

Public Financing for Nutrition in Bihar



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Budgeting for Nutrition-Specific Interventions in Bihar in 2014-18: Outlays, Adequacy and Expenditure

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List of Abbreviations

AE:	Actual Expenditures	IGMSY:	Indira Gandhi Matritva Sahyog Yojana
ANM:	Auxiliary Nurse Midwife	JSY:	Janani Suraksha Yojana
APIP:	Annual Programme Implementation Plan	JSSK:	Janani Shishu Suraksha Karyakram
AWC:	Anganwadi Centres	MoHFW:	Ministry of Health and Family Welfare
AWW:	Anganwadi Workers	MWCD:	Ministry of Women and Child Development
BHAP:	Block Health Action Plan	NHM:	National Health Mission
BE:	Budget Estimates	NIDDCP:	National Iodine Deficiency Disorders Control Programme
CHC:	Community Health Centre	ORS:	Oral Rehydration Salts
CSS:	Centrally Sponsored Schemes	PHC:	Primary Health Centre
DNIs:	Direct Nutrition Interventions	PIP:	Programme Implementation Plan
FC:	Finance Commission	PMMVY:	Pradhan Mantri Matru Vandana Yojana
FMR:	Financial Management Report	RE:	Revised Estimates
FY:	Fiscal Year	ROP:	Record of Proceedings
ICDS:	Integrated Child Development Services	SAM:	Severe Acute Malnutrition
IEC:	Information, Education and Communication	SNP:	Supplementary Nutrition Programme
IFA:	Iron Folic Acid		



Abstract

Background:

The state of Bihar has the highest proportion of stunted children (48%) in India. While the adverse effects of stunting are known, so are the solutions. A set of Nutrition-Specific or Direct Nutrition Interventions (DNIs) when delivered at 90% coverage, can reduce child stunting by 20%. These DNIs are delivered through Centrally Sponsored Schemes of two departments in the state. However, whether Bihar has prioritised the DNIs fiscally needs to be examined.

Methods:

We studied the budget outlays and expenditure data for 17 DNIs included in India's policy framework for the last 4 fiscal years (2014-15, 2015-16, 2016-17 and 2017-18). Resource gap analysis (i) against government norms and coverage was done for supplementary nutrition programme delivering three DNIs (supplementary food for pregnant and lactating women, complementary feeding for children (6-72 months) and additional food rations for severely underweight children) for two fiscal years – 2015-16 and 2016-17; and (ii) for seven DNIs delivered by health department (deworming and IFA supplementation

for both children and adolescents, and Vitamin A supplementation, diarrhoea control and SAM management for children) for FY 2017-18 against cost estimates of Chakrabarty and Menon (2017). Fund utilisation was assessed for two years (FY 2014-15 and 2015-16) for DNIs under social welfare department and for one year (FY 2016-17) under health department. Possible factors constraining fund utilisation in the state were also analysed.

Results:

In Bihar, (i) the DNIs budget has increased in absolute terms from INR 1,786 crore in FY 2014-15 to INR 2,687 crore in FY 2017-18, but it has decreased as a proportion of total state budget from 1.9% to 1.5% during the same period; (ii) The resource gap was 31% in FY 2015-16 and 27% in FY 2016-17 for ICDS-SNP; (iii) There is a significant resource gap for deworming for children, diarrhoea control and treatment of SAM (40-95%), and resource surplus for IFA and deworming for adolescents and Vitamin A supplementation in FY 2017-18; (iv) The fund utilisation for SABLA-SNP is low (50-60%) in both FY 2014-15 and 2015-16, with better fund utilisation for both ICDS-SNP

and IGMSY/PMMVY in FY 2015-16, compared to FY 2014-15; (v) The fund utilisation in DNIs delivered by health department is very low, with 5 DNIs (of 9 DNIs for which analysis was done) having fund utilisation <10%; (vi) factors constraining fund utilisation are rooted in systemic bottlenecks such as weak decentralised planning and budgeting, and human resource and infrastructure shortages in the state.

