Terms of reference for the study on Out of pocket Expenditure Incurred for Maternal HealthCare by BPL Women in karnatakain Public Health Facilities

Terms of Reference for A Study on Out of Pocket Expenditure Incurred for Maternal Health Care by BPL Women in Karnataka in Public Health Facilities

1. **Title of the study**:

   A Study on Out of Pocket Expenditure Incurred for Maternal Health Care by BPL Women in Karnataka in Public Health Facilities

2. **Department/Agency implementing the Scheme:**

   The Department of Health and Family Welfare Government of Karnataka.

3. **Background and the context**:

   Health assumed greater attention in programmes and policies with the centering of Human Development agenda as the final goal of development. Maternal and child health issues became prominent as the human development indicators focused on life expectancy, Infant Mortality, Child Mortality, Maternal mortality and malnutrition. Further, the Millennium Development goals and the maternal and child health related targets and indicators under Goals 4 and 5 of the MDGs prompted the member nations to devise appropriate strategies and pump more resources into the health sectors. According to the MDGs, the Infant Mortality and Under-five mortality targets for 2015 were fixed as two-thirds of the rate in 1990 and a reduction of maternal mortality by three quarters of that in 1990. As per these norms, the achievement targets for India were an IMR of 27 per 1000 live births, a CMR of 40 per 1000 live births and a maternal mortality of 87 per lakh live births by 2015. The MDG targets to be achieved by Karnataka are an IMR of 32 per 1000 live births, a CMR of 32 per 1000 live births and a maternal mortality of 70 per lakh live births.

   The Government of India launched the National Rural Health Mission (NRHM) in 2005 as a comprehensive strategy for attaining gains in health outcomes to meet the Millennium Development Goals by 2015. The central goal of the Mission was to increase public expenditure on health from the mere 0.9 per cent of GDP to about 2-3 per cent of GDP in the next five years so as to bring improvements in the health indicators – life expectancy at birth, infant mortality

rate, under 5 mortality rate and maternal mortality rate. After about 7 years of implementation of the Mission, the GoI in 2012 extended the span of the mission for another five years until 2017.

With the implementation of several maternal health programmes of the Central as well as the State Govt. there have been significant achievements in the reduction in maternal mortality and Infant Mortality rates in Karnataka as an outcome of increased institutional deliveries. The achievements are indicated in the

Table-1 Institutional Deliveries-IMR and MMR

	2011-12	2013-14	2015-16
Institutional Deliveries	72.6	69.7	85
MMR	213(SRS04-06)	144(SRS 2010-12)	115 HMIS 2015
IMR	41	32 (SRS2012)	29 (SRS2014)
U5 MR	48		31(SRS2014)

Source: DH&FW Annual Report 2016-17

Though the targets in IMR and U5 MR are achieved, we are yet to achieve the target in reduction in MMR to 70 and to increase the institutional deliveries to 100 percent in near future. Further, there is also a question of sustainability of these achievements in future. This is due to the increasing Out of Pocket expenditure on institutional deliveries in the State. The results of District Level Health Survey (DLHS) 4 have brought out the fact that there has been a significant increase in OOP expenditure on institutional deliveries in the State. The question is why OOP is still high despite of many demand side interventions that are introduced to remove the major financial burden of institutional deliveries on the BPL families.

Demand Side Financial Incentives

Demand side financial incentive (DSF) is a form of subsidy and it directly provides purchasing ability to consumers on certain publicly provided goods such as health and nutrition. DSF introduces two key changes in the public financing of such goods and services. First, it entitles the government to be a supplier of purchasing power to consumers instead of being a direct service provider. Secondly, it tunes financing as 'output-based' than 'input-based' and hence links the subsidy or its objective with the beneficiary. The NRHM (NHM) adopted the demand side financial (DSF) incentives as one of the main strategies to enhance maternal healthcare utilization. It preferred DSF in the form of conditional cash transfers (CCT) which aimed to

provide cash incentives to the beneficiary conditional upon the beneficiary's actions so as to raise the rate of institutional deliveries and thereby improve other crucial indicators like the IMR and MMR. During maternity medical attention is required at different stages. Various points of care that are required include ante natal checkups, immunizations, diagnostics, surgical charges, transport costs, post natal checkups etc. The various government health schemes in the state to reduce the costs of institutional delivery are:

Janani Suraksha Yojane (JSY):

This is 100 % Government of India funded Programme, through National Health Mission. The main objective of this scheme is to motivate all BPL, SC and ST Pregnant Women to deliver in Health Institutions, to reduce maternal and infant deaths. In this programme, pregnant women of BPL, SC & ST who deliver in health institutions in rural areas are provided Rs 700 cash incentives, in urban areas; Rs 600 and if they deliver through C-Section in private institutions are provided Rs 1500. If the said category Pregnant Women deliver at their homes, they are also provided Rs 500 cash incentives to meet their post-delivery wage loss.

Thayi Bhagya:

This Programme envisages, totally free Maternal & Child Health Care of all categories of Pregnant Women and Mothers in the State, with the core intention of zero Out of Pocket Expenditure to all women for MCH Services. The goals and objectives of this programme are achieved with main focus on equity, and ensuring quality MCH services which are available, accessible and affordable to all sections of the society. In addition to the said services, BPL, SC and ST category Pregnant Women and Mothers are provided incentives in cash and kind to motivate them to avail MCH Services in Government and Private Hospitals, with the sole intention of reducing Maternal & Infant Morbidity and Mortality.

Madilu:

This is one of the four components of Samagra Mathru Aarogya Palane (ThayiBhagya) Scheme, it is being implemented since 2007-08, with 50 % of the budget coming from GoI, through National Health Mission and the remaining 50 % of the budget is being provided by the State Government. In this programme, a kit containing 19 items which are useful to the post-natal women and her infant is being provided to BPL, SC & ST beneficiaries, who deliver in any Government Hospital in the State. This benefit is provided to all deliveries of BPL, SC & ST women in HPD districts (Bagalkote, Bijapur, Ballari, Raichur, Koppal, Raichur, Kalaburagi, Yadagiri, Gadag and Chamarajanagar) and for only two live births in

the remaining districts of the State. The line items of the kit are being procured from Karnataka Handloom Development Corporation and the soap items are being procured from Karnataka Soaps and Detergents Ltd. The approximate cost of each kit is Rs. 1380.

Prasooti Araike:

This is one of the four components of Samagra Mathru Aarogya Palane (Thayi Bhagya) Scheme, out of which, the three components, Viz., Prasoothi Araike, Thayi Bhagya and Thayi Bhagya Plus are 100 % Government of Karnataka funded schemes. Prasoothi Araike scheme is being implemented from 2007-08 with the objective of providing cash benefits to BPL, SC and ST communities Pregnant Women, to enable them to take nutritious diet during pregnancy and post-natal period to reduce maternal and infant morbidity and mortality. This scheme is implemented in all the districts of the State, except Kolar and Dharwad. Beneficiaries of this scheme receive cash incentives of Rs.1000 in two installments, the 1st installment is provided to the Pregnant Women during her 4-6 months' pregnancy and the 2nd installment of Rs.1000 is provided immediately after delivery, if the beneficiary delivers in any Government Hospital in the State. The 2nd instalment will include the JSY cash component. From 2014-15, the cash incentives, for the Pregnant Women and Post-natal mothers has been enhanced for SC & ST beneficiaries to Rs. 2000 each.

Janani Shishu Suraksha Karyakrama (JSSK):

This is also 100 % Government of India funded Programme, through National Health Mission. The main aim of this programme is to ensure, totally zero out of expenditure to Pregnant Women to avail free delivery services in Government Hospitals. In this Programme five free services are provided in all Government hospitals across the State. The services which are provided free of cost to all pregnant women are; free drugs and consumables, free diagnostics, free blood, free diet and free transport services from home to health institutions and back home. For all Government Hospitals; for providing free delivery services, for each case, Rs. 350 for drugs, (Rs. 1600 for C-Section deliveries), Rs. 200 for diagnostics, Rs. 150 for free diet (Rs. 350 in C-Section Deliveries) and Rs. 250 for referral transport is provided.

Extended Thayi Bhagya (Plus):

A cash assistance of Rs. 1000/- for a private hospital delivery is paid to rural SC, ST and BPL women for the first 2 live births in all other districts other than 10 High Priority Districts in accredited private hospitals.

