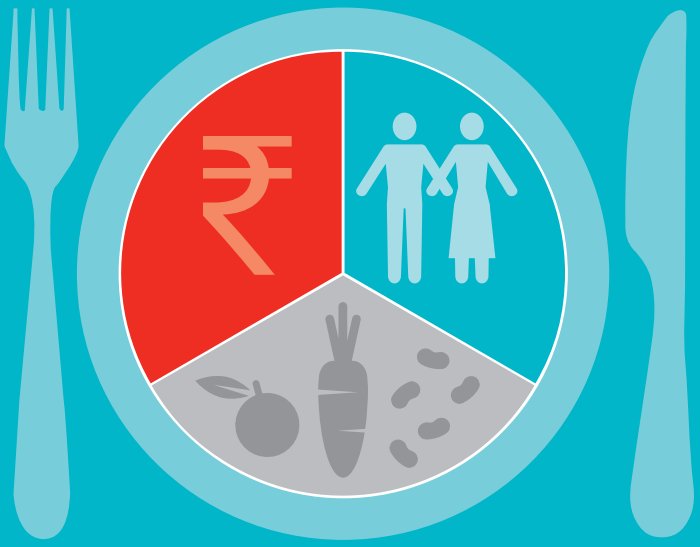
RESULTS FOR DEVELOPMENT

Nutrition Financing in Rajasthan: Trends and Gaps in 2016-17



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POLICY FINDINGS

from an analysis of nutrition programme costs and financing in Rajasthan, India

RESULTS FOR DEVELOPMENT INSTITUTE

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Summary

MALNUTRITION is a leading cause of death among children in India, and combating it should be a top priority for national and state governments. However, the causes of malnutrition are diverse, and an effective government response requires coordinated efforts from multiple sectors. To better understand financing for nutrition in Rajasthan, Results for Development Institute (R4D), with technical support from Budget Analysis Rajasthan Centre (BARC) examined 2016-17 state budgets and analysed trends across three fiscal years, 2014-15, 2015-16 and 2016-17. We present here the preliminary results.

TABLE 1: Summary of key findings

Budget allocations for **nutrition-specific programmes are lower today than before devolution:** ₹1,106 crores in 2016-17 BE, down from ₹1,278 crores in 2014-15 BE
Financing for nutrition-sensitive programmes (₹8,987 crores) is **nearly 9x as large** as for nutrition-specific programmes (₹1,106 crores), and can be better targeted
Utilization of nutrition-relevant budgets is poor, and particularly in **WCD and MHFW**, the key implementing departments for nutrition
There is a **69% funding gap** to scale the **core set of "India Plus" interventions** in Rajasthan

We found that budget estimates for nutrition-specific programmes were lower in 2016-17 than in the 2014-15 budget, despite a small up-tick since 2015-16, raising some concern about the state's fiscal commitment to nutrition. We also found that budget utilization for nutrition programmes was poor in 2014-15, particularly among Umbrella Integrated Child Development Services (ICDS) and National Health Mission (NHM), and significantly lower than the utilization rate of the full state budget, which implies that more could be done within existing budget allocations. We found that nutrition-sensitive programmes make up the vast majority of nutrition-relevant financing today, which makes it imperative for the relevant departments to factor the nutritional impact of their programmes into their decision-making, and reinforces the need for inter-departmental collaboration. We found that current financing for key programmes is simply inadequate to address resource needs, and that a 69% funding gap must be filled if the government wishes to scale up the India Plus interventions[i].

TABLE 2: Summary of recommendations

Maximize the impact of nutrition-specific interventions by: • Raising budget allocations for SNP, IGMSY and others • Improving utilization of allocated resources • Focusing investments on 'first 1000 days' window
Generate additional impact by enhancing existing programmes within nutrition-sensitive departments, e.g.: • Increase funding for IEC in Swachh Bharat Abhiyan • Diversify and fortify food provided through TPDS • Increase nutritional content of Mid-Day Meals
Consider establishing an independent state-level coordinating body, to further the nutrition agenda and facilitate a multi-sectoral approach to combat malnutrition

To better address the direct and underlying causes of malnutrition, we have a number of recommendations that can be taken up by government departments in Rajasthan. We recommend that budget allocations for core nutrition programmes be increased, better utilized, and better targeted to the populations where impact is greatest. We recommend that the large nutrition-sensitive programmes outside ICDS and NHM give greater emphasis to nutrition goals, and bolster funding and attention to the activities that have been identified as improving nutritional outcomes. Finally, given the need for increased resource mobilization for nutrition, the importance of a true multi-sectoral approach to combating malnutrition, and the strong leadership required to ensure progress is made on both of these fronts, we recommend that the Government of Rajasthan consider setting up an independent Nutrition Mission to drive forward the nutrition agenda, support and expand upon existing convergence initiatives, and monitor progress towards meeting Rajasthan's nutrition goals.

