Maternal Health in Karnataka-- As Seen from Budget Data

A PRELIMINARY ANALYSIS

FOR

DISCUSSION

AMONG CIVIL SOCIETY

GROUPS

CBPS

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October 2004

Caminante, no hay camino,
Se hace el camino al andar

A Mexican Saying

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I

Introduction

Karnataka is a state within the Indian Union, located in the south-west of the country. Its capital, Bangalore, has become well known in recent years as an IT centre and the preferred destination of multi-national corporations that want to outsource business operations. This has given the city—and the state by extension—a 'modern' reputation as a developed city.

Unfortunately, this is far from being the case. Not only is Bangalore an oasis of prosperity within the state, there are wide and increasing disparities within the city and across the state that pose major challenges to the city and state governments. Foremost among these challenges, when growth has averaged over 5% a year, are the low levels of capability and functionings, in Sen's sense of the term, of the majority of the people—a fact that comes out starkly from the state Human Development Report[1]. Levels of education are low, and the health status is poor. This has now become the priority for government policy.

Maternal health is one area of concern within this human development challenge. The main objective of this paper is to present for wider discussion in civil society groups, in India and abroad, the key features of Karnataka's maternal health situation[2]. Rather than provide conclusions, we raise questions from a scrutiny of the data that could form the basis for wide-ranging debate seeking workable solutions.

This is not a research publication, but a base paper for further work in civil society. Such work, as an engagement and partnership with the state, may be seen as a necessary condition for improving the system. Karnataka has an active civil society that has taken up many issues and engaged with the state in a positive way[3]. Reproductive and Child Health [RCH] issues therefore stand a good chance of being taken up if an informed discussion is embarked upon. This note hopes to start such discussion.

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[1] See Human Development in Karnataka, Planning Department, Government of Karnataka, Bangalore 2000. The second report, now under preparation, should tell us of progress made —or not! Data from this publication are cited below.

[2] To facilitate this process, we intend to put data on maternal health facilities in GIS format [for the districts we are working in], in an interactive website that has just been put in place. This is meant to provide a 'bottom-up' information system to help those working at that level. This work has only just begun. Please visit: www.cbpsindia.org and send us your suggestions.

[3] S Manjunath and Suresh Balakrishnan, "Engaging the State" Public Affairs Centre, Bangalore, 2004.

Where reproductive health is concerned, the background and context of the state[4] is given below.

- In India, the total number of women *per 1000* men in the population (sex ratio) is less than a thousand. This is a demographic oddity that reflects gender discrimination. Per 1000 men, there were 934 women in 1981 and this declined to 927 in 1991. For Karnataka the corresponding figures are 963 and 960—better than the national average, but the declining trend shows persistent and perhaps growing gender discrimination. Within Karnataka, taking the district as a unit, this sex ratio ranged from a low of 903 in urban Bangalore to *a positive figure of* 1063 in Dakshin Kannada.

- The mean age at marriage of women ranged from 17.32 years in Bijapur to 22.43 in Dakshin Kannada in 1981. It has shown a slight rise by 1991. This is a positive development.

- The infant mortality rate in 1988/89 and 1993/95 for Karnataka was 75, dropping to 65. The Indian figure is 88 dropping to 73. To put this in perspective, the IMR for Karnataka's neighbour to the south, Kerala, is 15 for boys and 16 for girls in 1994. Even with Indian yardsticks, there is much that needs to be done.

- The maternal mortality rate in Karnataka in 1992 was 450 maternal deaths per 1,00,000 women. Other Issues such as use of contraception, spacing of children, ante-natal care, quality of health services etc have a bearing on the status of maternal health.

- The life expectancy at birth in Karnataka was 60.6years in 1983 and 62.5 in 1993. This was higher than the Indian average of 55.4 and 60.3.

The Governance context in the state

The 73rd amendment to the Indian Constitution has brought in local self-government. A unique feature of this legislation is the reservation of at least one-third of all seats in the local bodies for women—only women can contest for election in these seats.

The amendment also outlines in its 11th schedule, functions that are to be devolved to local governance by the state legislatures—a three-tiered system of local self-government in rural areas; Concerns of public and reproductive health are in the domain of these 'panchayats'. Funds for these bodies are often devolved in the form of 'schemes' and 'projects' that are to be implemented under clear cut guidelines.

