# The Fiscal Underpinnings of Gender Equity

## Health, Nutrition and Welfare Programs for Women

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**(Research Assistance: Prashant Raymus)**

Sahaj

towards alternatives in health and development

EQUAL MEASURES 2030

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# Introduction

Budgets are the critical lifeline to create social equity across the board. Budgets are contested territory of competing interests but in most countries, including India, there is a strong constitutional mandate for committing budgets that lead to social and economic equity. This may be through fundamental rights or through directive principles for state policy.

Gender equity is a fundamental right in India (no discrimination based on sex) and the state endeavours to develop programs and services to respect, protect and fulfil this right. India is also committed to SDGs and here we will assess how India is committing its budgetary allocations to meet a few targets that impinge on gender equity, especially related to health, nutrition and welfare of women and girls. The focus would be on the following targets:

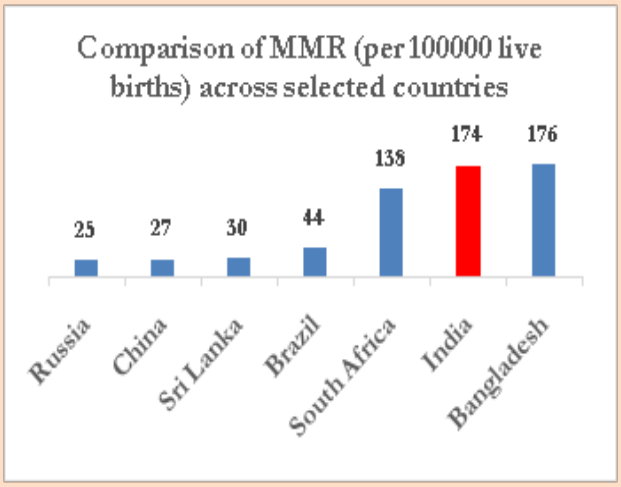
- Reducing maternal mortality (3.1),
- Ensuring universal access to sexual and reproductive health (SRH) services (3.7),
- Eliminating violence against women (VAW) in public and private spheres (5.2),
- Eliminating harmful practices such as child, early and forced marriage and female genital mutilation (5.3) and
- Ensuring universal access to SRH rights (5.6)

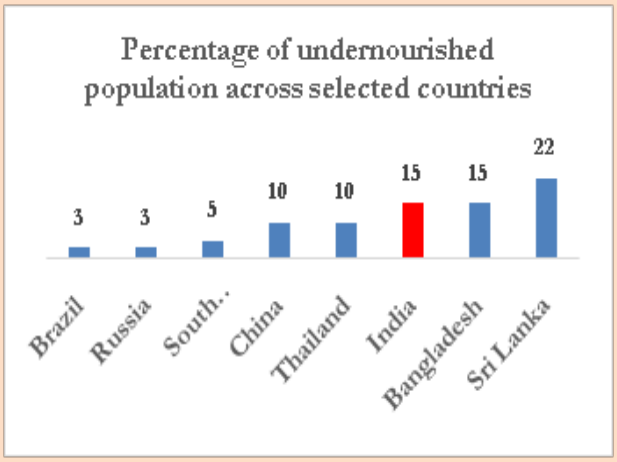
# Health, Nutrition and Welfare Deficit

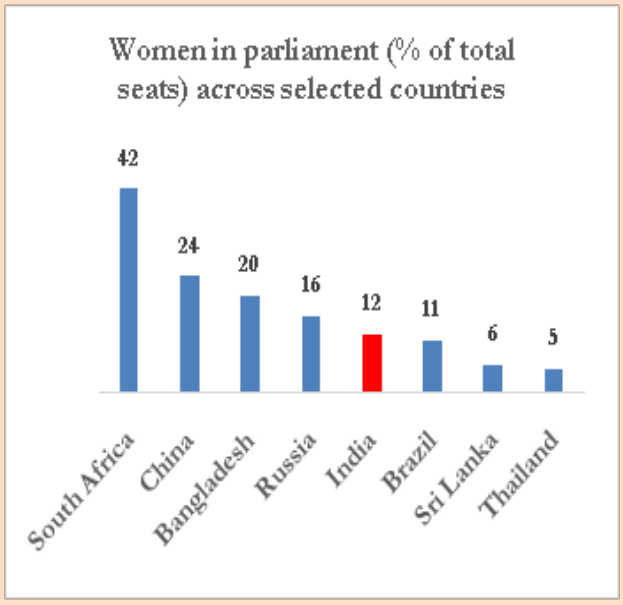
Under global oversight with commitments towards MDGs and SDGs, one has seen an increased pace of improvement in the above indicators during the last two decades. New focused programs and schemes specially targeted at women and girls to provide direct benefits and services in the arena of health, nutrition, livelihoods and protection from abuse; law-making in arena of domestic violence, sexual assault/abuse, sex selection etc. and resource allocations for these have been made. While we have seen some improvements over the years in outcomes related to many of these targets, inadequate allocation of resources for these various programs and schemes have made the implementation of these programs ineffective and/or very limited in its reach. This is largely responsible for the continued deficit we see in health, nutrition and welfare outcomes especially for women and girls.

Overall the health, nutrition and welfare deficit in India is still quite huge when compared with countries of similar level of development or even with countries which are less economically developed than India.

Following are some of the examples of this.