Conclusion:

To address the high levels of child stunting, Bihar needs to significantly

increase its investment in nutrition. The resource gaps for almost all DNIs analysed need to be addressed at the earliest. For this, both the Union and Bihar government should increase the budget outlays for the CSS and within them, budgets for the DNIs. Factors constraining the fund utilisation for DNIs, such as weak decentralised planning, staff shortages, insufficient infrastructure etc., need to be addressed at the earliest. Making addressing undernutrition a state priority would be crucial for this.





Introduction

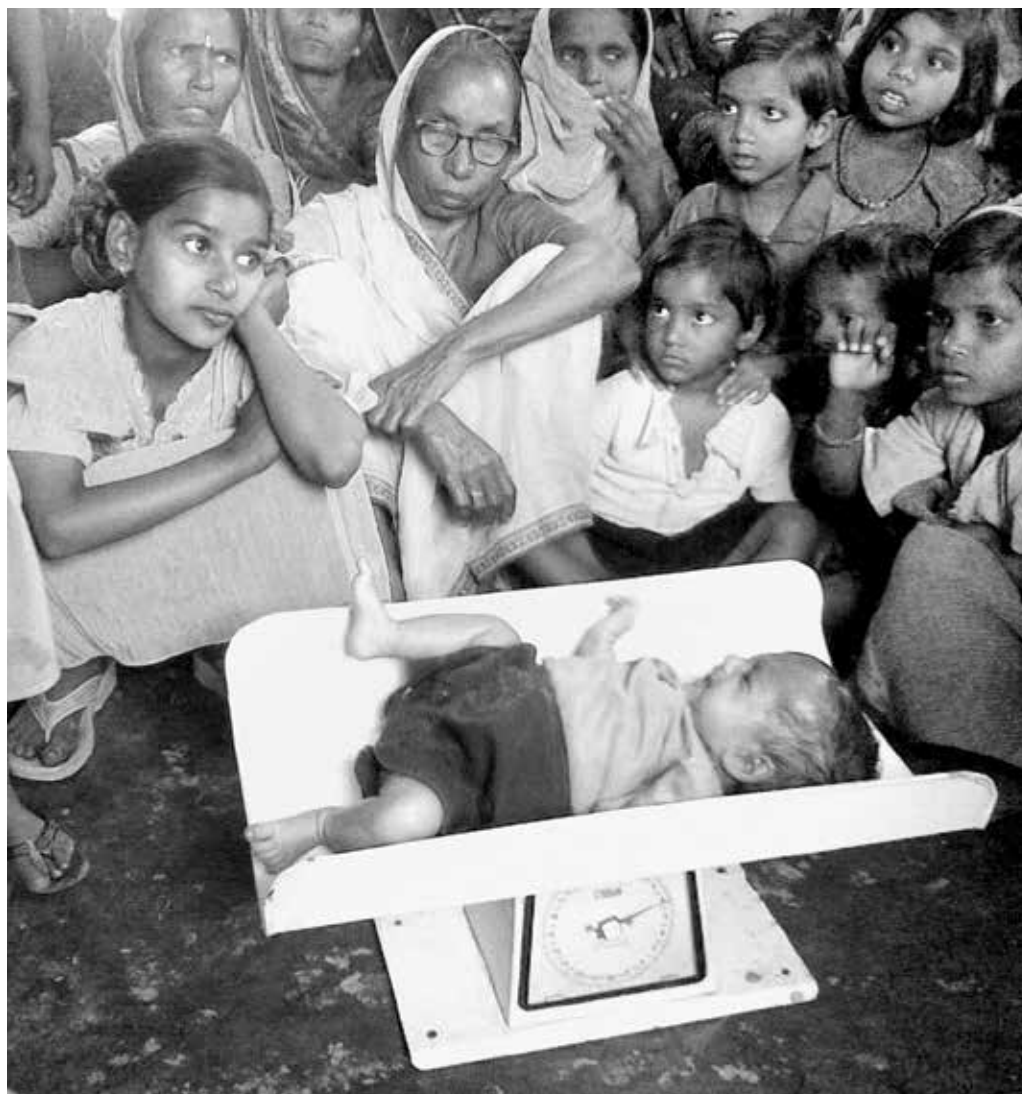
The State of Bihar has the highest proportion of stunted children in India (48%, as per NFHS-4 in 2015-16). Child stunting irreversibly hampers the child's cognitive and physical development, productive capacities and health, and increases the risk of degenerative diseases such as diabetes and cancer (WHO 2014). While the harms of stunting are widely documented, the solutions to reduce stunting are also known. A set of Direct Nutrition Interventions (DNIs) (or Nutrition-Specific Interventions) when delivered at 90% coverage, can reduce child stunting by 20% (Bhutta et al. 2013), by addressing the immediate causes of undernutrition arising out of inadequate diet and disease. These interventions include good caregiving and feeding behaviours (breastfeeding and complementary feeding and handwashing), treatment of severe acute malnutrition, micronutrient supplementation, deworming and diarrhoea control, nutrition of pregnant and lactating women, and health interventions (Bhutta et al. 2008).