Background

THE CASE FOR COMBATTING MALNUTRITION HAS BEEN WIDELY ESTABLISHED. Malnutrition continues to be one of the leading causes of child deaths, impaired physical and cognitive development, and increased susceptibility to illness.[1] Chronic malnutrition beyond the age of 2-3 years is hard to reverse and has long term impacts on education attainment and economic productivity.[2] In 2015, the Sustainable Development Goals encompassed 'ending all forms of malnutrition' and earlier this year, the United Nations General assembly declared 2016-2025 as the 'decade of action on malnutrition' which set forth a global movement to end malnutrition in all its manifestations by 2030.

Despite strong economic growth and a significant decline in malnutrition over the past decade, 16% of the Indian population is malnourished.[3] Globally, 35% of the world's low birth weight infants and 43% of the world's malnourished live in India.[4] Rajasthan, India's largest state by area, bears a significant malnutrition burden. According to the Rapid Survey of Children 2013-2014, Rajasthan ranks 10th-worst among 29 Indian states for stunting and 15th for wasting, with 36.4% of children under five classified as stunted and 14.1% classified as wasted.[5]

Historically, the Union government of India has funded social sector programmes through Centrally Sponsored Schemes (CSS). In February 2015, the centre accepted recommendations of the 14th Finance Commission which increased the share of tax devolved to states by 10 percentage points, representing 42% of the divisible pool of taxes of the centre. With the increase in untied funds that resulted from CSS cuts, states have newfound flexibility to tailor social programmes to fit their needs and context. However, these cuts may be damaging if states that lag behind in nutritional outcomes fail to utilize this increase to prioritize nutrition spending.

To understand how devolution is affecting financing for nutrition, the latest budget for fiscal year 2016-17 is likely to present a clearer picture than the 2015-16 budget. The 2015-16 union budget was passed soon after the centre accepted the recommendations, amidst uncertainties and a lack of clear guidelines to states. As such, states were still getting to grips with the new system, and many passed supplementary budgets through the year to course-correct. 2016-17 is therefore the first budget that provides a clear picture of how states are acting under the new system.

In this brief, we present an analysis of nutrition financing in Rajasthan by looking at 2016-17 state budget data and analysing trends for three fiscal years 2014-15, 2015-16 and 2016-17, which are key years for devolution. We estimate the total financing by assessing investments that have direct and measurable impacts on nutrition (nutrition-specific) and those that indirectly impact nutrition (nutrition-sensitive) such as investments in Water, Sanitation and Hygiene (WASH), Agriculture, Health, Education and Social Protection.

For ease of interpretation, we present actual amounts budgeted for all relevant programmes without further adjustment.[ii] For programmes that contain both nutrition-specific and nutrition-sensitive components (including ICDS and NHM), we report the split of funding to these different programmes using an allocation weight from a budget line-item analysis.

Research Strategy

We followed a similar methodology to R4D's 2015-16 analysis, which built on earlier analysis by Avani Kapur (Accountability Initiative) and Lawrence Haddad (GAIN) on financing and Purnima Menon (IFPRI), Christine McDonald (IFPRI) and Suman Chakrabarti (IFPRI) on costing.[6] We updated our work from 2015-16 with data from the 2016-17 budget. As with our previous analysis, we took a three-step approach:

1. Developed an estimate of government nutrition financing in Rajasthan based on state budgets.
2. Compared available funding for nutrition-specific interventions from detailed state budgets and plans with a costing of core nutrition interventions in Rajasthan to conduct a gap analysis.
3. Provided a set of recommendations that departments could take to improve nutrition outcomes in Rajasthan.

Key Findings

Under fiscal devolution, financing for nutrition-specific programmes is lower than in 2014-15; and utilization of nutrition budgets has been poor.