[4] Taken from Human Development in Karnataka, op cit.

With 37,000 women now elected to local bodies, there is a great opportunity to involve them directly in the implementation of these schemes and programmes[5]. Thus, in our work, the focus is on the Primary Health Centres in villages—and their sub-centres in remote habitations, which are mandated to provide RCH services. In our project, we intend to use budget processes to understand how these local bodies take up this responsibility[6]. With so many women serving as elected representatives, there is a major opportunity here for informed participation based on budget transparency.

Improvements in maternal health are goal 5 of the Millennial Development Goals adopted by the United Nations in 2000. In fact, for the global goals to be achieved, it is essential that India make big improvements in its RCH status. Recognising this, the GOI, in its 10th Plan, has adopted a more ambitious goal—it will achieve these targets earlier than the dates envisaged in the MGDs. Reproductive health is an important part of government policy that speaks of safe motherhood. These policies have been discussed elsewhere[7]. In this paper, we examine what the budget figures have to say about reproductive health.

This paper is organised as follows. This section has provided the background information to provide a context for the budget analysis that follows. Since what governments actually do is reflected in their budgets, the next section looks at budget data for maternal and reproductive health to understand what is being attempted and how well it is being done. The paper ends with a few concluding remarks. All Tables are given in the end.

II

What Do The Budget Figures Tell Us?

As part of a larger research-cum-action project in CBPS, this paper presents the information available about this activity [RCH] from the budgets of the Government of Karnataka[8]. Data about actual expenditures at the district level have to be collected at that level and that will be studied later. This paper is limited to what is available at the state level from the Departments of Finance and Health and it has been collected by our team.

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[5] M.A. Deepa: "How Do We Implement the Recommendations of Karnataka's Task Force on Health and Family Welfare?" CBPS, Bangalore 2002.

[6] There are complex issues of transition from a centralised to a decentralised system that need to be addressed in this regard. Training and capacity building at the local level will be required. It will be an uphill road.

[7] Maya Mascarenhaset.al. "Reproductive Health Care and Local Self Governance in Karnataka: A Situation Analysis" CBPS, Bangalore, unpublished.

[8] See also CBPS, The Health Budget in Karnataka, Bangalore 2002 which provided an overall picture for a decade but did not focus on this topic.

India is a union of states, with a federal division of responsibilities and powers. Health is a state subject under the Constitution—that is, the state government is primarily responsible for providing public health and maternal health services to citizens. This does not mean that the Union of India—called the Centre—has no role. The Centre has the responsibility for supporting the state in matters that concern the country as a whole. For example, the immunisation programme is funded by the Centre and implemented in co-operation with the states[9]. So is the Family Planning Programme. Thus, in trying to understand the financial allocations for maternal health in Karnataka, it is essential to include central government grants/allocations and expenditures as they supplement state allocations and expenditures in an important way.

In the budget documents, which follow the accounting scheme recommended by the Comptroller and Auditor General, maternal and reproductive health is a sub-head of the major heads "public health" and "family welfare" and the codes are 2210 and 2211 in the revenue account and 4210 and 4211 in the capital account of the government budgets. Data for this head is available in Karnataka from 1994-95 and is shown in Table 1. CSS refers to Centrally Sponsored Schemes that fall into this category. In addition to the CSS, there is state expenditure under both Plan and Non-Plan heads[11]. The last column shows the amounts actually released to the state for this purpose by the Government of India

Between 1994-95 and 2002-03 both the budget allocation and expenditure increased for the major head. While budget allocation increased steadily from Rs 6174.96 lakhs[10] to Rs 1,23,1243.8 lakhs, it will be noted that the expenditure has fluctuated over the years. While it increased from Rs 6187.01 in 1994-95 to Rs 9,7396.3 in the last year, it actually declined to Rs 7344 lakhs in 1996-97. Also, between 2002-2/2002-3 there was another decline. In almost all the years, **the expenditure was well below what was allocated**. In 1998-99, of the Rs 12599.08 lakhs allocated, only Rs 9118.9 was spent.