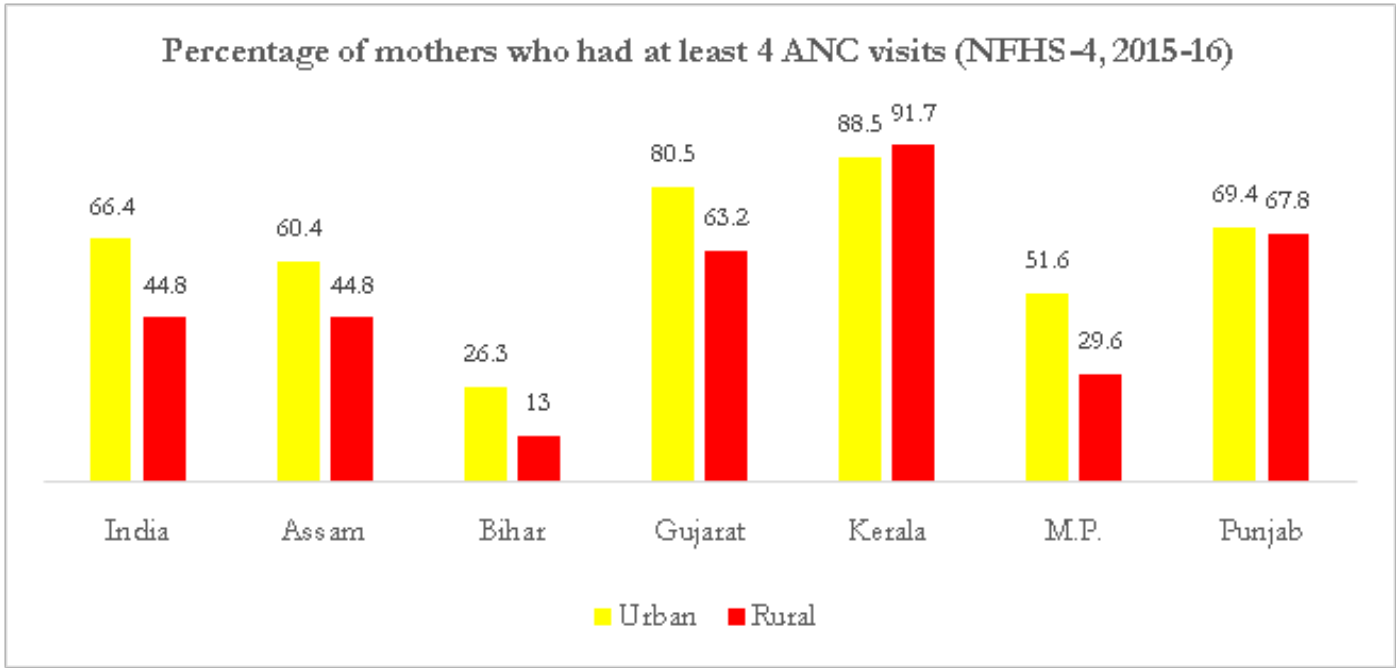

***Source: World Development Indicators, The World Bank***

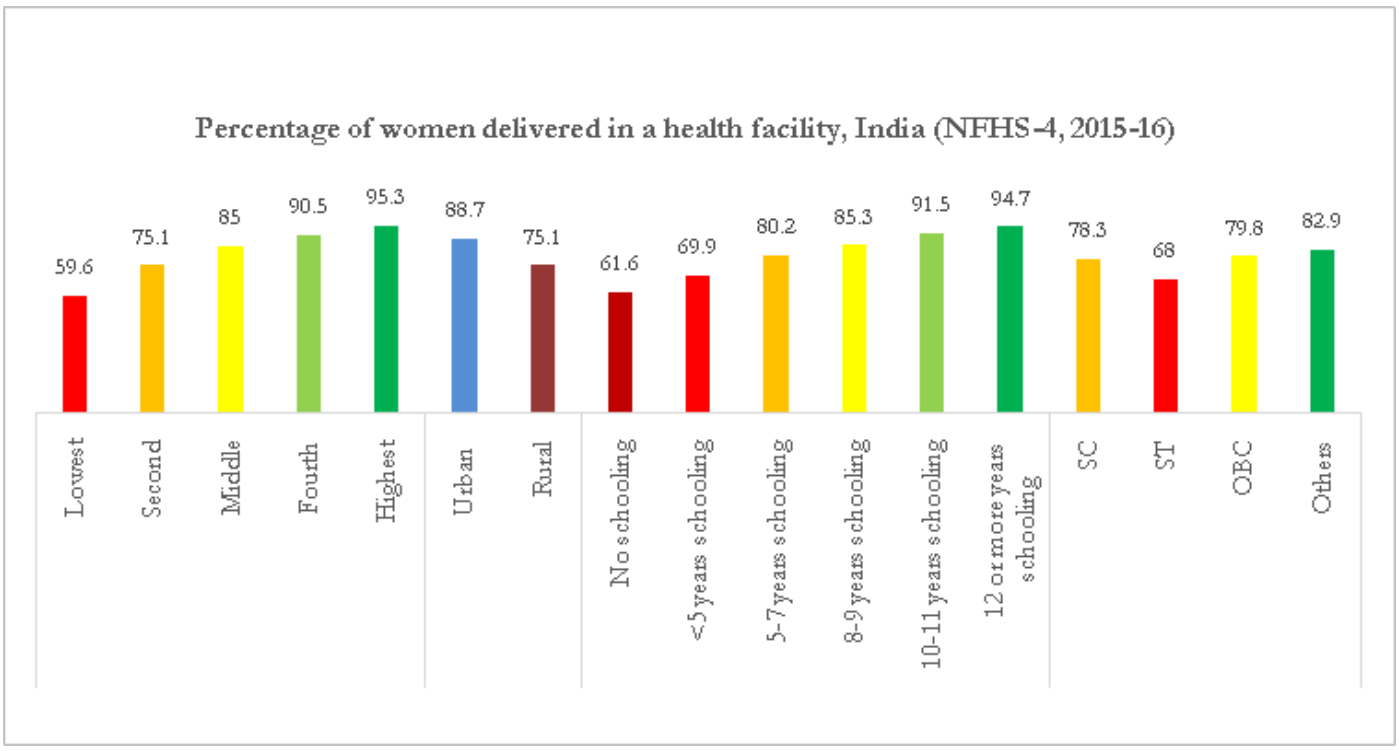
Within this too, we see strong class, caste and gender inequities on one hand and regional inequities on the other hand. A large part of this deficit is due to inadequate resource allocations for services in these sectors at one level and even the committed resources in the budget are either underspent or used inefficiently. A few indicators that highlight this deficit and impinge upon the above mentioned targets are given in Table 1.