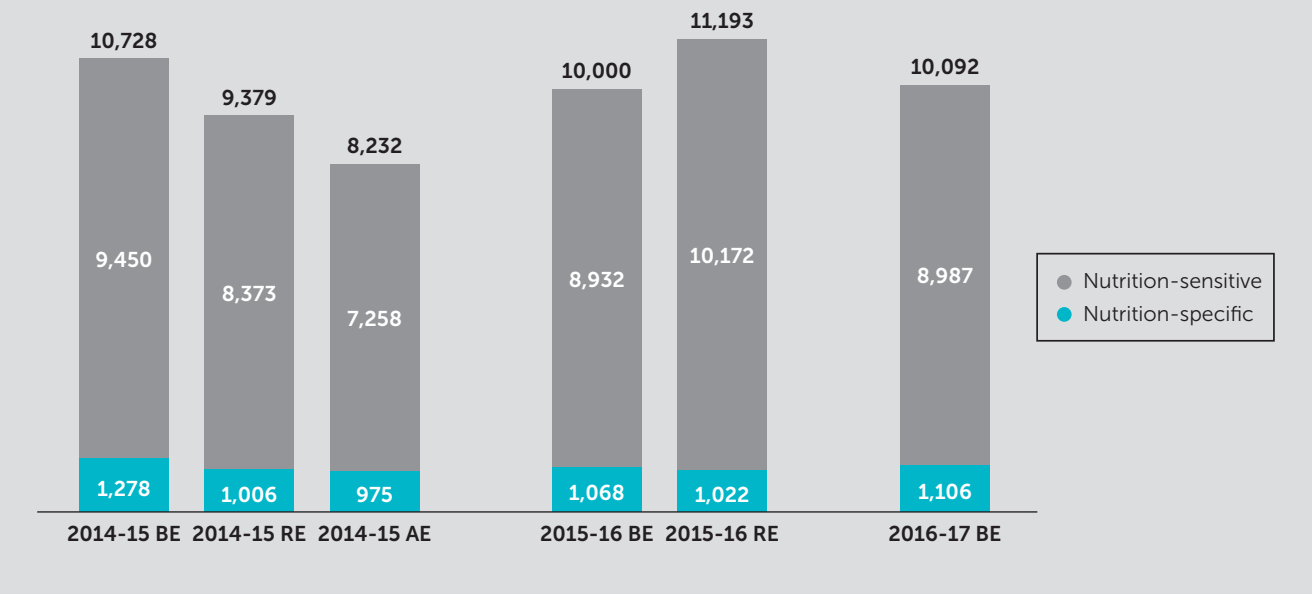
Utilization of nutrition-specific budgets has been poor. In fiscal year 2014-15, the government of Rajasthan budgeted ₹1,278 crores (budget estimates or BE)[iii] towards nutrition-specific programmes. This was revised down to ₹1,006 crores (revised estimates or RE) later in the year, and finally ₹975 crores (actual estimates or AE) was spent. This utilization rate of 76% indicates that almost one-fourth of the budget for nutrition-specific programmes was not utilized; the utilization rate for nutrition-sensitive programmes was also low at 77%. These utilization rates are notably low when compared with the overall Rajasthan state budget utilization of 89%.

Studies show that inefficiencies in planning and delayed release of funds from the centre result in low budget utilization, which is concerning since often releases for subsequent instalments are based on previous utilization trends.[7] It is still too early to explore utilization rates for 2015-16, as the actual estimates will be released with the 2017-18 budget.

Nutrition budget allocations in Rajasthan reflected in the Budget Estimates have been lower since devolution than they were in 2014-15. In 2015-16, nutrition-specific budget allocations dropped to ₹1,068 crores BE compared to the previous fiscal year's BE. This decrease was concerning, and was in part due to large budget cuts to CSS including the ICDS as part of the devolution process. The Ministry of Women and Child Development compensated for ICDS cuts by passing supplementary budgets through the year.[8] Greater resource allocation through the supplementary budgets contributed to a slightly higher RE (₹1,022 crores) than the 2014-15 RE. The true picture on what was actually spent in 2015-16 will be clear once the 2015-16 AE's are released – these may be higher than actual spending in 2014-15, but likely to be much lower than the ₹1,278 crores initially budgeted in 2014-15.