There is considerable ground to be covered for improving coverage of these interventions in the state, for example, in Bihar only ~10% pregnant women consumed iron-folic acid supplements during pregnancy, 35% children were breastfed within an hour of birth, and only 7.3% breastfed children 6-23 months received an adequate diet (IIPS 2016). Simultaneously, 34% people living in the state are living below the poverty line, compared to an all India average of 21% (Planning Commission 2014). With Bihar's budget being relatively small compared to other large states, and it being the third most populous state in India (Registrar General of India 2011), implies that despite a high proportion of spending on social sectors, overall investment in these critical sectors remains low (as reflected in its per capita social sector spending) (figure 9). Moreover, the state's fiscal capacity to generate own revenue is low (figure 2), increasing the state's dependence on central funds for critical social sectors schemes (including health and nutrition).

To top this, Bihar lost out financially in the process of devolution of untied resources from the Union Government to the states, following the recommendations of the 14th Finance Commission (14 FC) (Ministry of Finance 2015), reducing Bihar's entitlement from 10.9% resources from the divisible pool of central taxes under the 13th Finance Commission (13 FC) period to 9.6% under the 14 FC (ibid: 96) period. Although, in

Bihar has high burden of stunting but limited fiscal capacity to invest in delivering direct nutrition interventions.

The delivery of DNIs is contingent upon, among other factors, the financial resources being made available for the same.



absolute terms, the transfers from the Union Government to Bihar have increased from the 13 FC phase, owing to absolute increase in Union Government's tax collection (Figure 2), this amount is less than what Bihar would have received according to the 13 FC recommendations.

The delivery of DNIs is contingent upon, among other factors, the financial resources being made available by the state government for the same. In this context of poor nutritional indicators and limited state

capacity to invest in nutrition, the paper aims to analyse the budgets for DNIs in Bihar and identify the gaps therein.

The paper assesses:

- i. Budget Outlays for Direct Nutrition Interventions in Bihar over the last 4 fiscal years - FY 2014-15 to 2017-18
- ii. Resource adequacy of select DNIs
- iii. Fund utilisation of DNIs in most recent years
- iv. Bottlenecks constraining fund utilisation for DNIs in the state



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Methods

Framework for analysis:

We used Shrivastava et al. (2017) 17 DNIs framework for budget outlay analysis. The 17 DNIs are based on 14 India Plus interventions identified by Menon et al. (2015) and adds three additional interventions – maternal calcium, maternal deworming and supplementary nutrition for adolescent girls.

Process followed for budget analysis:

The budget for 17 DNIs was collated and categorised as follows: (i) behaviour change interventions (including counselling during pregnancy regarding good nutrition practices for pregnant women, counselling for optimal breastfeeding, and counselling for complementary feeding and handwashing); (ii) micronutrient supplementation and deworming (vitamin A and IFA supplementation, diarrhoea control and deworming for children (0-6 years), IFA and deworming for

adolescent girls, and IFA, deworming and calcium for pregnant and lactating women); (iii) supplementary feeding (for children 6 months to 6 years, severely underweight children 6 months to 6 years, supplementary food rations for adolescent girls and pregnant women and breastfeeding mothers); (iv) treatment of severe acute malnutrition (facility based treatment of SAM children 6 months to 5 years); and (v) others (insecticide treated bed-nets, conditional cash transfer to pregnant women and breastfeeding mothers).