**Table 1: Selected indicators of Health, Nutrition and Welfare Deficit in India and Selected States**

| Indicator | India | Assam | Bihar | Gujarat | Kerala | M.P. | Punjab | Source |
|---|---|---|---|---|---|---|---|---|
| Total Fertility Rate | 2.18 | 2.21 | 3.41 | 2.03 | 1.56 | 2.32 | 1.62 | NFHS-4 |
| Any Contraceptive Use | 54 | 52 | 24 | 47 | 53 | 51 | 76 | NFHS-4 |
| Maternal Mortality Ratio | 130 | 237 | 165 | 91 | 46 | 173 | 122 | SRS 2015-16 |
| U5MR | 39 | 52 | 43 | 33 | 11 | 55 | 24 | SRS 2016-17 |
| IMR | 34 | 44 | 38 | 30 | 10 | 47 | 21 | SRS 2016-17 |
| Health Facility Births | 79 | 71 | 64 | 89 | 100 | 81 | 91 | NFHS-4 |
| Full ANC | 21 | 18 | 3 | 31 | 61 | 11 | 31 | NFHS-4 |
| PNC in 2 days Mother | 65 | 58 | 46 | 66 | 89 | 57 | 89 | NFHS-4 |
| Full Immunization | 62 | 47 | 62 | 50 | 82 | 54 | 89 | NFHS-4 |
| ICDS services children | 54 | 56 | 49 | 61 | 49 | 63 | 59 | NFHS-4 |
| ICDS pregnant women | 52 | 56 | 33 | 55 | 30 | 70 | 59 | NFHS-4 |
| Stunting | 38 | 36 | 48 | 39 | 20 | 42 | 26 | NFHS-4 |
| Wasting | 21 | 17 | 21 | 26 | 16 | 26 | 16 | NFHS-4 |
| underweight | 36 | 30 | 44 | 39 | 16 | 43 | 22 | NFHS-4 |
| Women BMI <18.5 | 23 | 26 | 31 | 27 | 10 | 28 | 12 | NFHS-4 |
| Any anaemia women | 53 | 46 | 60 | 55 | 34 | 53 | 54 | NFHS-4 |
| Women participating in decision-making | 63 | 71 | 52 | 62 | 68 | 61 | 70 | NFHS-4 |
| Women experienced spousal violence | 31 | 27 | 45 | 23 | 16 | 35 | 21 | NFHS-4 |
| JSY 2016-17 in lakhs | 104.59 | 4.34 | 14.24 | 2.3 | 1.17 | 10.32 | 0.76 | NHM |
| (% of live births) | -38.3 | -58.6 | -48.1 | -17.2 | -22.5 | -50.6 | -16.9 | |
| Women 15-19 yrs mothers/ pregnant | 8 | 14 | 12 | 7 | 3 | 7 | 3 | NFHS-4 |
| Women 18-29 married by age 18 yrs. | 28 | 33 | 42 | 25 | 10 | 33 | 10 | NFHS-4 |

While the data in Table 1 gives a broad overview of selected indicators from the states which are part of this study, a deeper dive into NFHS-4 data shows huge caste, class and gender inequities. These are evident from the following figure.




The picture we get from these data is that maternal and child mortality is still a huge problem the country and many states are struggling with; that access to various basic healthcare services, including sexual and reproductive health services are grossly inadequate; that violence against women and marriages before legal age continue to be very high despite stringent legal provisions and investment in various supportive programs and services; and that the trajectory towards realizing the SDG targets is not going to be easy with the current levels of political commitments to these issues, the development of service delivery for dealing with them and the budgetary allocations for them. Thus if this deficit has to be reduced so that we move towards the SDG targets then budgets for service delivery would have to be increased substantially without further delays.

# Programs and Budget Investments for Dealing with these Deficits

The National Health Mission and the Women and Child Welfare and Social Welfare departments have designed and developed programs and schemes over the years to tackle above issues with the aim of providing good service delivery that would help both improve access to benefits and services for women and alleviate gender inequities we witness as regards these issues. Many of these schemes and programs have been around for decades but they have failed to make the intended impact and this has largely been because the budgetary commitments have been grossly inadequate. For instance, with regard to overall health budgets since 1981 (post Alma Ata) there has been an assessment that if comprehensive health for all has to be realized in India then budgetary allocations need to be more than doubled as a proportion of GDP.

The budgetary commitments continue to hover around one percent of GDP or 3% of the government budget even though there is growing evidence to show that the minimal requirement for a reasonable level of healthcare to reach targeted health outcomes is at least 2.5% of GDP or 8% of the government budget [1]. Similar is the story with nutrition, welfare of women and children, alleviation of domestic violence and other such programs and schemes. For instance the original plan for setting up one-stop crisis centres for women surviving violence, one in each district at a cost of Rs. 37 lakhs per centre would need a budget of Rs. 244 crores but the PMOs office in 2015 slashed this to a mere Rs. 18 crores saying one per state was adequate. (http://www.dnaindia.com/india/report-modi-government-says-no-to-rape-crisis-centres-in-every-district-2063977)

While the implementation and final spending is done by state governments, the Centre plays an important role in allocating resources via Centrally Sponsored Schemes. Budgets of a few selected schemes that impinge on SDG targets listed above are delineated in Table 2.

**Table 2: Union Govt. Selected Women Specific scheme expenditures, including grants to states under WCD and Health Departments (All Rs. in Crores)**

| | 2015-16 A/c | 2016-17 A/c | 2017-18 BE | 2018-19 BE |
|---|---|---|---|---|
| **WCD Total** | **17249** | **16874** | **22095** | **24700** |
| **Of which ICDS Total** | **16835** | **15893** | **20755** | **23088** |
| Anganwadi services | 15433 | 14433 | 15245 | 16335 |
| National Nutrition Mission | 56 | 199 | 1500 | 3000 |
| Maternity Benefit | 233 | 75 | 2700 | 2400 |
| Adolescent Girls scheme | 475 | 482 | 460 | 500 |
| **Empowerment & Protection of Women Total** | **239** | **793** | **1089** | **1366** |
| Beti Bachao Beti Padhao | 50 | 29 | 200 | 280 |
| One Stop Crisis Centres | 10 | 40 | 90 | 105 |
| Other/ Nirbhaya | 0 | 192 | 400 | 359 |
| **Health &FW Total** | **33121** | **37671** | **47353** | **52800** |
| **NRHM Total** | **18254** | **19826** | **21189** | **24280** |
| RCH (Flexipool, Immunzation & IDD) | 6490 | 7151 | 5966 | 7411 |
| Health Systems strengthening | 4914 | 5247 | 8383 | 9753 |
| **NUHM** | **717** | **491** | **752** | **875** |
| **NHM Total** | **19882** | **22454** | **26691** | **30130** |

***Source: Union Expenditure Budgets 2017-18 and 2018-19, Health and FW Dept. and WCD Dept.***

1 While WHO recommends 5% of GDP for healthcare given the economies of scale and pricing in India we can achieve the same results with a lower level of resources

The selected programs spending and budget allocations for the last few years in Table 2 shows huge fluctuations. The 2015-16 and 2016-17 expenditures are actuals and hence the real story. The more recent years 2017-18 and 2018-19 are budget estimates and with given history of large underspending, the actual expenditures are likely to be much lower. The problem with each of these schemes is that they are transfered to states as the implementation is by states. When underspending happens the Centre blames the states for poor governance and financial management. The states on the other hand blame the Centre for delayed approvals and releases of funds. The truth is that both are right – states do not submit utilization certificates on time and hence the Centre is unable to release funds on time, and the Centre does not trust the states to advance grants upfront. But the larger problem is that the budgetary allocations are grossly inadequate to meet the objectives of the various programs. Let us illustrate this with the example of Anganwadi services which provide nutrition to children and pregnant and lactating mothers. This program is entirely Centre funded as part of the National Food Security Act.