In 2016-17 nutrition-specific allocations were ₹1,106 crores (BE). This represents a 3% increase as compared to 2015-16 BE and could be seen

FIGURE 1: Nutrition financing in Rajasthan (in crore ₹)



as a positive trend. However, as 2015-16 BE represented a dramatic cut on the 2014-15 BE, amid uncertainty around devolution, it could be misleading to use the 2015-16 BE as a single reference point. In comparison with 2014-15, the 2016-17 BE is 13% lower than the 2014-15 BE, but also 13% higher than the actual expenditures in the 2014-15 AE. If utilization is much better in 2016-17, it is possible that actual expenditures in 2016-17 will eventually exceed the actual pre-devolution expenditures. Nevertheless, the budget priority given to nutrition-specific interventions in 2016-17 does not yet appear to have returned to pre-devolution levels, at least as expressed in the BE figures for each year.

In 2016-17, 89% of the nutrition financing was generated from nutrition-sensitive programmes

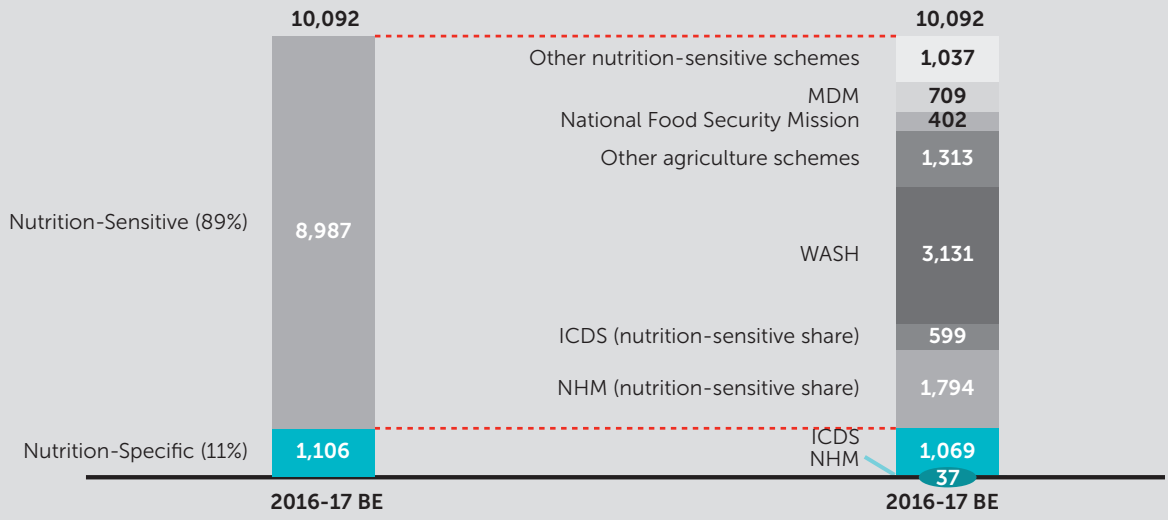
In 2016-17, around 11% of the total nutrition financing came from nutrition-specific programmes, with the vast majority of this coming from ICDS.

In this analysis, nutrition-specific financing refers to a subset of programmes within ICDS and NHM that directly improves nutrition outcomes of pregnant and lactating mothers and children under six.

ICDS Umbrella Scheme is the primary driver of nutrition-specific financing contributing to nearly 97% of the nutrition-specific funding (10.6% of total nutrition financing). In India, the ICDS core scheme provides food supplementation to pregnant and lactating women, and children under six through the Supplementary Nutrition Programme (SNP), primarily designed to bridge the gap between the recommended dietary allowance and the average daily intake. Another important scheme under ICDS Umbrella is the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA) which delivers an integrated package of services to adolescent girls that includes nutrition provision, iron and folic acid supplementation and counselling.

NHM contributes only 3% of nutrition-specific financing (or 0.4% of total financing). Although NHM provides some key nutrition-specific interventions through micronutrient supplementation, counselling of mothers and management of acute malnutrition, the allocations for these interventions are a very small share of the total NHM budget, which is generally focused on health programming that is only indirectly related to nutrition.

FIGURE 2: Sector-wise breakdown of Nutrition Financing in 2016-17 (in crore ₹)



The remaining 89% of total nutrition financing came from nutrition-sensitive programmes.

WASH schemes including *Swachh Bharat Abhiyan* and *Sampoorna Swachhata Abhiyan* formed the largest share at 31% of the total nutrition financing. WASH interventions, particularly around behaviour change communication, can have significant impacts on nutrition for children under five. Episodes of diarrhoea caused by improper sanitation and handwashing practices have detrimental impacts on children by a) reducing capacity to consume adequate quantities of food b) decreased absorption of nutrients from food and c) increased susceptibility to infections.