Why is this pattern emerging? If money allocated—however inadequate it may be from a normative point of view—is not being spent, then there must be other bottlenecks in the administrative system. The question is not one of more money being allocated, but of improving the absorptive capacity of the RCH system for CSS and other schemes. CBPS has noted in earlier studies that money meant for such priority areas has often remained unspent. There are both bureaucratic rigidities and poor accounting practices that partly explain this. **This is a matter to be investigated on the ground.** We will examine this question in two selected districts of Karnataka and build the figures upwards.

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[9] It may be relevant to note that these programmes are largely funded from internal sources. Donor funding plays a rather small role in India.

[10] A lakh is one hundred thousand and is the unit used in India. A hundred lakhs are called a crore. The financial year is from April 1 to the next March 31. All figures are in nominal terms —unadjusted for inflation.

[11] See footnote 12 for an expansion of there categories.

The state budget figures under this head have been shown separately for Plan[12] and Non-Plan, though the distinction has now ceased to have any meaning. Even if theseare added up, it is clear that the state allocations for RCH—family welfare, the broader category—are much lower than those of the Centre. Here also the difference between the budget allocations and the actual expenditures is marked—it is positive in each year for which we have data, meaning that expenditures were below allocations. Both allocations and expenditures fluctuate over the years—and there is a huge jump in Plan allocations in the state in 2002-03—from Rs 396.37 lakhs to Rs 4664.63. This is difficult to understand unless something very large and new was taken up. This needs further investigation.

Non Plan expenditures usually refer to normal routine expenditures in which the largest component is salary payments to staff. Here, if the expenditure is less than allocation, it probably means that there are vacant positions that have not been filled up. Which positions these are, and where they fall—in the capital or in the districts—and how they affect the absorptive capacity of the department, has to be explored separately.

GOI releases to the state, while growing in nominal terms over this period, also show large fluctuations. This is true of the expenditure by the state of these funds—and this expenditure, as a rule, is well below the allocations. If funds allocated are consistently not spent, could it be that such funds are not really needed? Health indicators given above do not support such a hypothesis. This is a puzzling pattern that needs deeper investigation.

In Table 1, we had examined the total allocations and expenditures for the category that included RCH. In [the very large] Table 3[13], we present data from the budget documents on how that total is divided into different line items. It will be immediately noted that for the RCH line item—in bold in the Table—there is no expenditure in 1999-2000 and 2000-2001 either in Plan or Non-Plan. In 2001-02 a sum of rupees 65 lakhs was spent. This rose to rupees 2633 lakhs in 2002-03 [revised estimate] and rupees 5581 lakhs in the budget estimate of 2003-04. This is a sharp increase. Perhaps some large projects with international funds have been taken up. This is to be investigated further.

Amazingly, there is no expenditure at all in the state for Family Welfare! It is only central funds for this activity.

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[12] Government investments are made through five year Plans. A new project taken up in a Plan is called a Plan scheme and is funded by Plan allocations. After the five years it becomes a regular or routine scheme and is to be funded under the non-Plan allocations. Over the years, states have not had the non-Plan funds to take over such new schemes, and have continued to use Plan funds for such schemes. Thus the distinction has lost any meaning today.

[13] We decided to keep the Table in this paper as this data may be useful to the many groups that are working on this issue, and which have no easy access to such data.

It is a positive sign that under the capital account, the expenditures for medical and public health show an increase—from 2316 lakhs in 1999-2000 to 5522 in the budget estimates of 2002-03. The revenue account shows fluctuations but drops in the last year. In centrally sponsored schemes, there is fluctuating expenditure on family welfare, with an overall increase in the capital account.

The clear picture that emerges is that expenditures fluctuate quite a bit across the years. This cannot make it easy to plan work in a systematic manner. At a later stage, it may be interesting to relate how this financial volatility impacts on RCH outcomes.

The Local Self-Government context for RCH

Programmes such as RCH have to be implemented locally. In India, after the 73rd and 74th amendments to the constitution, these subjects too have been kept for the newly created constitutional local governments—three tier panchayats in rural areas and municipalities in urban areas. The devolution process, is however, in the midst of a transition, and self-government at the local level has yet to become a reality[14].

