How to design nutrition financing

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AS the world grapples with the effects of the novel coronavirus (Covid-19) pandemic, the Indian public welfare system is being put to the test. With the virus moving to lower income countries, there are indications that the impact on vulnerable populations, including malnourished women and children, will be catastrophic.

Globally, in 2017, nutrition related factors contributed to about 45% of child deaths under the age of 5.[1] India is no exception. A 2017 study found that malnutrition was the main risk factor for death in children under-5 in every Indian state, accounting for 68% of total under-5 deaths.[2] Similarly, findings from the Global Nutrition Report 2017 indicate that more than half (51.4%) of women of reproductive age have anaemia, making India the country with the highest number of anaemic women in the world.[3] Add to this the increased vulnerability of malnourished children to infectious diseases such as Covid-19, and we are faced with a very bleak picture.

The need for a multi-sectoral approach to malnutrition has been felt even in ordinary times. Several factors affect the nutritional status of children – from inaccessibility to nutritious food and inappropriate feeding and care practices to poor household environments, including poor access to water and sanitation. One family may have multiple vulnerabilities.

Preventing and eliminating malnutrition therefore requires a holistic and comprehensive plan, one that focuses both on nutrition specific interventions (such as complementary feeding, breastfeeding, micronutrient supplementation with a focus on the first 1,000-day window from conception to age two) and on a wide range of nutrition sensitive interventions

1. World Health Organization, Fact Sheet: 'Children: Reducing Mortality', 2019. https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality

2. India State-Level Disease Burden Initiative Malnutrition Collaborators 'The Burden of Child and Maternal Malnutrition and Trends in Its Indicators in the States of India: The Global Burden of Disease Study 1990-2017', *Lancet*, Child & Adolescent Health 3(12), 2019. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30273-1/fulltext

3. Global Nutrition Report, 'India Nutrition Profile', 2017. https://globalnutritionreport.org/resources/nutrition-profiles/asia/southern-asia/india/

TABLE 1

Mapping Core Direct Nutrition Specific Interventions by the Union Government

Stage	*Intervention*	*Ministry*
Pregnancy	Counselling during pregnancy	MWCD+MoHFW
Post-pregnancy until child is 6 months	Counselling for breastfeeding	MWCD+MoHFW
Post-pregnancy until child is 6 years	Counselling for complementary feeding and WASH	MWCD+MoHFW
Pre-pregnancy	Food supplements for adolescent girls	MWCD
Pregnancy	Food supplements for pregnant women	MWCD
Post-pregnancy until child is 6 months	Food supplements for lactating women	MWCD
6-72 months	Food supplements for children	MWCD
6-72 months	Food supplements for malnourished children	MWCD
Pre-pregnancy	IFA for adolescent girls	MoHFW
Pre-pregnancy	Deworming for adolescent girls	MoHFW
Pregnancy	IFA for pregnant women	MoHFW
Pregnancy	Calcium for pregnant women	MoHFW
Pregnancy	Deworming for pregnant women	MoHFW
Post-pregnancy until child is 6 months	IFA for lactating women	MoHFW
Post-pregnancy until child is 6 months	Calcium for lactating women	MoHFW
6-59 months	Iron supplements for children	MoHFW
12-59 months	Deworming for children	MoHFW
6-59 months	Vitamin A supplements for children	MoHFW
Pregnancy	Insecticide treated bed nets (ITNs)	MoHFW
0-59 months	Immunization	MoHFW
2-59 months	ORS and therapeutic zinc supplements for treatment of diarrhoea	MoHFW
6-72 months	Treatment of SAM (severe acute malnutrition) children at Nutrition Rehabilitation Centres	MoHFW
Pregnancy	Conditional cash transfer- JSY	MoHFW
Post-pregnancy until child is 6 months	Conditional cash transfer-PMMVY	MWCD

Note: IFA= iron and folic acid; ORS= oral rehydration salts; WASH= water, sanitation and hygiene; JSY= Janani Suraksha Yojana; PMMVY= Pradhan Mantri Matru Vandana Yojana.

from childhood (such as increased access to health services, safe water and sanitation). The core principle for achieving the best nutrition outcomes is to make sure that all necessary supportive actions reach a family with multiple vulnerabilities simultaneously, and in a timely manner.

The Covid-19 crisis has disrupted the implementation of several existing nutrition specific and nutrition sensitive programmes, making matters worse. As states struggle to cope with the immediate needs of ensuring food security and social protection whilst strengthening public health systems, a comprehensive, decentralized and agile system capable of responding to the diverse socioeconomic needs of the most vulnerable populations is imperative.

Unfortunately, India's nutrition financing architecture seems unprepared to handle the current crisis, and part of the problem lies in its design.