(Source: H&FW Annual Report 2016-17)

In spite of the above schemes and services that claim to be free of cost, the DLHS-4 reports

reveal that there has been out-of-pocket expenditures in the public health facilities. The details of the average delivery expenses incurred per beneficiary in public facilities across the districts of Karnataka are shown in table 1.

Table -2 Out of Pocket expenditure on delivery in public health facilities

Sl No	District	OOP Expenditure(Rs)	
		Total	Rural
1	Bagalkot	1600	1500
2	Bangalore (R)	5590	6160
3	Bangalore (U)	5410	6650
4	Belgaum	1500	1400
5	Bellary	3850	3690
6	Bidar	1590	1730
7	Bijapur	1800	1800
8	Chamarajanagar	3060	2330
9	Chikamagalur	5920	5670
10	Chikkaballapur	4320	4410
11	Chitradurga	3200	1810
12	Dakshina Kannada	3150	2910
13	Davangere	2910	2680
14	Dharwad	2270	2120
15	Gadag	2490	2600
16	Gulbarga	1700	1700
17	Hassan	4020	3890
18	Haveri	3700	4020
19	kodagu	3220	3330
20	Kolar	3390	3170
21	Koppal	2710	2160
22	Mandya	2310	2010
23	Mysore	3300	3200
24	Raichur	2180	1820
25	Ramanagara	5340	6360
26	Shimoga	4680	4780
27	Tumkur	3250	3390
28	Udupi	3800	1900
29	Uttar Kannada	3580	3840
30	Yadgir	3120	2980
	Karnataka	3130	3000
	SD	1074.0	1046.0
	Max.Min Ratio	3.94	4.75

Source: DLHS-4 2012-13 reports

As it can be observed in the table the top five districts that had the highest OOP have been in the southern divisions. Chikkamagalur topped the list with an OOP of Rs. 5920 per delivery which was followed by Bangalore Rural with Rs. 5590, Bangalore Urban with Rs.

5410, Ramanagara with Rs. 5340 and Shimoga with Rs.4680. The least average OOP expenditures were observed in the north Karnataka districts of Belgaum (Rs.1500), Bidar (1590), Bagalkot (Rs. 1600), Gulbarga (Rs.1700) and Bijapur (Rs. 1800) and (3170) on an average delivery expenses incurred per beneficiary.

Another interesting fact that can be observed is that in few districts the rural OOP had been higher than the total OOP. This scenario is observed in 11 districts as shown in table 2 below. Again the differences had been the highest in the southern districts of Bangalore Urban and Ramanagara. This is again a discouraging fact. All these indicate that there is underutilization or the inefficiencies of the various schemes made available in reaching out to the beneficiaries.

Table -3 Out of Pocket Expenditure in Rural areas

District	Total	Rural	Difference
Bangalore(R)	5590	6160	570
Bangalore(U)	5410	6650	1240
Bidar	1590	1730	140
Chikkaballapur	4340	4410	70
Gadag	2490	2600	110
Haveri	3700	4020	320
Kodagu	3220	3330	110
Ramanagara	5340	6360	1020
Shimoga	4680	4780	100
Tumkur	3250	3390	140
Uttar Kannada	3580	3840	260

Source: DLHS-4 2012-13 reports

Therefore, it is essential to know why the OOP is very high and in 18 districts above the State average. The SD is also very high showing significant differences across the districts. What are the reasons and different components and what are its consequences and implications for the future.

4 Evaluation Scope, Purpose and Objectives

The study covers all the 30 districts of the State from four administrative divisions. As the OOP differs across the rural and urban areas, therefore, the study will cover both the rural and urban areas. The purpose of the study is to examine the magnitude and dimensions of OOP expenditure at macro as well as micro household level and the sources though which it is met and the implications of it.

Evaluation Objectives

1. To assess the awareness of the government maternal health schemes among the sample of mothers who delivered in public health facilities.

2. To assess the items of out-of-pocket expenditures incurred by the family per delivery in the public health facility.
3. To find out the reach of the Maternal Health schemes to the targeted beneficiaries across the regions.
4. To examine the financial adequacy of various Maternal Health schemes.
5. To examine the regularity, and real time disbursement of the cash and other incentives under the schemes.
6. To examine the component of transport cost in the OOP expenditure.
7. To analyse the sources through which the OOP expenditure is met by the family.
8. To suggest appropriate measures for improving the "better reach" of the maternal schemes and in turn improving their effectiveness.