Since the state is responsible for providing health services, it is useful to look at this data in a more detailed manner, for example for health related civil works. However, as Table 2 shows, little is available to permit any statement. It is also puzzling why five cells in the second year are blank. **Was there no allocation, or is the information missing?** We are investigating this issue, made complex by the fact that local agencies like Primary Health Centres are not given cash but supplies in kind.

It is not surprising that information at this level is scanty, as shown in Table 4 for RCH components. State and central devolutions are shown separately. There is very little own revenue at this local level. The lowest tier has no allocations at all. Given this is the level in touch with women, this is surprising.

This amount shown in Table 4 is for all zilla panchayats taken together—27 of them; there are 175 taluk panchayats and over 5000 gram panchayats. For a population of over 50 million, this does not seem much—a matter that has to be further investigated.

The CBPS project has decided to focus on two districts of the state for in-depth work. These are Chitradurga and Chamrajanagar, both quite backward in terms of RCH indicators. We have begun to collect data locally, and give below some preliminary information. These are the shares of these two districts from the amounts given above in Table 4. for all districts taken together. These are for all developmental activities. In Tables 6 and 7 we examine the RCH components.

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[14] Vinod Vyasulu, "Transformation in Governance Since 1990's: Some Reflections "Economic and Political Weekly, 5th June, 2004.

Table 6 shows the allocations for each of the districts at the district level, and Table 7 for the taluk or intermediate level. There is no allocation at the level at which women can be reached—the gram or village level. **Apart from the issue of money allocated and spent, is the issue of the level at which these funds are administered, and the role of locally elected bodies in them.** This is an issue that requires investigation.

An important conclusion is this: The budget allocation figures do not reflect the pattern of expenditure on the ground where RCH and Family Welfare are concerned. The trends reflected here have to be checked out on the ground to understand the processes at work. Only after this can questions of efficiency, effectiveness etc be taken up.

III

Issues For Debate and Discussion

This paper has provided some of the data from the state government budget and used it to raise some issues that should be relevant to groups working on issues of maternal health in Karnataka. The following points may be noted as a result of this exercise:

- The data given club activities together. Thus RCH is part of a larger category and efforts have to be made at the local level to pinpoint the exact allocations and expenditures. At the state level, some aggregate analysis is possible. For the local level data have to be collected.

Although health is a state subject, in order to get an idea of the total resources devoted to RCH, it is essential to pool central and state budget figures, adjusting for double counting. More is spent than just state allocations. The issue is: How much? On what? And how is this decided?

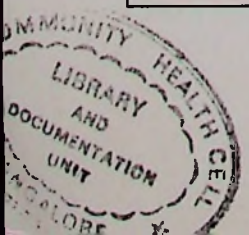
- This exercise has shown that budget allocations and expenditures suffer from poor marksmanship in the budget process. Allocations tend to be higher than actual expenditures almost always. There is great fluctuation in allocations and expenditures over the years. This makes planning of projects and programmes over the years rather difficult. It also raises issues of the validity of the budget process as a system. If the numbers routinely are out of synch, then why? What does it mean on the ground?

- The quality of information at the local level is poor and there is a need for careful cross checking and validation. In India, where the RCH service has to be delivered *in situ* in villages, this is important, as the database for Primary Health Centres and sub-units is rather poor and needs to be systematically collected. In fact, it has to be constructed from the value of the supplies —drugs, linen, vehicles etc—given to these bodies in kind.

Table 2. State allocation under medical and public health programmes and related civil works for the years 1999-01, in lakhs			
Ab. Code	**ITEM**	**1999-2000**	**2000-01**
2210	**Name of the item**		
2210	Strengthening of PHU's maternity homes (Rev)	4.00	-
2210	Buildings-Health sub centres (additions and alterations)	2.00	2
2210	Primary health centres (GOI pattern) (MNP)	20.00	40
2210	Buildings-maternity home	2.00	2
2210	Provision for ambulances	4.00	-
2210	Repairs to hospital equipments	0.80	1
2210	Supply of equipments	2.50	-
2210	Supply of Linen	2.00	-
2210	Cancer control	1.00	-
4210	Primary health centre buildings	9.00	10
4210	Upgradation of primary health centres-community health centres	5.00	4
	Total	52.30	59