Fragmented nutrition financing systems: The government's nutrition financing strategy has so far focused on interventions delivered through centrally sponsored schemes (CSS) such as the Integrated Child Development Services (ICDS) and National Health Mission (NHM), as well as a host of state-specific schemes. The result is a fragmented system that fails to account for the linkages between

TABLE 2

Mapping Select Nutrition Sensitive Interventions by the Union Government

Intervention	*Ministry*
Swachh Bharat Mission-Gramin	Ministry of Drinking Water and Sanitation
Swachh Bharat Mission-Urban	Ministry of Housing and Urban Affairs
Jal Jeevan Mission	Ministry of Drinking Water and Sanitation
Mid-Day Meal Scheme	Ministry of Human Resource Development
Public Distribution System	Ministry of Consumer Affairs and Public Distribution
National Food Security Mission	Ministry of Consumer Affairs and Public Distribution
Agriculture	Ministry of Agriculture & Farmers' Welfare
Samagra Shiksha	Ministry of Human Resource Development
Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS)	Ministry of Rural Development
Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (SABLA)	Ministry of Women and Child Development
Beti Bachao Beti Padhao	Ministry of Women and Child Development

nutrition and gender, water and sanitation (see Tables 1 and 2 for details of select nutrition specific and nutrition sensitive interventions).

These multiple central and state nutrition interventions in India are financed by different Union ministries and state departments, each with its own planning, budgeting and implementation structures. This fragmentation of fiscal flows can have adverse effects at the household level. For instance, while the National Food Security Act (NFSA) legally mandates a maternity benefit of Rs 6,000 to every pregnant mother, the entitlement is currently delivered via two different schemes run by two different ministries. Rs 5,000 is paid as compensation for wage loss if a pregnant woman fulfils specific health and nutrition related conditionalities under the Pradhan Mantri Matru Vandana Yojana (PMMVY), managed by the Centre's Ministry of Women and Child Development (WCD). The remaining Rs 1,000 is in the form of a conditional cash transfer for incentivizing institutional delivery under the Ministry of Health and Family Welfare's (MoHFW) Janani Suraksha Yojana.

A key nutrition specific programme is the ICDS, aimed at providing basic education, health and nutrition services for early childhood development. These objectives are met through a package of six services – supplementary nutrition, pre-school formal education, nutrition and health education, immunization, health check-up, and referral services – split equally between the women and child development and health ministries. Under ICDS, the anganwadi worker, who comes under the WCD ministry, has the key role of ensuring counselling to pregnant and lactating mothers on adequate nutrients including vitamin A and iron and folic acid (IFA) supplementation. However, the actual provisioning of vitamin A and IFA falls within the ambit of the NHM, which is under the health and family welfare ministry.

Delays or inefficiencies in even one of the schemes can result in the household being denied its entitlement. A study conducted by Menon et al (2019)[4] mapping both nutrition specific and nutrition-sensitive interventions at the household level in villages in Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha and West Bengal found that on average, households received only eight of 13 nutrition specific interventions and four of six nutrition sensitive interventions. In fact, only 23 of the 1,417 households surveyed (1.6%) had received all 13 nutrition specific interventions, and only 5.6% received all six nutrition specific interventions. Only two of 1,417 households (0.1%) received all 19 interventions.

Weak planning and incremental budgeting: This fragmentation can be resolved by a stronger budgeting and planning system. For the most part, India follows an incremental budgeting system where a budget is prepared using the previous period's budget, with incremental amounts added for the new period. In practical terms, this means that allocations are determined not on the basis of shortfalls in the prescribed minimum standards of service but on incremental budgets prepared by respective departments across state and Union governments. As a result, most schemes, despite being universal, do not actually budget for coverage at scale. A comparison between the estimated number of children aged 6-72 months using population projections for 2019 and the actual number registered to receive supplementary nutrition in the ICDS's management information systems (MIS) found that states such as Nagaland and Manipur were serving the requisite populations, whereas coverage was lower than 30% in Kerala (27%), Delhi (25%) and Bihar (20%).[5]

Rigidity and inefficiencies in CSS design: The situation is exacerbated by the peculiarities of CSS as instruments of social policy financing.

1. A key feature of CSS design is their centralized nature. Their guidelines tend to be the same across states, with fixed norms and unit costs usually set at the national level. Even implementation details, such as the process of hiring, training modules/schedules and communication strategies, are laid down by the Centre. The rigidity of these centrally funded, centrally designed but locally executed schemes makes it difficult for states and local governments to adapt implementation to the needs of their specific jurisdictions.