These 17 DNIs are embedded in four CSS of two departments – Social Welfare and Health and Family Welfare. There are no state-specific schemes in Bihar for the delivery of DNIs in the state. Since interventions are embedded within the programmes of two departments, for overall analysis, it is pertinent to analyse budgets for DNIs at three levels (Figure 3): (i) budget outlays of the two nodal departments delivering the DNIs in Bihar – Social Welfare and Health; (ii) budget outlays for the four CSS, within which the budgets for the DNIs are subsumed (Integrated Child Development Services (ICDS), SABLA, Indira Gandhi Matritva Sahyog Yojana (IGMSY) / Pradhan Mantri Matru Vandana Yojana (PMMVY) and National Health Mission (NHM)), and (iii) budget outlays for the 17 DNIs. Fiscal years included are 2014-15, 2015-16, 2016-17 and 2017-18.

17 DNIs are embedded in four CSS of two state departments – Social Welfare and Health and Family Welfare.

Process followed for studying budget outlays:

The budget outlays for DNIs delivered through the Social Welfare Department was collated from the Detailed Demand for Grants for FY 2016-17 and 2017-18 (Government of Bihar 2016, 2017) and the first supplementary budget for FY 2017-18 (Government of Bihar, 2017). The estimates collected for the study years are as follows: Actual Expenditure (AE) for FYs 2014-15 and 2015-16, Revised Estimates (RE) for FY 2016-17, and Budget Estimates (BE), along with 1st Supplementary Budget for FY 2017-18.

The budget data for DNIs delivered through NHM was collated from the Record of Proceedings (ROPs) and the Financial Monitoring Reports (FMRs) for the fiscal years 2014-15, 2015-16, 2016-17 and 2017-18 (Ministry of Health and Family Welfare, 2017). The ROPs capture the amounts approved by the Union Ministry of Health and Family Welfare (MoHFW) for a scheme, against the amounts proposed by the states (in State Programme Implementation Plans). The FMRs on the other hand report the actual expenditure on various schemes under the NHM, against the funds available for a specific programmatic head.

Process followed for studying 'adequacy' of budget outlays:

We studied adequacy of budgets for

select DNIs, where data was available, using two approaches.

First, we assessed 'adequacy' for ICDS-SNP against government's norms and stated coverage. This analysis was done for two fiscal years 2015-16 and 2016-17. The programme provides supplementary nutrition for children 6-72 months, for pregnant and lactating women (till 6 months after delivery) and additional food rations for severely underweight children 6-72 months. The respective unit costs for provision of supplementary nutrition for normal children, severely underweight children and pregnant and lactating women were INR 6/-, INR 9/- and INR 7/- per person per day¹.

The resource requirement for each target group under SNP during a year is based on the number of beneficiaries, respective unit costs and the days SNP is to be provided, i.e. 300 days in a year. The number of beneficiaries of the scheme for the 2 years was taken from the Directorate of ICDS, Government of Bihar. These resource requirements were then compared with the budget outlays (Revised Estimates) of FY 2015-16 and 2016-17 to assess resource gaps, if any, for the state.

Second, we assessed 'adequacy' of budgets for DNIs delivered through NHM. These are the interventions for which cost estimates have

Adequacy of resources for ICDS-SNP was assessed against the government's norms and stated coverage.

1. The unit costs for ICDS-SNP were revised by the Union Government in September 2017 for normal children (6-72 months), severely underweight children (6-72 months) and pregnant and lactating women to INR 8/-, INR 12/- and INR 9.5/- per person per day. This will be applicable from September 2017 and hence reflected in supplementary grants for ICDS-SNP for FY 2017-18.



been generated by Chakrabarty and Menon (2017). These cost requirements were compared with the approved budgets for FY 2017-18. To ensure comparability of budget and cost estimates of Chakrabarty and Menon (2017), some DNIs were grouped. Hence we have the following interventions for which adequacy analysis has been done: (i) IFA and deworming for adolescent girls; (ii) vitamin A for children (0-59 months); (iii) paediatric IFA; (iv) deworming - children; (v) treatment of diarrhoea (zinc and ORS); (vi) treatment of SAM. We could not assess resource gap for maternal interventions pertaining to IFA, calcium and deworming as the disaggregated budget data for these is not available in public domain for FY 2017-18.