Table 3. Expenditure (plan and non-plan) for the entire state from 1999-00 to 2003-04, in Lakhs

State plan schemes plan and non-plan expenditure	1999-2000			2000-01			2001-02			2002-03 RE			2003-04 BE		
Description	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total
Medical and public health	140.24	581.12	721.36	187.61	579.14	766.75	185.89	600.32	786.21	174.58	709.76	884.34	123.92	752.90	876.82
Family welfare	136.91	10.03	146.94	128.13	8.68	136.81	187.82	12.29	200.11	186.19	9.66	195.85	179.75	9.71	189.46
Total	277.15	591.15	868.30	315.74	587.82	903.56	373.71	612.61	986.32	360.77	719.42	1080.19	303.67	762.61	1066.28
Health and family welfare															
Capital outlay on medical and public health	94.17	0.00	94.17	71.61	0.00	71.61	79.03	0.00	79.03	33.57	0.00	33.57	21.65	0.00	21.65
Capital outlay on family welfare	14.04	0.00	14.04	30.15	0.00	30.15	20.49	0.00	20.49	8.50	0.00	8.50	6.50	0.00	6.50
Total	108.21	0.00	108.21	101.76	0.00	101.76	99.52	0.00	99.52	42.07	0.00	42.07	28.15	0.00	28.15
Rural health services	72.16	95.28	167.44	95.28	95.28	190.56	95.28	72.16	167.44	72.16	72.16	144.32	72.16	72.16	144.32
Family welfare															
Maternity & child health	-	-		-				65.00	65.00	1017.86	1615.85	2633.71	2465.85	3115.85	5581.70
Services and supplies	150.83	153.05	303.88	-	255.30	255.30	300.02	314.96	614.98	314.97	314.97	629.94	314.97	314.97	629.94
Selected area programmes (WB IIP)	4467.52	4771.74	9239.26	-	6387.65	6387.65	8541.77	9865.60	18407.37	11927.48	13378.37	25305.85	13378.37	13378.37	26756.74
Other expenditure	360.37	364.14	724.51	-	445.45	445.45	498.72	499.00	997.72	499.00	498.99	997.99	498.99	498.99	997.98
Total	4978.72	5288.93	10267.65	-	7088.40	7088.40	9340.51	10744.56	20085.07	13759.31	15808.18	29567.49	16658.18	17308.18	33966.36
Major head wise expenditure under state plan scheme															
Medical and public health	7766.58	11072.93	18839.51	13445.54	14669.23	28114.77	13689.27	12778.40	26467.67	17859.65	17815.01	35674.66	16498.78	11835.76	28334.54
Family welfare	673.75	661.21	1334.96	379.02	521.78	900.80	499.55	325.79	825.34	861.67	719.60	1581.27	910.74	558.87	1469.61
Total	8440.33	11734.14	20174.47	13824.56	15191.01	29015.57	14188.82	13104.19	27293.01	46239.94	50150.97	96390.91	17409.52	12394.63	29804.15