2. The institutional arrangements for CSS require multiple levels of jurisdiction to work together. This does not happen in the absence of a transparent articulation of roles and responsibilities across different layers. For instance, the NHM is implemented through specially created autonomous societies that run parallel to the line departments. At the same time, the line departments have their own health infrastructure and officers who are tasked with responsibilities similar to these parallel implementation societies. In many states, panchayats at the district and village level are also required to deliver health and sanita-

4. P. Menon et, al., 'Rethinking Effective Nutrition Convergence: An Analysis of Intervention Co-coverage Data', *Economic and Political Weekly* 54(24), 15 June 2019.

5. A. Kapur and R. Shukla, Integrated Child Development Services, Budget Briefs 2020-21. Accountability Initiative, Centre for Policy Research, New Delhi, 2020.

tion. In such a situation, where multiple institutions – national, state and local – operate with overlapping roles and responsibilities within the same jurisdiction, the lines of accountability are bound to be blurred, making coordination difficult.

3. Most CSS are designed as cost sharing programmes between the Union and states. With the division of CSS into 'core', 'core of the core' and 'optional' programmes, states are expected to contribute 50-60% of the total approved budgets from their own plan funds. Within a scheme, however, the matching ratio is uniform across states, irrespective of their fiscal capability. The release of funds by the central government is contingent on states releasing their own share and meeting other conditionalities such as the submission of utilization certificates (UCs). The uniform fund sharing ratio often makes it difficult for low-income states to put in their share. As subsequent fund release is contingent on the states contributing their share, there are significant differences between approved allocations and the actual grants released to fiscally weaker states. In 2016-17, for instance, only 85% of total NHM approved budgets were released to the states.[6] These differences undermine the reach and impact of CSS. In an analysis of the NHM, for instance, Rao (2017)[7] found that despite the original objective of providing additional resources to states that needed them, complexities in design and processes meant that states with poorer health indicators did not necessarily get larger per capita transfers.

4. The numerous conditionalities for fund transfer, along with multiple lines of accountability, make fund flows in CSS extremely unpredictable. Funds usually reach the point of service delivery in the last quarter of the financial year, resulting in inefficient expenditure and large quantities of unspent budgets at the end of the financial year.[8] A study of NHM in Uttar Pradesh conducted by Accountability Initiative at the Centre for Policy Research (CPR) found that a file had to pass through a minimum of 22 desks before funds were released from the treasury to the state health society (SHS). Other studies[9] have found that in Bihar, a file had to transit 32 desks, and in Maharashtra, 25 desks. Confusion over roles and responsibilities makes it impossible to affix blame for these delays. In the absence of regular monitoring and penalties for delays in transfer, fund flows remain unpredictable and bunched up in the last quarter of the financial year.

These inefficiencies often result in inequities in both financing and access. A recent study on the extent and equity of ICDS coverage in the decade from 2006-16 found that while overall access to nutrition and health services had improved, the poorest quintiles of the population were still left behind, particularly in states with the largest burden of malnutrition, such as Bihar and Uttar Pradesh.[10]

Redesigning nutrition financing architecture: In the best of times, an overlapping and conditional financing structure such as the one described above results in administrative and fiscal inefficiencies, impacting the last mile delivery to households. The Covid-19 crisis makes even more critical a decentralized and dynamic nutrition financing structure that can respond promptly to different geographies and demographics. From a fiscal perspective, this will require a redesign of nutrition financing keeping the following factors in mind.

Ensuring resource adequacy: The first step is to scale up resources and ensure adequate finances. Studies have shown significant gaps between actual expenditures and requirements. For instance, a study of budgetary outlays for nutrition specific interventions conducted by CBGA and UNICEF in 2017 found a resource gap of as much as 75% in Chhattisgarh, 74% in Bihar, 73% in Uttar Pradesh, and 66% in Odisha,[11] all states with a relatively higher burden of malnutrition among children under five years of age.

Costing studies using disaggregated local unit costs would help determine the total quantum of funds required for nutrition at scale. In the current system, unit cost data is often not available or is completely outdated. For instance, there are no recent estimates of unit costs for counselling women on breastfeeding and other nutritional practices. Similarly, despite calls for indexing supplementary nutrition to inflation, these have not been updated since 2017. The annual flexi grant given to anganwadi centres to meet unforeseen costs, for instance, has remained a mere Rs 1,000 for decades.

6. Centre for Policy Research, National Health Mission. Budget Briefs. Accountability Initiative, Centre for Policy Research, New Delhi, 2017-18.

7. M.G. Rao, Central Transfers to States in India: Rewarding Performance While Ensuring Equity. NITI Aayog, New Delhi, 2017.