Process for analysing utilisation of funds for DNIs

The analysis on fund utilisation consists of – quantifying the

underutilisation of funds (or underspending) to the extent possible and analysing the causal factors for underutilisation of funds. For assessing utilisation of funds for DNIs, the budget outlays were compared with the actual expenditure for the two departments separately.

(i) Fund utilisation under Social Welfare Department: This analysis was carried out for ICDS-SNP, SABLA-SNP and IGMSY / PMMVY for two fiscal years – 2014-15 and 2015-16. These are the two years for which data on actual expenditure is available in the public domain. The figures for budget outlays (Revised Estimates) for FY 2014-15 and 2015-16 were compiled from detailed budgets books of social welfare department. Data on actual expenditure for FY 2014-15 was collated from the detailed budget books of social welfare department for the year 2016-17, and for FY 2015-16, from budget books of year 2017-18. We

Adequacy of resources for DNIs delivered by the health department was assessed against the cost estimates given by Chakrabarti and Menon (2017).



Apart from quantifying the fund utilisation, factors constraining fund utilisation for DNIs were also assessed.

have used Revised Estimates instead of Budget Estimates, as Revised Estimates give more accurate data on the quantum of funds available in a year for these schemes. Also, these are the years when substantial additional budgets were added through supplementary grants in these schemes over the initial budget estimates.

(ii) Fund utilisation under NHM: This analysis was done for one fiscal year – FY 2016-17. The FMR for FY 2016-17 is provided by the Union Ministry of Health and Family Welfare (MoHFW, 2017). The data on Actual Expenditure for FY 2016-17 was compared with the Total Budget Available for the year, as given in FMR. This analysis could not be done for other years, as FMRs for those years were not available in the

public domain at the time of study.

Apart from quantifying the fund utilisation, we tried to understand factors constraining fund utilisation for DNIs. Das (2014) highlighted how the main reasons (or causal factors) for underutilisation of funds in the social sector schemes are rooted in institutional and procedural constraints in the implementation of schemes and deficiencies in the planning process. These include deficiencies in decentralised planning, delay in the flow of funds, and systemic weaknesses such as shortage of staff, etc. In order to assess some of these factors, we relied on secondary literature, including relevant government documents. These include reports of the Comptroller and Auditor

General (CAG) of India, including the performance audit by CAG of NHM and ICDS in Bihar, the Joint Review Missions of NHM and the Economic Survey of Bihar. Interactions were also held with government officials at the state level to get their perceptions on reasons for low levels of fund utilisation in the schemes. We also draw on insights from the survey carried out in Purnea district (see working paper 3 – Singh et al. 2017 for details) to assess fiscal bottlenecks.



Results

Budgets for nodal departments:

Between FY 2014-15 and FY 2017-18, the total state budget of Bihar increased by 88% from INR 94,698 crore in FY 2014-15 to INR 1,78,399 crore in FY 2017-18 (Figure 4). While this increase in state budget has been accompanied by a substantial increase in the health department's budget, the increase in SWD budget is not much. The budget for the health department has more than doubled during the period, from INR 3,610 crore in FY 2014-15 to INR 7,921 crore

in FY 2017-18. During the same period the budget for the social welfare department increased by 55% from INR 4,883 crore in FY 2014-15 to INR 7,561 crore in FY 2017-18. The health department budget constituted 3.8% of the total state budget in FY 2014-15, increasing to 5.4% in FY 2016-17 before declining to 4.4% in FY 2017-18. On the other hand, social welfare department budget constituted 5.2% of the total state budget in FY 2014-15, and declined to 4.2% in FY 2017-18.

Budgets for four CSS:

The doubling of the health department budget is reflected in an almost four-fold increase in budget outlays for NHM between FY 2014-15 (INR 965 crore) and FY 2016-17 (INR 3,713 crore). The NHM budget constituted more than a quarter of health department budget in FY 2014-15, which increased to 45% in FY 2016-17. However, with the decline in health department's budget in FY 2017-18, the NHM budget also witnessed a reduction and again constituted about 27% of health department's budget (Figure 5).