5. Evaluation Questions (Inclusive not exhaustive):

The evaluation questions to be addressed in the study are:

1. What is the status of Karnataka vis-à-vis other States in India with regard to OOP on maternal health care? What is the trend in OOP over last ten years as per the available data in NFHS/DLHS?
2. Why OOP is high in Karnataka? How it reflects on the access and implementation of various maternal health schemes in the State? What are the findings of the micro level studies in this regard? (The ECO has to analyse the studies related to the access, implementation and impact of various maternal health schemes through a comprehensive review of literature)
3. What are the factors contributing to the high OOP in maternal health care? Examine separately the issues in urban and rural areas. (A Hypothesis may be framed for testing)
4. There are significant variations in OOP across the districts in the South and North Karnataka. There are also variations within the divisions. How these can be explained in terms of economic conditions, infrastructure, geographical conditions and social factors? (A Hypothesis may be framed for testing)
5. Whether OOP varies across the caste groups within and across the regions? What are its implications in terms of access to health services for women?(A Hypothesis may be framed for testing)
6. What are the components of OOP? Whether transport costs form a major component of it? Examine whether money is spent on medicines and other medical assistance and other clinical facilities is due to its non availability or otherwise at the place of health facility.

7. What is the extent of awareness about various maternal health schemes among the women? What are the sources of information? Whether it varies across regions and Caste groups?
8. Whether beneficiaries face any problems in getting the required eligibility documents to avail the benefits of various schemes? To what extent it has contributed to increase in OOP.
9. What is the role played by ASHA, Village level health workers and Anganwadi teacher in providing information and in helping the women to get the benefits? Whether OOP varies across women accompanied/ supported by them or not?
10. Under the Maternal Health Schemes assistance is provided in the form of cash. How it is utilized? Whether the whole or part is utilized for the pregnant woman, mother and the child? Whether there are any deviations in it?
11. How the high OOP has been financed? Look into the different sources and examine whether this has pushed the women/family into poverty and indebtedness as it is observed in some of the Studies?
12. Whether the Maternal health programmes are implemented effectively in the State and across the Regions? Whether the beneficiaries are selected as per the norms and guidelines of these schemes? Find out whether the schemes have reached to the poorest and the marginalized women and women in remote areas.
13. What are the problems and difficulties faced by the beneficiaries in receiving the benefits? Is there any time gap between the requirement and receipt? If so, what are its consequences?
14. What are the problems faced by the implementing agencies at various levels in implementing these schemes?
15. Examine the actual average requirement of funds at household level for health care during pregnancy and delivery in public health facility. Estimate the gap if any. To what extent the different maternal health schemes meet the requirements?
16. Whether OOP varies across the primi gravida and multi gravida (pregnancies)? What is the impact of high OOP on second and subsequent deliveries in the households having 3or more children?
17. What suggestions can be given to reduce OOP to a minimum level of Rs. 500 and to a zero level?

6 Evaluation Methodology and Sampling:

The study follows a set of methodology to arrive at final conclusions.

- Review of literature and of the studies in the field.
- Analysis of the secondary data available at the State and the district level from various reports and surveys and data at PHC level.
- Collection and analysis of Primary data through a structured interview schedule.
- Focused Group discussions –Beneficiaries- SHGs- Health Department officials
- Case studies

A pre-testing or piloting of the questionnaire would be done in order to identify the problems that are likely to arise while using it for data collection. Based on the insights from the pilot study the questionnaire would be modified.

The other stake holders like health department officials at district and taluka as well as PHC level, health workers, ASHA workers and any prominent NGO in the field will be interviewed with an interview schedule.

Formats to be prepared for data compilation and analysis and the data would be analyzed using simple statistical techniques like percentage, average, standard deviation and other suitable techniques.

FGDs to be conducted to find out the access to and utilization of different Maternal health schemes and the reasons for high OOP.

Indicators –A set of indicators as related to the socio economic background of the sample, information and awareness about different maternal health schemes, access and benefits received from the schemes, the components of OOP -medical and non medical, adequacy and utilization of financial assistance, gap analysis between the receipts and expenditure etc. to be framed to get the results.