The ICDS program is meant for under-6 years children and pregnant and lactating mothers. From 2016 SRS we estimate that about 15 crore children and 2 crore women should be covered under this scheme. In 2016 according to ICDS data the total beneficiaries were 10.3 crores that is only 54% of those who are entitled to receive these services. The expenditure for this for 2016-17 from Table 2 is Rs. 14,632 crores (Anganwadi +NNM). If we use the NFSA rules the expenditure on supplementary nutrition for the mandated calories should be daily Rs. 6 for children, Rs. 9 for malnourished children and Rs. 7 for women @ 2015 prices. According to this the budget allocation for supplementary nutrition should be at least as under [2]:

1. Women 2 crores x Rs.7 x 300 days = Rs. 4200 crores
2. Malnourished children (one-fourth of 15 crore) 3.75 crore children x Rs. 9 X 300 days = Rs. 10125 crores
3. Normal Children (15-3.75=) 11.25 crore children x Rs. 6 x 300 days = Rs. 20250 crores

All this adds up to a budget requirement of Rs. 34,575 crores just for the nutrition supplement. So the deficit from the actual expenditure of Rs. 14,632 crores (which includes salaries and other overheads) is Rs. 19,943 crores. Even if we consider only the existing registered beneficiaries of 10.3 crores then the budget for supplementary nutrition should be a minimum of Rs. 21,012 crores plus salaries and other overheads. So clearly even for existing beneficiaries the budget allocation is about half of what is required.

Similarly from the health department if we take the RCH flexi pool and health systems strengthening (mission flexi pool) which provides key healthcare services for maternal and child health – ANC, PNC, immunizations, ASHA, subcentre services, JSY, JSSK etc. the expenditure in 2016-17 of Rs. 18,322 crores (Table 3) of which Rs. 12,398 crores (Table 2) is from the Centre, is a huge deficit. For instance for the 2.5 crores of births each year the maternity benefit @ Rs. 6,000 per woman itself would be about Rs. 15,000 crores (in 2016-17 only Rs. 75 crores was spent on maternity benefit), let alone the ANC services, institutional deliveries, JSY,P NC, JSSK, ASHA services and immunization services for children. The current budgetary allocation largely focuses on ANC, institutional deliveries and immunisations and services provided by ASHAs but this too does not assure universal coverage as revealed by NFHS and HMIS data.

**Table 3: NHM Total and Selected Program Expenditures for India and Selected States** **(All Rs. in Crores)**

***Source: NHM Finance Management Reports***

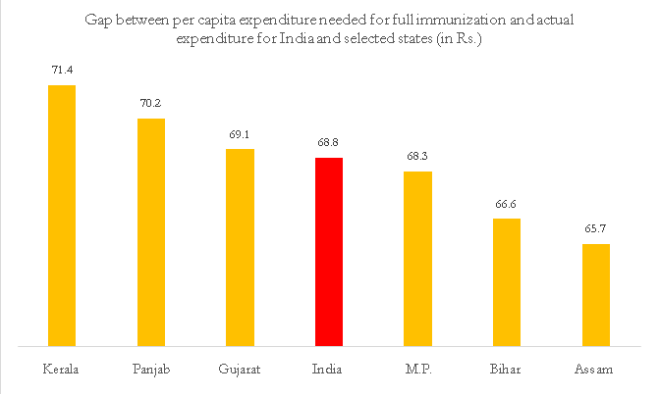
| | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2016-17 Per capita |
|---|---|---|---|---|---|
| **India** | | | | | |
| NRHM-RCH Flexi pool | 14060 | 15823 | 17150 | 18322 | 143 |
| RCH Flexi pool | 6812 | 7347 | 7923 | 8642 | 68 |
| Mission Flexi pool | 6412 | 7661 | 8353 | 8877 | 69 |
| Routine Immunization | 442 | 430 | 524 | 557 | 4 |
| Pulse Polio | 394 | 355 | 345 | 240 | 2 |
| IDD control | 0.34 | 3 | 5 | 7 | |
| Total NHM | 21138 | 23077 | 26397 | 28458 | 222 |

2 In Sept 2017 the WCD issued a notification revising the rates upward by about 0ne-third. But even this increase is probably inadequate as revealed in a writ petition in the Bombay High Court from 2010 where the petitioners in the Melghat malnutrition deaths case worked out that in 2010 at least Rs. 30 per day per child for 4 months was needed to provide hot cooked meals to the malnourished children to bring them back to the normal level (Writ Petition 3278 of 2010 order dated Dec 4, 2010)

| | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2016-17 Per capita |
|---|---|---|---|---|---|
| **Assam** | | | | | |
| NRHM-RCH Flexi pool | 747 | 755 | 1102 | 1052 | 319 |
| RCH Flexi pool | 436 | 461 | 514 | 535 | 162 |
| Mission Flexi pool | 286 | 273 | 557 | 485 | 147 |
| Routine Immunization | 19 | 13 | 24 | 21 | 6 |
| Pulse Polio | 6 | 7 | 7 | 10 | 3 |
| IDD control | 0 | 0 | 0.45 | 0.25 | |
| Total NHM | 957 | 916 | 1186 | 1095 | 332 |
| **Bihar** | | | | | |
| NRHM-RCH Flexi pool | 1113 | 1134 | 1174 | 1059 | 101 |
| RCH Flexi pool | 729 | 706 | 746 | 657 | 63 |
| Mission Flexi pool | 290 | 312 | 326 | 314 | 30 |
| Routine Immunization | 48 | 59 | 60 | 55 | 5 |
| Pulse Polio | 46 | 57 | 43 | 33 | 3 |
| IDD control | 0 | 0 | 0.04 | 0.07 | |
| Total NHM | 1481 | 1427 | 1622 | 1136 | 108 |
| **Gujarat** | | | | | |
| NRHM-RCH Flexi pool | 593 | 581 | 789 | 932 | 146 |
| RCH Flexi pool | 213 | 236 | 288 | 367 | 57 |
| Mission Flexi pool | 344 | 307 | 458 | 526 | 82 |
| Routine Immunization | 24 | 26 | 29 | 31 | 5 |
| Pulse Polio | 12 | 11 | 13 | 7 | 1 |
| IDD control | 0.08 | 0.31 | 0.13 | 0.09 | |
| Total NHM | 977 | 874 | 1272 | 1036 | 162 |
| **Kerala** | | | | | |
| NRHM-RCH Flexi pool | 330 | 270 | 292 | 316 | 88 |
| RCH Flexi pool | 151 | 130 | 139 | 151 | 42 |
| Mission Flexi pool | 167 | 128 | 140 | 150 | 42 |
| Routine Immunization | 8 | 8 | 9 | 10 | 3 |
| Pulse Polio | 5 | 4 | 4 | 3 | 1 |
| IDD control | 0 | 0.09 | 0.01 | 0.43 | |
| Total NHM | 673 | 510 | 633 | 343 | 95 |
| **Madhya Pradesh** | | | | | |
| NRHM-RCH Flexi pool | 1152 | 1245 | 1553 | 1554 | 197 |
| RCH Flexi pool | 600 | 676 | 760 | 796 | 101 |
| Mission Flexi pool | 493 | 520 | 736 | 703 | 89 |
| Routine Immunization | 14 | 37 | 43 | 45 | 6 |
| Pulse Polio | 14 | 11 | 14 | 8 | 1 |
| IDD control | 0 | 0.17 | 0.29 | 0.58 | |
| Total NHM | 1584 | 1738 | 2047 | 1608 | 204 |
| **Punjab** | | | | | |
| NRHM-RCH Flexi pool | 275 | 299 | 401 | 429 | 148 |
| RCH Flexi pool | 101 | 125 | 150 | 163 | 56 |
| Mission Flexi pool | 160 | 160 | 232 | 253 | 87 |
| Routine Immunization | 7 | 8 | 11 | 10 | 3 |
| Pulse Polio | 7 | 6 | 8 | 4 | 1 |
| IDD control | 0 | 0 | 0 | 0 | |
| Total NHM | 438 | 461 | 649 | 470 | 162 |