8. For details, see Accountability Initiative Budget Briefs, www.accountabilityindia.org

9. See for instance, M. Choudhury and R.K. Mohanty, Utilisation, Fund Flows and Public Financial Management under the National Health Mission. NIPFP Working Paper Series, National Institute of Public Finance and Policy, New Delhi, 2018. https://www.nipfp.org.in/media/medialibrary/2018/05/WP_ 2018_227.pdf

10. S. Chakrabarti et. al., 'India's Integrated Child Development Services Programme: Equity and Extent of Coverage in 2006 and 2016', *Bulletin of the World Health Organization*, February 2019.

11. CBGA and UNICEF, Budget Outlays for Nutrition-Specific Interventions: Insights from Bihar, Chhattisgarh, Odisha and Uttar Pradesh. UNICEF and CBGA, New Delhi, 2017.

Directing resources effectively: Having determined the total quantum of funds required at the local level, the next step is to ensure that funding is aligned with strategic priorities. National and state-specific nutrition plans can play a key role in developing a sustainable, multi-sectoral, multi-stakeholder strategy that identifies where funding is needed in the local context, and the size of the local funding gap. It further helps direct funding to high-impact, high-need and most cost-effective nutrition interventions.

The launch of the Poshan Abhiyan (formerly known as the National Nutrition Mission) in 2017 to make India free from malnutrition aims to ensure that all nutrition related programmes converge on households with mothers and children in the first 1,000 days – the core target population for the scheme. To this end, a key requirement is the creation of convergent nutrition action plans across states. With most schemes functioning with their own planning, budgeting, and implementation architecture, the ability to achieve true and effective convergence is likely to be hampered.

Convergent nutrition planning needs to be accompanied by a decrease in the number of schemes and an increase in sectoral allocations or untied block grants, which allow pooling of resources and give states the flexibility to spend according to their needs.

Examples of how this can be done are available in NITI Aayog's Report of the Sub-Group of Chief Ministers on Rationalisation of Centrally Sponsored Schemes.[12] The sub-group was constituted in 2015 following the recommendations of the 14th Finance Commission, which paved the way for more fund devolution directly to states. Unfortunately, despite an increase in devolution, the continued presence of multiple schemes and an increase in the states' share of CSS funding has once again hampered the flexibility of states to invest as per their needs. The recent allocation by the 15th Finance Commission of untied funds for nutrition to the tune of Rs 7,735 crore may be the impetus needed to move towards a more decentralized planning and budgeting approach, with states in the frontline of not just implementation but also planning and decision-making.

This is even more important during the current Covid-19 crisis. As states prioritize health and social welfare, financing and directing resources effectively for nutrition-specific programmes will be very important.

Equity: This is the third principle for nutrition financing, critical during the pandemic when many families are even more vulnerable with respect to incomes and food security. All nutrition financing must thus be undertaken using the principles of equity, ideally converging at the household level and prioritizing the 'leave no one behind' dictum. This would entail ensuring that we budget at scale and simultaneously make systematic efforts to ensure that the poorest and most vulnerable (who would also be most affected by this pandemic) are reached.

Transparency and accountability: All nutrition financing must be transparent and accountable throughout the process of release of allocations and disbursement. This in turn should be accompanied by concerted efforts to track nutrition spending. One way this can be done is by introducing nutrition specific and nutrition sensitive budget lines that enable easy tracking. These should be tracked through independently delivered budget analysis to compare costed nutrition plans with actual expenditure across all related sectors. Here too there are lessons that can be learnt from ongoing efforts. In 2020-21, Odisha became the first state in India to initiate the concept of Nutrition Budgeting, mapping both nutrition specific and nutrition sensitive schemes across departments.[13]

Strengthening public finance management system: This is essential if we are to streamline inefficiencies in the approval and fund flow process. A just-in-time expenditure information network (EIN) that brings all expenditure units under one system needs to be built. The beginnings have already been made with the public finance management system or the integrated financial management system. Designed as a web based online transaction system for fund management, it allows registration of bank accounts of all implementing agencies on a portal, and once registered and verified, e-payments can be made to implementing agencies or even beneficiaries. It is similar to the online banking system, where we can register a beneficiary and transfer funds through national electronic funds transfer (NEFT). Coupled with other innovations such as e-budgeting or automatic approvals and e-governance, it could lead to greater predictability in fund flows.

In recent years, we have seen positive developments in policy, funding and outcomes on child nutrition in India. Now, when the Covid-19 pandemic has placed a significant strain on our already vulnerable populations, it is time is institute a far more decentralized, agile and equitable nutrition financing architecture.

12.NITI Aayog, Report of the Sub-group of Chief Ministers on Rationalisation of Centrally Sponsored Schemes. NITI Aayog, New Delhi, 2015.

13. Government of Odisha, Nutrition Budget 2020-21. https://finance.odisha.gov.in/Budgets/2020-21/Annual_Budget/Nutrition_Budget.pdf