devki Joshi	ANM	SC Chankande, Champawat	12.11.2013

**Table A-3. Amounts Proposed in DHAPs
Compared to the Amounts Approved in ROP (in crore⁴ Rs.)**

Budget Heads	Amount Proposed in DHAP		Amount Approved in ROP		% of proposed amount approved	
	11-12	12-13	11-12	12-13	11-12	12-13
Haridwar						
RCH Flexipool	1,033.3	1,231.6	558.2	687.0	54.0	55.8
Additionalities Under NRHM	475.3	497.3	259.0	419.0	54.5	84.3
Routine Immunisation	64.1	64.6	42.2	81.4	65.8	192.8
Nainital						
RCH Flexipool	1,231.6	836.9	520.1	578.2	42.2	69.1
Additionalities Under NRHM	427.6	254.8	335.2	389.9	78.4	153.0
Routine Immunisation	64.6	30.5	23.9	60.9	37.0	199.7
Champawat						
RCH Flexipool	224.5	218.3	186.1	276.86	82.9	126.8
Additionalities Under NRHM	150.7	150.8	172.3	149.43	114.3	99.1
Routine Immunisation	14.29	14.3	10.79	24.51	75.5	171.5

Table A-4. Utilisation of RCH Flexipool Funds by CHC (in Rs.)

	2010-11		2011-12		2012-13	
	Funds available	Expenditure	Funds available	Expenditure	Funds available	Expenditure
Haridwar						
CHC Narsan	2,585,545	2,022,050	2,545,645	1,722,991	2,166,495	1,584,946
CHC Laskar	3,995,739	3,415,723	4,622,481	3,031,753	4,852,329	3,353,645
Nainital						
CHC Betalghat	640,047	352,030	942,132	673,165	1,073,145	743,784
CHC Kotabagh	N/A	N/A	1,712,514	1,381,670	1,882,379	1,438,913
Champawat						
CHC Champawat	1,997,816	1,773,130	3,219,126	2,740,597	3,895,757	2,533,680
CHC Lohaghat	3,336,716	3,233,525	4,014,281	3,679,095	5,204,772	3,965,319

⁴ Crore is a unit in the South Asian numbering system equal to ten million.

Table A-5. Utilisation of NRHM Additionalities Funds by CHC (in Rs.)

	2010-11		2011-12		2012-13	
	Funds available	Expenditure	Funds available	Expenditure	Funds available	Expenditure
Haridwar						
CHC Narsan	3,019,697	2,764,010	2,452,837	2,076,450	3,044,574	2,637,750
CHC Laskar	2,602,160	2,215,700	2,191,296	1,942,782	2,749,768	2,448,706
Nainital						
CHC Betalghat	1,397,599	1,170,585	1,064,665	812,650	2,136,557	1,895,643
CHC Kotabagh	N/A	N/A	2,122,851	2,049,819	2,300,059	2,126,673
Champawat						
CHC Champawat	6,052,114	5,895,813	1,181,594	978,596	3,194,249	3,019,372
CHC Lohaghat	5,353,675	5,301,279	2,422,480	2,284,856	2,437,919	2,292,854

Table A-6. Utilisation of RI Funds by CHC (in Rs.)

	2010-11		2011-12		2012-13	
	Funds available	Expenditure	Funds available	Expenditure	Funds available	Expenditure
Haridwar						
CHC Narsan	934,061	885,950	531,161	472,150	914,836	828,925
CHC Laskar	409,875	392,850	483,650	401,200	885,900	495,275
Nainital						
CHC Betalghat	222,125	170,600	219,480	154,750	346,622	296,098
CHC Kotabagh	N/A	N/A	146,130	130,530	394,526	360,366
Champawat						
CHC Champawat	449,500	403,170	290,553	194,200	773,877	625,185
CHC Lohaghat	453,991	395,605	329,306	262,270	677,481	679,876

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