To take another example of delivering all basic vaccines under the Universal Immunization program as per the Comprehensive Multiyear Strategic Plan for UIP (MoHFW, WHO and UNICEF, 2013)[3] the budget requirement per year is Rs. 9451 crores (which works out to Rs. 75 per capita[4]) as against the actual expenditure of only Rs. 797 crores in 2016-17 (Table 3), so a clear shortfall of 11.8 times. So how can all children and women get protection and have reduced mortality rates?

Table 3 also gives expenditures for key programs under NHM and if we look at state level spending then the story across states with some variation is not very different from the national story. Using the example of immunization for the states assuming the requirement of an average of Rs. 75 per capita to deliver all vaccines, we find the following gaps in per capita expenditures for immunization in India and the selected states.




***Source: NHM Finance Management Reports***

It is very clear from the above estimates that UIP is far from realization unless we make the required budgetary allocations. Whichever program's budget we assess the story of gross deficit in allocations and spending will show up sharply and realizing the SDG targets linked to that program will remain a huge challenge. Even if we look at NHM or NRHM as a composite primary healthcare program the investment of Rs. 222 per capita in 2016-17 with some variance across states due to special status of states like Assam (Rs. 332 per capita) to a low of Rs. 95 per capita in a developed state like Kerala, (Table 3) is very low to achieve primary health goals which are the core of the Health SDGs [5].

Table 3 also reveals that over the years one sees declining commitment to allocations for this, either absolute decline or an increase which does not even compensate for inflation and thus leading to inefficiency and ineffectiveness of the programs performance.

If 2.5% of GDP or Rs. 3200 per capita is what is needed for universal access to healthcare as per the National Health Policy and 60% of that should be for primary healthcare then the budgetary allocation for NHM should be at least Rs. 1900 per capita in sharp contrast to the present Rs. 222 per capita. So the deficit for primary healthcare is a whopping 8.5 times for the country as a whole.

Further in Table 4 which details budgets and expenditures of key activities under NRHM across states we see that even the low level of budget allocation is underspent in all the selected states and the national average expenditure vis-à-vis the budget is less than 60%. From among selected states Bihar, MP and Assam have higher underspending with Bihar's underspending being higher than the national average. Across programs and in different states too we see huge variations in actual spending. For example, at the national level safe abortion spending was less than ONE percent of the allocated budget and across different states expenditures varied from 0% to over 100% for various healthcare programs. It is interesting to see that cash transfer programs like JSY witness full expenditure and even more than 100% but other critical inputs like training, BCC and medicines are grossly underspent.

On the positive side we see an increased public debate and media attention to many of these issues which does propel periodically some increases in budgetary allocations to these programs at least for fire-fighting, for instance when an epidemic strikes, or children die in large numbers due to malnourishment or rape cases get highlighted in the media etc. Further implementation of gender and child budget statements which separately highlight allocations for women and child specific programs and outcome budgets that link allocations to performance and outcome indicators at the national level and in some states, including Assam, provides an opportunity to make assessment of budgetary commitments easier. Also outcome budgets in few states are including mention of SDG targets linked to each program and scheme, even though it is still very rudimentary and needs expert inputs.

3 http://www.itsu.org.in/download.php?f=Multi-Year-Staregic-Plan-2013-17-LR.pdf

4 The report also uses per capita instead of per vaccinated person since given the varying age groups and categories of persons covered by the different vaccine mix it is difficult to work out the unit cost per vaccinated person.

5 These figures refer to only NHM allocations and exclude state budgetary allocations for primary healthcare which would for example be very large for a state like Kerala which is not dependent as much on Centre funds for primary healthcare programs.