Agriculture sector made significant contributions (17% of the total) through the National Food Security Act (NFSA), Public Distribution Scheme and Crop Husbandry Schemes.

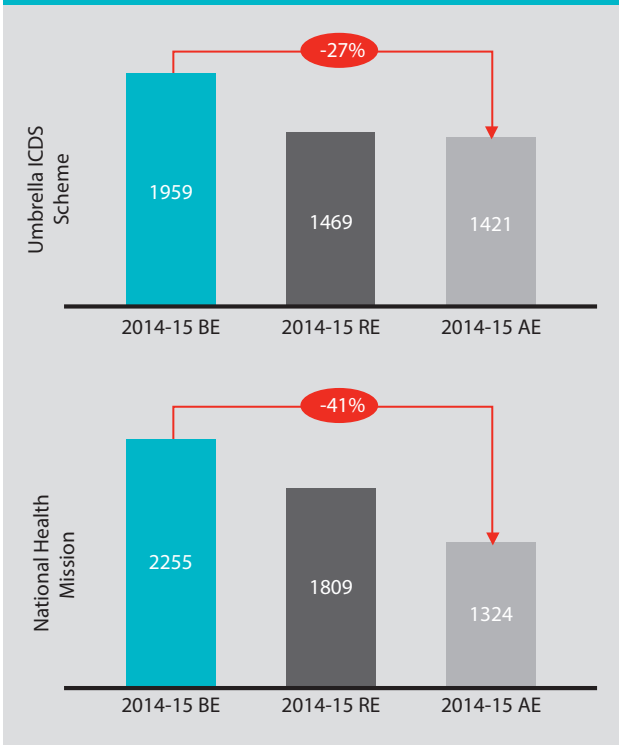
Education sector schemes such as the Mid-Day meal (MDM) programme contributed to 7% of the total nutrition financing. MDM, which provides hot cooked meals to children in primary and secondary schools, is considered an important nutrition scheme in India. For this analysis we classify MDM as nutrition-sensitive as the beneficiaries are outside the population most impacted by nutrition interventions, and MDM will not have a direct effect on the stunting and wasting rates for children under the age of five. Moreover, food under MDM is largely unfortified, reducing its potential nutritional value. Therefore, much of its societal impact lies in increased school enrolment and not improved nutrition outcomes.[9]

Budget under-utilization is particularly acute in key implementing departments for nutrition

Critical budgets for nutrition were largely unspent in 2014-15.

Underutilization of the overall state budget for Rajasthan was 11%, comparing the AE to BE for 2014-2015.[iv] A closer look at the programmes run by the Department of Women and Child Development (WCD) and Department of Medical, Health and Family Welfare (MHFW) reveals lower utilization in these programmes than the state budget average.

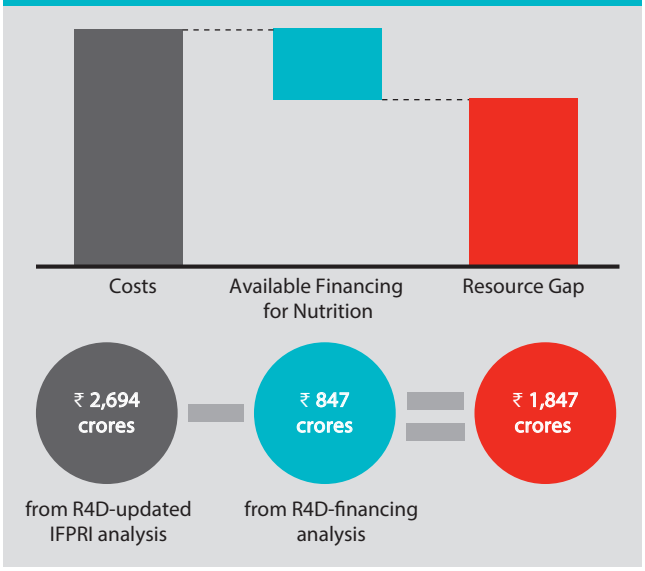
FIGURE 3: Underutilization in key schemes in 2014-15 (in crore ₹)



ICDS budgets were underutilized by 27% which implies that over a quarter of ICDS BE remained unspent for fiscal year 2014-15, in the department with greatest responsibility for nutrition-specific interventions. NHM funds in 2014-15 were underutilized by an even larger 41% of the budgeted amount. While NHM does not currently spend a large amount on nutrition-specific interventions, this underutilization represents a missed opportunity to reallocate and utilize funds for impactful nutrition programmes.