Description	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total	Plan	Non-plan	Total
Capital a/c Medical & public health	1021.21	1295.22	**2316.43**	741.47	6765.78	**7507.25**	8739.24	9376.45	**18115.69**	7160.75	7902.82	**15063.57**	3357.00	2165.00	**5522.00**
Family welfare	-			20.51	141.07	**161.58**	215.41	132.38	**347.79**	206.19	145.08	**351.27**	0.00	0.00	**0.00**
Total	1021.21	1295.22	**2316.43**	761.98	6906.85	**7668.83**	8954.65	9508.83	**18463.48**	7366.94	8047.90	**15414.84**	3357.00	2165.00	**5522.00**
Revenue a/c Medical and public health	879.82	793.07	**1672.89**	899.34	983.97	**1883.31**	1017.85	1178.08	**2195.93**	850.38	703.64	**1554.02**	830.63	423.64	**1254.27**
Family welfare	2769.22	2323.21	**5092.43**	1052.60	2134.53	**3187.13**	1999.45	6722.97	**8722.42**	4023.46	8189.63	**12213.09**	6409.07	5965.00	**12374.07**
Total	3649.04	3116.28	**6765.32**	1951.94	3118.5	**5070.44**	3017.3	7901.05	**10918.35**	4873.84	8893.27	**13767.11**	7239.7	6388.64	**13628.34**
Centrally sponsored schemes —Capital a/c															
Family welfare	20.43	310.21	**330.64**	225.83	1412.06	**1637.89**	2036.69	1271.68	**3308.37**	2808.56	1903.80	**4712.36**	850.00	650.00	**1500.00**
Housing	5.75	20.59	**26.34**	85.92	112.73	**198.65**	75.37	64.44	**139.81**	29.83	24.13	**53.96**	94.00	45.50	**139.50**
Total	26.18	330.8	**356.98**	311.75	1524.79	**1836.54**	2112.06	1336.12	**3448.18**	2838.39	1927.93	**4766.32**	944	695.5	**1639.5**
Centrally sponsored schemes—Revenue a/c															
Medical and public health	82.40	88.13	**170.53**	81.34	119.03	**200.37**	39.47	67.61	**107.08**	51.32	70.34	**121.66**	129.00	133.00	**262.00**
Family welfare	4211.91	5696.34	**9908.25**	6031.76	7952.96	**13984.72**	5986.37	6642.15	**12628.52**	7927.67	9872.70	**17800.37**	11299.57	11450.67	**22750.24**
Total	4294.31	5784.47	**10078.78**	6113.1	8071.99	**14185.09**	6025.84	6709.76	**17735.6**	7978.99	9943.04	**17922.03**	11428.57	11583.67	**23012.24**
Centrally sponsored schemes —Capital a/c															
Medical and public health	66.51	86.62	**153.13**	51.9	50.17	**102.07**	48.84	40.83	**89.67**	-	-	**0**	-	-	**0**

Table 4. Zilla panchayat- plan 2004-05- Allocations to Zilla, Taluk and Grama panchayats (in lakhs)

Sector	Zilla Panchayat			Taluk Panchayat			Grama Panchayat			Total for the sector		
	State	Central	Total	State	Central	Total	State	Central	Total	State	Central	Total
2	3	4	5	6	7	8	9	10	11	(3+6+9)	(4+7+10)	(5+8+11)
Medical and Public health	1755.17	0.00	1755.17	268.16	0.00	268.16	0.00	0.00	0.00	2023.33	0.00	2023.33
Family welfare programme	76.23	10794.52	10870.75	0.00	0.00	0.00	0.00	0.00	0.00	76.23	10794.52	10870.75
Welfare of women and children	2371.39	0.00	2371.39	90.44	13674.01	13764.45	0.00	0.00	0.00	2461.83	13674.01	16135.84
Nutrition	0.00	0.00	0.00	3902.25	0.00	3902.25	0.00	0.00	0.00	3902.25	0.00	3902.25

Note: The gram panchayats—village councils—have no role in health related issues.
This is the tier nearest to the people.

Table 5. Zilla panchayat- plan 2004-05- Allocations to Zilla, Taluk and Grama panchayats in Chitradurga and Chamrajanagar (in lakhs)

Sector	Zilla Panchayat			Taluk Panchayat			Grama Panchayat			Total		
	State	**Central**	**Total**	**State**	**Central**	**Total**	**State**	**Central**	**Total**	**State**	**Central**	**Total**
2	3	4	5	6	7	8	9	10	11	(3+6+9)	(4+7+10)	(5+8+11)
Chitradurga	829.04	1484.61	2313.65	742.11	1215.13	1957.24	925.00	223.30	1148.30	2496.15	2923.04	5419.19
Chamrajanagar	670.80	1224.88	1895.68	436.30	625.18	1061.48	600.00	130.00	730.00	1707.10	1980.06	3687.16

Note: This is for all developmental activities—employment schemes, housing etc.