**Table 4: 2016-17 Budget and Expenditures of Selected NHM Activities for India and across Selected States**

| 2016-17 FMR of NRHM | | | | | | | | | | | | | | | | Rs. Crores | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | All States | | | Assam | | | Bihar | | | Gujarat | | | Kerala | | | Madhya Pradesh | | | Punjab | | |
| Item | Budget | Expenditure | %Spent | Budget | Expd | %Spent | Budget | Expd | %Spent | Budget | Expd | %Spent | Budget | Expd | %Spent | Budget | Expd | %Spent | Budget | Expd | %Spent |
| **Total NRHM (Mission +RCH+Immunization+NIDDCP+Disease Flexipools)** | 33640.81 | 19407.21 | 57.69 | 1474.95 | 1089.45 | 73.86 | 2457.84 | 1133.99 | 46.14 | 1211.42 | 1004.18 | 82.89 | 405.57 | 331.62 | 81.77 | 2257.07 | 1598.35 | 70.82 | 558.95 | 451.14 | 80.71 |
| **Total NRHM Flexipool Excluding Disease Programs** | 31637.27 | 18322.01 | 57.91 | 1378.18 | 1051.70 | 76.31 | 2249.35 | 1059.20 | 47.09 | 1135.12 | 931.66 | 82.08 | 374.20 | 315.61 | 84.34 | 2175.10 | 1553.69 | 71.43 | 523.77 | 429.45 | 81.99 |
| **A. RCH Flexipool** | 12828.09 | 8642.1 | 67.37 | 692.63 | 535.41 | 77.30 | 1084.89 | 656.80 | 60.54 | 414.42 | 367.27 | 88.62 | 177.66 | 151.44 | 85.24 | 1049.38 | 796.12 | 75.87 | 185.63 | 162.63 | 87.61 |
| **A.1 Maternal Health** | 4460.07 | 3170.4 | 71.08 | 178.29 | 163.37 | 91.63 | 433.06 | 333.38 | 76.98 | 86.68 | 87.70 | 101.18 | 35.89 | 30.00 | 83.57 | 392.37 | 312.16 | 79.56 | 46.97 | 50.84 | 108.24 |
| A.1.1.1 Safe Abortion | 217.73 | 1.85 | 0.85 | 0.00 | 0.00 | | 1.70 | 1.53 | 90.00 | 0.01 | 0.01 | 60.00 | 0.00 | 0.00 | 0.00 | 0.07 | 0.06 | 85.71 | 0.04 | 0.00 | 0.00 |
| A.1.1.2 RTI/STI | 3.96 | 9.77 | 246.72 | 0.00 | 0.00 | | 0.00 | 0.00 | | 0.01 | 0.00 | 30.00 | 0.00 | 0.00 | | 0.00 | 0.00 | | 0.00 | 0.00 | |
| A.1.2 RCH outreach | 41.27 | 31.89 | 77.27 | 0.00 | 0.00 | | 0.00 | 0.00 | | 0.24 | 0.17 | 70.83 | 0.04 | 0.04 | 113.89 | 3.98 | 2.87 | 72.11 | 0.00 | 0.00 | |
| A.1.3 JSY | 2168.03 | 1788.1 | 82.48 | 75.18 | 92.74 | 123.36 | 343.40 | 272.86 | 79.46 | 28.23 | 30.03 | 106.38 | 14.99 | 13.64 | 90.99 | 192.40 | 189.23 | 98.35 | 10.82 | 12.36 | 114.23 |
| A.1.6 JSSK (pregnancy) | 1959.94 | 1306.74 | 66.67 | 101.18 | 70.43 | 69.61 | 84.36 | 58.49 | 69.33 | 54.45 | 54.81 | 100.66 | 18.63 | 15.93 | 85.51 | 194.43 | 118.70 | 61.05 | 36.06 | 38.47 | 106.68 |
| **A.2 Child Health** | 381.92 | 247.87 | 64.90 | 24.12 | 7.37 | 30.56 | 21.11 | 8.13 | 38.51 | 24.74 | 19.58 | 79.14 | 1.85 | 0.66 | 35.68 | 46.82 | 33.19 | 70.89 | 5.00 | 3.10 | 62.00 |
| A.2.10 JSSK (infant) | 95.42 | 95.31 | 99.88 | 1.74 | 0.05 | 2.87 | 3.06 | 0.10 | 3.27 | 7.88 | 7.75 | 98.35 | 1.10 | 0.00 | 0.00 | 1.10 | 0.57 | 51.82 | 1.70 | 0.79 | 46.47 |
| **A.3 Family Planning** | 895.29 | 577.01 | 64.45 | 20.39 | 12.28 | 60.23 | 136.62 | 78.35 | 57.35 | 49.61 | 44.72 | 90.14 | 5.79 | 2.24 | 38.69 | 102.76 | 85.83 | 83.52 | 7.58 | 4.48 | 59.10 |
| **A.4 RKSK** | 98.73 | 41.79 | 42.33 | 3.71 | 0.54 | 14.56 | 7.02 | 1.69 | 24.07 | 2.11 | 1.16 | 54.98 | 0.80 | 0.37 | 46.25 | 6.54 | 2.50 | 38.23 | 2.50 | 0.34 | 13.60 |
| **A.5 RBSK** | 680.07 | 444.92 | 65.42 | 20.81 | 13.23 | 63.58 | 22.70 | 18.75 | 82.60 | 52.71 | 63.07 | 119.65 | 16.89 | 24.44 | 144.70 | 87.03 | 52.95 | 60.84 | 18.26 | 13.69 | 74.97 |
| **A.7 PNDT** | 16.63 | 8.35 | 50.21 | 0.25 | 0.18 | 72.00 | 0.58 | 0.03 | 5.17 | 0.63 | 0.45 | 71.43 | 0.00 | 0.00 | | 0.77 | 0.15 | 19.48 | 1.67 | 1.16 | 69.46 |
| **A.8 Human Resources** | 4425.96 | 3022.44 | 68.29 | 349.51 | 268.51 | 76.82 | 345.04 | 149.92 | 43.45 | 128.76 | 85.05 | 66.05 | 91.27 | 70.26 | 76.98 | 285.21 | 223.81 | 78.47 | 81.78 | 67.78 | 82.88 |
| **A.9 Training** | 574.32 | 180.27 | 31.39 | 31.67 | 9.00 | 28.42 | 28.20 | 7.54 | 26.74 | 19.65 | 15.59 | 79.34 | 4.45 | 2.67 | 60.00 | 33.16 | 15.78 | 47.59 | 7.28 | 2.72 | 37.36 |
| **A.10 NRHM Management** | 1268.11 | 919.58 | 72.52 | 63.10 | 60.20 | 95.40 | 90.56 | 59.00 | 65.15 | 47.57 | 48.13 | 101.18 | 20.44 | 20.58 | 100.68 | 94.74 | 69.75 | 73.62 | 14.60 | 18.52 | 126.85 |
| **B. Mission Flexipool** | 17364.47 | 8876.66 | 51.12 | 641.78 | 484.64 | 75.51 | 988.74 | 314.04 | 31.76 | 672.57 | 525.91 | 78.19 | 182.16 | 150.25 | 82.48 | 1049.91 | 703.73 | 67.03 | 309.25 | 252.64 | 81.69 |
| **B.1 ASHA** | 2462.52 | 1681.87 | 68.30 | 104.06 | 88.76 | 85.30 | 226.16 | 86.17 | 38.10 | 123.49 | 117.73 | 95.34 | 13.80 | 8.10 | 58.70 | 130.12 | 137.38 | 105.58 | 38.14 | 33.18 | 87.00 |
| **B.2Untied funds for RKS etc.** | 1461.88 | 978.45 | 66.93 | 36.43 | 33.99 | 93.30 | 37.81 | 25.21 | 66.68 | 79.61 | 73.40 | 92.20 | 19.93 | 18.94 | 95.03 | 105.02 | 64.58 | 61.49 | 23.71 | 20.55 | 86.67 |
| **B.10 BCC/IEC** | 546.53 | 233.66 | 42.75 | 32.68 | 18.65 | 57.07 | 34.34 | 10.79 | 31.42 | 16.05 | 12.88 | 80.25 | 7.09 | 4.22 | 59.52 | 35.89 | 17.80 | 49.60 | 8.78 | 6.29 | 71.64 |
| **B.16.2 Drugs for Maternal and Child Health** | 2194.55 | 1143.68 | 52.11 | 115.78 | 121.21 | 104.69 | 144.96 | 41.97 | 28.95 | 70.76 | 77.43 | 109.43 | 7.64 | 8.35 | 109.29 | 161.18 | 108.34 | 67.22 | 68.64 | 40.49 | 58.99 |
| **C. Immunization** | 1425.11 | 796.57 | 55.90 | 43.52 | 31.39 | 72.13 | 175.55 | 88.30 | 50.30 | 47.37 | 38.39 | 81.04 | 13.21 | 13.90 | 105.22 | 74.68 | 53.26 | 71.32 | 28.43 | 14.19 | 49.91 |