There is a 69% funding gap to scale the core set of India Plus nutrition interventions

FIGURE 4: The funding gap in 2016-17 for 13 India Plus interventions



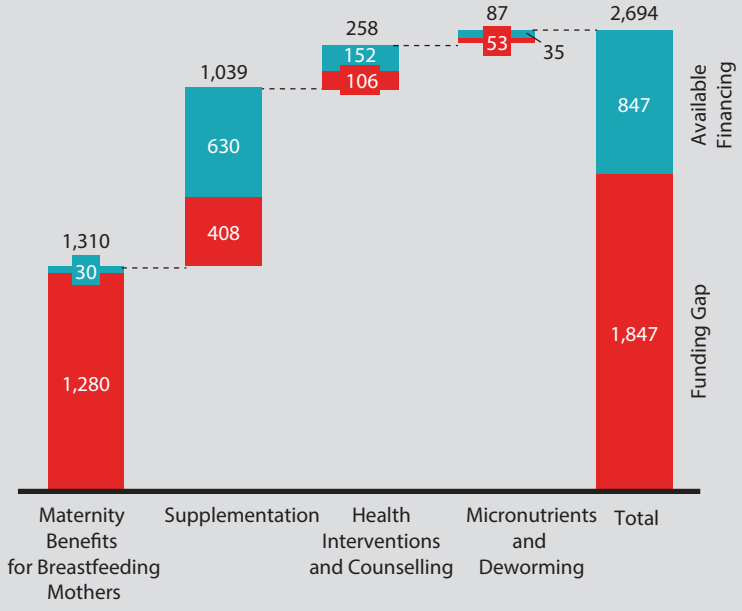
The previous analyses deal purely with the composition and trends in financing for nutrition. However, this does not indicate how much nutrition financing is actually needed, and whether current levels are adequate.

In order to understand how the available financing for nutrition measures against resources required, we compared 2016-17 budgets to a resource needs estimate of scaling up India Plus[v] interventions in Rajasthan, derived from an analysis by IFPRI.[10] We calculated that of the ₹2,694 crores required to fully scale up 13 core nutrition interventions, in 2016-17, only 31% was being financed through the government, leaving a funding gap of 69%.[vi]

A key driver of this gap is the deficit in funding needed to scale up maternity benefits for breastfeeding mothers. Currently, the only intervention in place for this resource need is the Indira Gandhi Matritva Sahyog Yojana (IGMSY) – a conditional cash transfer scheme which serves as partial compensation for wage loss during and after pregnancy, as well as assistance in supporting nutrition needs for the first two live births, for women above the age of 19. Despite an official announcement at the end of 2014 that the programme would be scaled up, the scheme is still being implemented in pilot mode, resulting in low allocations.[11] If we focus on the remaining 12 core interventions, the total resource need is ₹1,384 crores, of which ₹817 crores is being financed, leaving a smaller, but still significant, resource gap of ₹567 crores (41%).

Overall, the budgeted funding gap across 2014-15, 2015-16 and 2016-17 has been gradually increasing, from 66% in 2014-15 to 69% in 2016-17. In areas such as supplementation[vii], the funding gap has grown over the years, whereas for micronutrient and deworming it has steadily reduced. Maternity benefits for breastfeeding mothers continues to be a grossly underfunded intervention in Rajasthan, pending scale-up of IGMSY.

FIGURE 5: Breakdown of available financing and funding gap (in crore ₹)



For the pictorial representation above, financing and funding gap for interventions under Health and Counselling have been combined together.

Policy Recommendations

The numerous underlying causes of malnutrition can only be addressed effectively using a multi-sectoral approach that mobilizes and utilizes resources effectively. As illustrated in the analysis above, nutrition-relevant programming is not limited to ICDS and NHM but is conducted by multiple sectors including WASH, Agriculture and Education. Therefore, coordination across nutrition-specific and nutrition-sensitive government departments and building on existing convergence initiatives between ICDS and NHM[viii], will be required as the state moves towards improving nutritional outcomes.

Drawing on the analysis presented in this brief as well as global evidence, R4D offers the following recommendations to strengthen the fight against malnutrition in the state.