Sample selection

The sample design is Multi stage stratified Random Sampling design

I Stage Selection of the year/years for evaluation study

The sample selection for the study requires decision on selection of year/years to draw the sample.

The total number of sample for the study would be distributed equally between the years 2014-15 and 2015-16. The year 2014-15 is not steady with regard to the NRHM finances in the State. It is expected that timely disbursements of the scheme incentives would have hampered. Therefore, a proportionate sample will be drawn from among the given year and the next year beneficiaries.

II Stage - Geographical coverage The State is divided into four strata on the basis of administrative divisions -– 4 administrative Divisions in the State

III Stage - Selection of Districts

The data from DLHS-4 survey forms the basis for selection of the sample district for the study form the four divisions. The sample districts are selected based on the OOP expenditure. The districts with high OOP are also the districts with high OOP in rural areas except in Bangalore division where rural OOP is high in Bangalore Urban district. Further these districts are also the districts with institutional deliveries above the State average.

Table -6 Division wise and District wise OOP Expenditure and the Institutional Deliveries

Bangalore Division			
District	OOP Total	OOP Rural	Institutional
Bangalore(R)	5590	6160	97.
Bangalore(U)	5410	6650	95.
Chikkaballapur	4340	4410	91
Chitrdurga	3200	1810	91.
Davangere	2910	2680	95.
Kolar	3390	3170	93
Ramanagara	5340	6360	98.
Shimoga	4680	4780	97.
Tumkur	3250	3390	96.
Karnataka	3130	3000	89
Mysore division			
District	OOP Total	OOP Rural	Institutional deliveries
Chamarajanagar	3060	2330	96.
Chikamagalur	5920	5670	97.
Dakshina Kannada	3150	2910	98.
Hassan	4020	3890	98.

Kodagu	3220	3330	95.
Mandya	2310	2010	96.
Mysore	3300	3200	98.
Udupi	3800	1900	98.
Karnataka	3130	3000	89
Belgaum Division			
District	OOP Total	OOP Rural	Institutional Deliveries
Bagalkot	1600	1500	86.
Belgaum	1500	1400	89.
Bijapur	1800	1800	80.
Dharwad	2270	2120	93.
Gadag	2490	2600	83.
Haveri	3700	4020	90.
Uttar Kannada	3580	3840	95.
Karnataka	3130	3000	89
Gulbarga Division			
District	OOP Total	OOP Rural	Institutiona Deliveriesl
Bellary	3850	3690	81
Bidar	1590	1730	92.
Gulbagra	1700	1700	77.
Koppal	2710	2160	70.
Raichur	2180	1820	73.
Yadgir	3120	2980	76.
Karnataka	3130	3000	89

Source: DLHS-4 2012-13 reports

Table-7 Districts in the Sample

	Name of the Division	Name of the District
1	Bangalore Division	Bangalore (R)
2	Mysore Division	Chickmagalur
3	Belgaum Division	Haveri
4	Kalaburagi Division	Bellary
5	Lowest OOP with Institutional Deliveries at State average	Belgaum

- Belgaum is to be included in the sample as it has lowest OOP and the institutional delivery percentage is equal to State average. This may serve as a model for filling up the policy gaps.

IV Stage Selection of PHCs

From each district 10 percent of PHCs will be selected randomly. Their geographical distribution will cover the urban, rural and remote areas.

Table-8 No. of PHCS in the Sample Districts

District	DH	TH	CHC	PHC	Total	Sample 10%
Bangalore Rural	-	7	2	50	59	6
Chikkamagalur	1	7	5	90	103	10
Haveri	1	6	5	73	85	9
Bellary	2	6	11	73	92	9
Belgaum	1	9	16	150	176	18
Total	5	35	39	436	515	52

Source: DH&FW & Karnataka At A Glance-2015-16

V Stage Selection of beneficiaries

The list all pregnant women belonging to the BPL category who have availed the benefits and services from public health facilities during the years 2014-15 and 2015-16 would be obtained from the districts and PHCs. From these PHCs 5 percent of the beneficiaries who have availed benefits under various maternal health schemes will be selected randomly for the two years for the final analysis. The household of the BPL mothers would be the primary unit of data collection for the study.