**Source: Same as Table 3**

# Case Study of Assam

Assam as a state is one of the poorer performers when we look at indicators in Table 1 above. It has one of the highest MMR in the country as also very high under 5 and infant mortality. It also does not do well with regard to some of the key health programs like ANC, institutional deliveries, PNC and immunization. Also it has a higher proportion of women being married before the legal age as well as one of the highest proportion of women who are mothers or pregnant in the 15-19 years age group which increases the risk of maternal and infant mortality. However Assam's performance in access to JSY benefits is laudable. These performances are largely a consequence of budgetary expenditures. For instance, Table 4 shows that JSY expenditure was 123% of total budgetary allocation indicating a high priority and this gets reflected in the high proportion of mothers who received JSY benefits. On the other hand the low levels of allocation and spending on children's and women's health like immunization, ANC, JSSK, RBSK, RKSK etc. are reflected in the very high mortality rates and low levels of utilization of these services.

Table 5 looks deeper into budget allocations/expenditures of specific schemes of the WCD and Health departments of Assam and the pattern of spending that emerges more or less corroborates the above observations. As we have discussed above that in terms of benchmarks like 2.5% of GDP for health spending by governments, allocations for maternity benefit and supplementary nutrition as per the NFSA law, allocations for primary healthcare and NHM as per IPHS standards and the mandate in the National Health Policy etc. The WCD and Health department budgets are grossly inadequate to meet the objectives of the various specific programs and schemes listed in Table 5 as well as the targets defined for SDGs. This gives an impression that allocations to various schemes are often made for political expediency and not for serious development of programs to achieve the mandated goals and targets.

Apart from the overall low levels of allocation and spending, even what is allocated is underspent on many of these programs and over the years we see huge fluctuations in allocations and expenditures. ICDS, SNP, Maternity benefits, SABLA all show ups and downs in program allocations and spending reflecting lack of consolidation efforts within the program. Most programs under Women's Empowerment and Child Protection also suffer a similar fate. While the Health department programs have generally seen an upward momentum in allocations some critical programs like Primary Healthcare and NHM too have witnessed fluctuations in allocations. The allocation for Primary Health Centres for 2018-19 has seen a very sharp drop to Rs. 129 crores from Rs.428 crores in the preceding year. ICDS as a program has seen a major decline from Rs. 843.66 crores of allocation in 2015-16 to a low of Rs. 752 crores in 2018-19. What is worse is that in 2016-17 against an allocation of Rs. 628 crores only Rs. 493 crores was spent.

However underspending is also huge across the board. In Table 5 for years 2015-16 and 2016-17 we have both Budget Estimates and Actual Expenditures and for each program/scheme we see huge underspending from the budgeted amounts, with exception of ICPS and the Family Welfare program. So what clearly emerges is that like elsewhere across the country in Assam too we see inadequate allocations for key programs that could impact gender equity and even what is allocated is underspent rendering the programs ineffective in reaching their intended objectives.

**Table 5: Budget Allocation & Expenditures of Selected WCD & Health Schemes in Assam (Rs. Lakhs)**

***Source: Demand for Grants of respective Ministry and respective years (For NHM – PIP and ROPs respective years)***

| | 2015-16 (BE) | 2015-16 (Ac) | 2016-17 (BE) | 2016-17 (Ac) | 2017-18 RE | 2018-19 (BE) |
|---|---|---|---|---|---|---|
| WCD Total (Rev+Capital) | 165821 | 141839 | 119350 | 95733 | 186470 | 209872 |
| ICDS Total | 84366 | 79121 | 62858 | 49293 | 81193 | 75209 |
| Anganwadi services | 9037 | 3982 | 5172 | 8213 | 13164 | 26223 |
| Special Nutrition Programme | 35678 | 37493 | 36077 | 29082 | 40275 | 30300 |
| Nutritional Support to Pregnant Women (MAMONI) @Rs.2000/- | 0 | 0 | 0 | 0 | 0 | 0 |
| National Mission For Empowerment Of Women Including IGMSY (Maternity Benefit) | 2879 | 65 | 2058 | 914 | 5113 | 2225 |
| Rajiv Gandhi scheme for empowerment of Adolescent Girls (SABLA) | 4521 | 1221 | 1111 | 119 | 1517 | 333 |
| Empowerment & Protection of Women Total | 15227 | 8377 | 4126 | 1394 | 11233 | 35699 |
| Beti Bachao Padhao | 0 | 0 | 432 | 45 | 150 | 200 |
| One Stop Centres | 0 | 0 | 749 | 0 | 432 | 433 |
| Scheme for protection of woman from domestic Violence | 30 | 14 | 14 | 14 | 15 | 20 |
| Financial Assistance & support services to victim of rape | 0 | 0 | 5 | 0 | 5 | 300 |
| Home for Destitute Women and Helpless widows | 29 | 33 | 79 | 57 | 93 | 112 |
| Compensation of Wages to Pregnant Women Workers of Tea Gardens | 0 | 0 | 0 | 0 | 1800 | 5593 |
| Implementation of Integrated Child Protection Scheme (ICPS) | 751 | 874 | 1776 | 2030 | 3333 | 3207 |
| Welfare of Children in need of Care and Protection | 11 | 15 | 18 | 17 | 21 | 22 |
| Vocational Training and Rehabilitation Centre For Women, Guwahati | 76 | 35 | 45 | 41 | 55 | 54 |
| Women Welfare and Children Condition | 13 | 22 | 68 | 20 | 38 | 46 |
| Health &FW Dept. Total (Rev+Capital) | 291484 | 266924 | 376126 | 297835 | 545106 | 508217 |
| NRHM Total | | | | 105170 | 268439 | 251524 |