RECOMMENDATION I: Maximize the impact of nutrition-specific interventions

Low budgetary allocations, underutilization of existing budgets and insufficient targeting prevent existing nutrition-specific interventions from maximising their impact. The MHFW and WCD which run the NHM and ICDS can take the following steps:

1. Increasing the budget for nutrition-specific interventions. Budgets for nutrition-specific interventions in Rajasthan have been consistently inadequate to meet estimated resource needs, and despite the increased transfer of untied funds due to fiscal devolution, these budgets have not grown substantially.

WCD

SNP: The 2016-17 budget for SNP did not increase from the previous year, despite the need for additional funding to close the resource gap for supplementation. The share of SNP for pregnant and lactating women and children under three met at most[ix] 66% of the resource need. Preliminary analyses by R4D on the nutritional intake gap for pregnant women in Rajasthan suggests that (a) SNP is currently only reaching 37% pregnant women and that (b) even at full coverage, closing the nutritional intake gap among the poorest wealth quintile would require a substantial increase in the nutrient value of food SNP provides, which would imply an increase in programme resources needed.[x] These analyses confirm that increased investments in SNP could fill an important need.

IGMSY: The primary driver of the financing gap is the lack of investments towards maternity benefits for breastfeeding. Currently, only 2% of the resources needed to scale up are available through IGMSY in Rajasthan.The scheme is functional in two pilot districts[12] in Rajasthan and requires a major push in funding to increase coverage and reach the targeted population.

MHFW

Nutrition-specific programming under NHM requires an overall increase in funding to meet resource needs. The move to incorporate previously underfunded Infant and Young Child Feeding (IYCF) activities under the recently launched Mother's Absolute Affection (MAA) scheme is seen as a positive step towards increasing nutrition-specific funding under NHM. Other areas in need of funds are micronutrient and deworming interventions and treatment of severe malnutrition. Despite a successful pilot and plans to scale up, allocations for the Community Management of Acute Malnutrition (CMAM) programme will need to be increased substantially above the 2016-17 level to cover all severely acutely malnourished children.

2. Increasing utilization of existing budgets. Utilizing existing budget allocations is an important first step towards meeting nutrition targets. In 2014-15, ICDS utilized 72% of their budget and NHM utilized only 59% of their budget. These figures demonstrate that over one-quarter of the ICDS budget and two-fifths of the NHM budget

remained unspent, and much more can be achieved by making full use of the existing funding for nutrition.

Studies by Centre for Budget and Governance Accountability (CBGA) show that poor utilization rates and inefficiencies in social sector schemes can be eliminated by removing bottlenecks in scheme design, planning and release of funds.[13] By granting states greater flexibility in scheme design and planning, fiscal devolution allows states to redesign interventions such that bottlenecks leading to poor utilization are addressed. The effects of devolution on fund utilisation for 2015-16 can be assessed when 2017-18 budgets are released.

3. Directing budgets towards most impactful interventions. Investments made in nutrition during the first 1000 days are relatively low cost and generate significantly higher returns on health and education outcomes and economic productivity than investments made at later stages in life.[14] Directing budgets towards this crucial window can, therefore, help MHFW and WCD maximise their gains on investments in nutrition. Specifically, ICDS should prioritize on its activities for children under the age of two since lack of sound feeding and care practices at this age can result in poor and irreversible nutrition outcomes.[15]

RECOMMENDATION II: Maximize the impact of nutrition-sensitive interventions

Given the large amount of funding that is allocated to nutrition-sensitive interventions, optimizing the use of resources allotted for the components of these schemes that positively affect nutritional outcomes has the potential to reduce the malnutrition burden in Rajasthan. Nutrition-sensitive government departments listed below could take the following steps to improve nutritional outcomes:

Department of Panchayati Raj: Poor WASH practices can increase risk of gastrointestinal diseases that lead to undernutrition, increasing in turn susceptibility to disease, and forming a vicious cycle that threatens the survival of children under five.[16] In 2016-17, the government funded less than 3% of the resources needed to scale up counselling for handwashing. Increasing funding of the Information, Education and Communication (IEC) component of the *Swachh Bharat Abhiyan* can contribute significantly to disease prevention and improved nutritional outcomes for children in Rajasthan.