7. Deliverables and time Schedule:

The whole study is to be completed in 6 months from date of signing the MOU with KEA. The evaluating agency is expected to adhere to the following timelines and deliverables.

1	Work plan /Inception Report submission	Within One month of signing the agreement.
2	Field Data Collection	Two-three months from date of work plan approval
3	Draft report Submission	Within one month after field data collection
4	Final Report Submission	Within One month from draft report submission
5	Total duration	6 months

8 Qualities Expected from the Evaluation Report :

The following are the points, only inclusive and not exhaustive, which need to be mandatorily followed in the preparation of evaluation report:-

a) By the very look of the evaluation report it should be evident that the study is that of Health Department of the Government of Karnataka, and Karnataka Evaluation Authority (KEA) which has been done by the Consultant. It should not intend to convey that the study was the initiative and work of the Consultant, merely financed by the Karnataka Evaluation Authority (KEA).

b) Evaluation is a serious professional task and its presentation should exhibit it accordingly. Please refrain from using glossy, super smooth paper for the entire volume overloaded with photographs, graphics and data in multicolor fancy fonts and styles.

c) The Terms of Reference (ToR) of the study should form the first Appendix or Addenda of the report.

d) The results should first correspond to the ToR. In the results chapter, each question of the ToR should be answered, and if possible, put up in a match the pair's kind of table, or equivalent. It is only after all questions framed in the ToR that is answered, that results over and above these be detailed.

e) In the matter of recommendations, the number of recommendations is no measure of the quality of evaluation. Evaluation has to be done with a purpose to be practicable to implement the recommendations. The practicable recommendations should not be lost in the population maze of general recommendations. It is desirable to make recommendations in the report as follows:-

(A) **Short Term practicable recommendations**

These may not be more than five in number. These should be such that it can be acted upon without major policy changes and expenditure, and within say a year or so.

(B) **Long Term practicable recommendations**

There may not be more than ten in number. These should be such that can be implemented in the next four to five financial years, or with sizeable expenditure, or both but does not involve policy changes.

(C) **Recommendations requiring change in policy**

These are those which will need long period of time, resources and procedure to implement.

9. Cost and schedule of Budget releases:

Output based budget release will be as follows-

a. The **First instalment** of Consultation fee amounting to 30% of the total fee shall be payable **as advance** to the Consultant after the approval of the inception report, but only on execution of a bank guarantee of a scheduled nationalized bank valid for a period of at least 12 months from the date of issuance of advance.

b. The **Second instalment** of Consultation fee amounting to 50% of the total fee shall be payable to the Consultant after the approval of the Draft report.

c. The **Third and final installment** of Consultation fee amounting to 20% of the total fee shall be payable to the Consultant after the receipt of the hard and soft copies of the final report in such format and number as prescribed in the agreement, along with all original documents containing primary and secondary data, processed data outputs, study report and soft copies of all literature used to the final report.

Tax will be deducted from each payment as per rates in force. In addition, the evaluator is expected to pay statutory taxes at their end.

10. Minimum Qualification of the consultant:

Consultants should have and provide details of evaluation team members having technical qualifications/capability as below-

Sl. No	Subject Experts Requirements	Educational Qualification	Experience in the relevant field
1.	Principal Investigator	A social science post graduate with first class/Ph.D.	10 and more years
2.	1st Core Team Member	A post Graduate in/Women's Studies /Sociology /Social Work with diploma in Public Health Management (Preferable)	5-10 years
3.	2nd Core Team Member	Data analyst -Post Graduate in Statistics /Economics with adequate computer knowledge and software packages	5 years

And in such numbers that the evaluation is completed within the scheduled time prescribed by the ToR. Consultants not having these number and kind of personnel will not be considered as competent for evaluation.

11. Contact persons:

The entire process of evaluation shall be subject to and conform to the letter and spirit of the contents of the government of Karnataka order no. PD/8/EVN(2)/2011 dated 11th July 2011 and orders made there under.

EXECUTIVE DIRECTOR
Karnataka State Health System Resource Centre
SIHFW Campus, 1st Cross
Magadi Road, Bangalore - 560 023
(Nodal Officer)

11/10/17
Chief Evaluation Officer
Karnataka Evaluation Authority

Dr Chaya R. Degaonkar