Table 6. Estimates of Primary health Schemes at the Zilla panchayat for the year 2004-05

Z.P scheme [in lakhs]	Chitradurga	Chamrajanagar
Primary health centres (GOI pattern) (MNP)	326.07	186.12
Of which salary component	316.05	182.35
Primary health centres (MNP)	93.66	31.24
Of which salary component	93.45	31.03
Upgradation of primary health centres community health centres	61.75	26.79
Of which salary component	61.68	26.72
Drugs and chemicals to allopathy and ISM	47.92	19.72
Population centres	195.19	0.00
Of which salary component	178.47	0.00
Total	**1374.24**	**503.97**

Note: MNP is Minimum Needs Programme; ISM is Indian Systems of Medicine—The salary component is very high, as can be seen in rows 2 and 9.

Table 7. Estimates of Primary health Schemes at the Taluk panchayat for the year 2004-05

T.P scheme [in lakhs]	Chitradurga	Chamrajanagar
Strengthening of PHUs-maternity homes (rev)	12.90	4.16
Of which salary component	12.81	4.06
Establishment of sub-centres (MNP)	18.66	39.75
Of which salary component	18.47	36.69
Buildings (includes ISM)	18.53	3.90
Water and electricity (includes ISM)	4.97	1.00
Telephone charges (includes ISM)	3.90	2.93
Total	**90.24**	**92.49**

Prepared as a background note for the international workshop in "Budget Work and Maternal Health", organised by Fundar and the International Budget Project, Mexico City, November 4-6, 2004.

We are grateful to Helena Hofbauer for inviting us to write this paper.

This work is part of a project funded by the John D and Catherine T Foundation. Our budget work has been supported by the Ford Foundation. This note brings together these two streams of work. We acknowledge this support gratefully.

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CBPS

The Centre for Budget and Policy Studies (hereinafter referred as the Centre) is a non-partisan, non-profit, independent society established by a group of professionals based in Bangalore and registered under the Karnataka Registration of Societies Act in February 1998 (no 777 of 1997-1998). The President is Dr. D. K. Subramanian and the Secretary and Director is Dr. Vinod Vyasulu.

The objective of the Society is to contribute through research to understanding and implementing a process of long run, sustainable, equitable development in countries like India. Equity, as we understand it, extends across time - future generations must not be deprived of resources because of irresponsible use - and class and gender - all human beings have inalienable rights that society must ensure.

An area in which the CBPS has made a contribution is in the context of the ongoing process of democratisation and decentralisation following upon the 73rd and 74th amendments to the Indian Constitution. In this context, budgets of different governmental bodies are important statements of policy priority. Budget analysis at local levels is an area where much needs to be done. An example is the work of the Centre in studying the budgets of two zilla panchayats [Dharwad and Bangalore (Rural)] in Karnataka. The report was published and is being used in programmes to orient those who have been newly elected to panchayats. In order to study decentralisation in urban areas, the finances of Urban Local Bodies- city municipal councils were taken up for study. The finances of Mandya and Udupi in Karnataka have been completed. Studies on the finances of City Municipal Councils around Bangalore are in progress.

One way of meeting our objective is by providing inputs into ongoing debates in society on matters of policy priority. Industry is one such area. CBPS did a study and published a monograph on the functioning of different sectors of industry, its impact on employment, livelihoods, productivity and the like. Ecological and environmental sustainability is another important area of decentralised functioning. CBPS has studied the working of programmes like drinking water, watershed development and joint forest management to see how local bodies can contribute to the meeting of national objectives. Studies of other important policy areas are on the anvil. Another area of importance is an understanding of the nature of the local economy. The Centre has worked on this issue and a manual on the method to calculate District Income in India, sponsored by the Planning Commission, has been published by Macmillan India. CBPS has collaborated with a software company, Spatial Data Pvt Ltd, to develop this as a software called Indicat' using maps with GIS engine. District officials of Kerala have been trained in using this software to calculate their district income. Further work on this will continue.

CBPS prepared report on a case study of the marginality of productivity, income and food security in Koraput district of Orissa, based on primary data of 200 households that was collected by CBPS.

CBPS will remain a small body of professionals who will work by interacting and networking with others who share such interests. With this in view, CBPS conducted a Workshop for groups of South Asia on 'Civil Society and Budget Analysis' on behalf of the International Budget Project, Washington. A report on the workshop has been published.

The results of all this work are disseminated in training workshops and in follow up programmes.