| | 2015-16 (BE) | 2015-16 (Ac) | 2016-17 (BE) | 2016-17 (Ac) | 2017-18 RE | 2018-19 (BE) |
|---|---|---|---|---|---|---|
| RCH Flexipool &Immunization &IDD | | | | 79104 | 237844 | |
| Health Systems strengthening | | | | 12924 | 16801 | 20879 |
| NUHM | | | | 1425 | 3715 | 3532 |
| NHM Total | | | | 100380 | 272154 | 255056 |
| Maternity and Child Health | 1557 | 1295 | 1554 | 1317 | 2243 | 2585 |
| Rural & Urban Family Welfare Services | 12004 | 16156 | 19812 | 19086 | 28677 | 32071 |
| School Health Scheme (under 01-urban health services -allopathy) | 542 | 426 | 570 | 447 | 773 | 795 |
| Total 01-Urban Health Services-Allopathy | 27113 | 20488 | 27944 | 22296 | 60224 | 29828 |
| Total 03-Rural Health Services - Allopathy | 168383 | 161182 | 219051 | 148296 | 286129 | 257624 |
| Primary Health Centres (103) under Rural Health Services - Allopathy | 32276 | 26611 | 33927 | 29842 | 42861 | 12951 |
| Community Health Centres(104) under Rural Health Services - Allopathy | 7979 | 5842 | 8431 | 6461 | 10755 | 11914 |
| Hospital and Dispensaries - total | 46119 | 35827 | 50572 | 40044 | 82245 | 53240 |
| Prevention and control of diseases (101) under 06 | 16416 | 13943 | 13815 | 11296 | 15468 | 16432 |
| Assam Bikash Yojana (Mamoni, Majoni, Moromi) | 6000 | 1500 | 1350 | 1350 | 0 | 0 |

**Majoni -**fixed deposit of Rs. 5,000/- for 18 years. On her 18th Birthday, the girl will be able to encash the fixed deposit. In case she is married before attaining 18 years of age, the fixed deposit will be forfeited.

**Rashtriya Bal Swasthya Karyakram (RBSK)** is an important initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. This aims to improve survival outcomes by decreasing morbidity and improving the quality of life of our children.

**School health programme under NRHM** is now expanded to include comprehensive screening for all children: Systemic approach to early identification of 4Ds:

Defects at birth, Diseases, Deficiencies and Developmental delays including Disabilities in children 0 to 18 years of age.

# Conclusions and Suggestions

The above assessment of budget allocations and expenditures of some of the key programs and schemes that are targeted to reduce gender inequities and specifically for the benefit of women and girls leads us to a conclusion that there is lack of serious intent in achieving the objectives/goals of these programs and schemes. These programs and schemes are launched with a lot of fanfare but end up being populist proclamations directed towards electoral outcomes or public relations exercises or even as fire-fighting. The budgets and their trends tell us the real story underlying these programs and schemes. The huge fluctuations we see over the years in allocations for many of these programs and the underspending clearly indicate that political interest in establishing well consolidated programs and schemes that efficiently target goals like SDGs is very marginal. Political interest is driven either for electoral gains or as fire-fighting mechanisms. For instance if rape or maternal deaths are being highlighted in the media and in public debate then a new scheme is launched or an existing scheme is allocated budgetary resources. But even here we see that as a fire fighting response the allocated resources are grossly underutilised. The *Nirbhaya* Fund for compensation of rape survivors, one stop crises centres and domestic violence protection is a classic case of this missing political will. Similarly in the health sector allocations for maternal and child health programs and primary healthcare which largely focus on maternal, reproductive and child health needs are grossly inadequate as well as what is allocated is not fully utilised and this ends up with the programs being ineffective.

What we can conclude from this analysis is that the experience with meeting SDG targets may not be very different from the preceding MDGs as the budgetary deficits for the programs that target the SDG goals remain a challenge. These can only be accomplished if clear benchmarks for budgetary commitments are made to realize the targets for each of the SDG goals. A few suggestions for this are give below:

**Maternity Benefit Scheme:** At least Rs. 6000 per birth – for estimated 2.73 crore live births the required budgetary allocation should be Rs. 16380 crores; if we use the Tamil Nadu benchmark of Rs. 18000 per birth then the budget required would be Rs. 49,140 crores. This will assure achievement of targets related to maternal and child health and mortality.

**NHM/RCH and Primary Healthcare:** With a benchmark of 2.5% of GDP as mandated by the National Health Policy 2017, the total health budget should be a minimum of Rs. 419,000 crores or Rs. 3200 per capita and @60% from primary healthcare the allocation for NHM and PHC should be at least Rs. 251,000 crores or Rs. 1900 per capita. This will assure achievement of targets related to maternal and child health and mortality and access to sexual and reproductive health services.

**Anganwadi/ICDS:** As per NFSA norms at least Rs. 34,575 crores (@2015 prices) should be allocated. In 2017 there was an upward revision of 33% in norms and so it should be about Rs. 46, 000 crores. This will assure achievement of targets related to maternal and child health and mortality.

**Domestic Violence Protection/One stop crisis Centres/Nirbhaya Fund:** The budgetary requirement @ Rs. 37 lakhs per district centre (2015 prices) should be a minimum of Rs. 244 crores. Compensation for rape victims would need additional resources. Recent SC judgement has mandated between Rs. 5 to 10 lakhs as minimum compensation. Given that 6.3 per lakh rape cases are registered @ Rs. 10 lakhs the *Nirbhaya* Fund should have at least Rs. 8355 crores (against the Rs. 3500 crores which is lying unutilised[6]) of annual allocation just for compensation. This will assure achievement of targets related to elimination of domestic and sexual violence against women.

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6 https://timesofindia.indiatimes.com/india/supreme-court-approves-scheme-to-grant-compensation-to-rape-acid-attack-victims/articleshow/64126185.cms

## Data Driven Dialogues for Gender Equality and SDGs

Through this project, SAHAJ and EM2030 are set out to generate a policy dialogue for more encompassing, holistic and realistic state and national level plans for better implementation towards achieving the selected targets for girls and women. This work is going on in six selected states, viz., Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Punjab and at the national level.

One of the important objectives of the project is to increase political will and dialogue amongst key stakeholders, particularly government, on the importance of data and evidence-based implementation around selected targets from- Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 5 (Achieve gender equality and empower all women and girls).

Sahaj

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