Food, Civil Supplies & Consumer Affairs Department: The Targeted Public Distribution System (TPDS) plays an integral role in ensuring food security for poor Indian households, but malnutrition cannot be solved by ensuring household food security alone. In addition to food security, lowering the burden of malnutrition requires that vulnerable households have sustained access to nutritious foods (i.e., foods that can provide households with recommended daily intake of all key nutrients) at affordable prices. TPDS could have increased impact on nutrition through fortification of food grains and expansion of the food basket to include more nutritious food such as pulses. In the budget speech of 2015-16, Chief Minister Vasundhara Raje announced provision of fortified food through TPDS to all covered under the NFSA–a well-received move towards improving nutrition security of low income households.[17]

Ministry of Human Resource Development: Food provided under the MDM scheme could be made more nutritious by using fortified grains and adding more items such as milk, eggs and fruit to supplement nutrition needs of growing children. Given the inter-generational cycle of malnutrition, children born to undernourished mothers are more likely to be malnourished themselves. Thus, MDM can play an important role in meeting nutrition requirements of school going children including adolescent girls.

RECOMMENDATION III: Establish an independent coordinating body with the aim to end malnutrition

Combatting malnutrition requires a strong political will as well as interdepartmental coordination. Establishing a state-level nutrition coordinating body with a clear mandate to end malnutrition is one way to move forward the nutrition agenda. Indian and international evidence[18] show that such bodies can successfully champion the issue of malnutrition, raise financing for nutrition programmes, and enable innovative multi-sectoral solutions to address the diverse underlying causes of malnutrition. A successful example is Maharashtra's Rajmata Jijau Mother - Child Health and Nutrition Mission, which has played an important role in battling malnutrition in the state through interdepartmental convergence, monitoring and evaluation, and capacity building of frontline workers.[19]

An independent coordinating body in Rajasthan could:

1. Mobilize resources for nutrition programmes by working across departments,
2. Support ongoing convergence efforts between ICDS and NHM, and facilitate greater convergence with other nutrition-relevant departments,
3. Set nutrition targets for the state and track programmatic and financial progress through a routine monitoring system, and,
4. Develop processes to use data for more evidence-based nutrition budgeting and planning.

Following Maharashtra, several states such as Madhya Pradesh, Uttar Pradesh, Odisha, Gujarat, Karnataka, and most recently Andhra Pradesh, have instituted Nutrition Missions that can provide useful lessons to Rajasthan.

Endnotes

i India Plus package is a set of 14 interventions that are currently included in India's policy framework.

ii In a separate analysis not reported here, R4D applied weights to budgets amounts, in line with international practice, in recognition that rupees spent on nutrition-sensitive programmes are likely to have less impact on nutrition than rupees spent on nutrition-specific programmes, and that programmes targeted at the first 1000 days of a child's life are likely to have a greater impact than less targeted programmes. While this alters the apparent proportion of nutrition funding derived from each department, it does not materially affect the trends or conclusions of the work.

iii Budget allocations are presented in three forms: Budget Estimates (BE), which are initial allocations to a ministry or scheme in the budget books for the following year; Revised Estimates (RE), which are generated once the financial year is underway and some ministries and schemes need to revise the amount of funding that was originally allocated in the budget estimates; and Actual Estimates (AE), which reflect the final amounts that were spent under the different schemes and ministries.

iv Given the two-year lag in release of AEs, the most recent utilization data is available for the 2014-15 fiscal year.

v For this analysis, we have used 13 out of 14 of the core interventions. We did not include insecticide treated nets because this intervention applies to states with a high malaria prevalence which does not include Rajasthan. The 13 interventions are grouped into five categories- Maternity Benefits for Breastfeeding Mothers, Supplementation, Health Interventions, Counselling and Micronutrients and Deworming.

vi The gap analysis was done using the budgeted estimates for nutrition interventions. Given the non-optimal utilization rates of schemes, the actual expenditure for these schemes tends to be lower than what is budgeted – making this gap wider.

vii Supplementation interventions comprise complementary food supplements, supplementary food rations and additional food rations for severely malnourished children.

viii For example, at a local level, initiatives such as the Akshada Project aim to support collaboration between Auxiliary Nurse Midwives (ANMs), Accredited Social Heath Activists (ASHAs), and Anganwadi Workers (AWWs).

ix Available financing of SNP for pregnant and lactating women and children under two, could not be broken down from the budget, thus the entire SNP budget, including provisions for children from 3-6 years has been used.

x Using National Sample Survey (2011) data, R4D compared consumption behaviour of pregnant women in Rajasthan against advised intake for protein, fat and energy to estimate the nutrition gap.

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