Budget outlays for ICDS increased from INR 1,853 crore in FY 2014-15 to INR 3,289 crore in FY 2017-18. The ICDS budget constituted about 38% of the department's budget in FY 2014-15, rising to 44% in FY 2017-18. The budget outlays for SABLA increased in the last 4 years, except during FY 2015-16. The budget outlays for the scheme were INR 118 crore in FY 2014-15, decreasing to INR 17 crore in FY 2015-16, before

While the increase in state budget has been accompanied by a substantial increase in health department's budget, the increase in social welfare department's budget has not been significant.



While DNIs budgets increased in absolute terms, as a proportion of total state budget, DNIs budgets declined from 1.9% in FY 2014-15 to 1.5% in FY 2017-18.

increasing multi-fold to INR 178 crore in FY 2016-17 and INR 257 crore in FY 2017-18. Budget outlays for IGMSY / PMMVY experienced a major push in the year 2017-18, following the scaling up of the scheme at the national level. The budget outlays increased from INR 27 crore in FY 2014-15 to INR 136 crore in FY 2017-18.

Budgets for DNIs:

The total budget outlays for DNIs first decreased from INR 1,786 crore in FY 2014-15 to INR 1,551 crore in FY 2015-16 and then increased to INR 1,981 crore in FY 2016-17 and INR 2,687 crore in FY 2017-18 (Figure 6). As a proportion of total state budget, budget outlays for DNIs have declined from 1.9% in FY 2014-15 to 1.4% in FY 2015-16 and to 1.3% in FY 2016-17, but increased slightly to 1.5% in FY 2017-18. The per capita budget outlays on DNIs have increased in last 4 years,

from INR 380 in FY 2014-15 to INR 572 in FY 2017-18.

A large proportion of the increase in DNIs budget during the study period may be attributed to increased allocations for SNP. In FY 2017-18, ~76% of the total DNIs budget is comprised of supplementary feeding. The DNIs under 'Others' comprise a close second at ~18% of DNIs budget, followed by behaviour change interventions (~3.2%), micronutrient supplementation and deworming (~2.8%) and treatment of SAM (<1%). Similar composition of DNIs budget is observed in previous fiscal years.

In FY 2017-18 ~95% of the budget for behaviour change counselling is accounted for by the ICDS-IEC. While budget outlays for infant and young child feeding (IYCF) have marginally increased from INR 1 crore in INR 4.4

crore FY 2014-15 to FY 2017-18, the budget outlays for ICDS-IEC have increased significantly during the same period from INR 4.4 crore to INR 82 crore.

The budget outlays for micronutrient supplementation and deworming increased significantly from INR 45 crore in FY 2014-15 to INR 74.5 crore in FY 2017-18. In FY 2014-15 no budget was allocated for diarrhoea control, 0.9 crore INR for deworming of children and INR 2.7 crore for deworming of adolescents. In FY 2017-18, only INR 0.1 crore was allocated for IFA for adolescents, as opposed to INR 27 crore in FY 2016-17. As a response to the state's demand for INR 16 crore for this head under National Iron Plus Initiative in FY 2017-18, the Union Ministry of Health and Family Welfare stated that the state has committed unspent amount of INR 25 crore for this activity (Ministry of Health and Family Welfare 2017). The budget outlays for IFA and calcium (combined) for pregnant and lactating women increased from INR 8.2 crore in FY 2014-15 to INR 11.2 crore in FY 2015-16 and FY 2016-17. The budget outlays for these have not been reported separately in FY 2017-18 and are subsumed within the *Janani Shishu Suraksha Karyakram* (JSSK) budget. Hence, it has not been possible to capture the same. Budget outlays for deworming for pregnant and lactating women are not reported for any of the four years.

The budget outlays for supplementary feeding have also seen


an increase from INR 1,314 crore in FY 2014-15 to INR 2,037 crore in FY 2017-18. The fiscal year that stands out here is FY 2015-16 where the budget outlays for both ICDS-SNP and SABLA-SNP declined from FY 2014-15, before increasing again in FY 2016-17 and FY 2017-18. The initial budget outlays for SABLA in FY 2017-18 (as per Budget Estimates) were just INR 53 crore, with INR 197 crore being added through the first supplementary grant in August 2017 (Government of Bihar, 2017). It is expected that an additional budget will be allocated for ICDS-SNP through supplementary grants in FY 2017-18, due to revised unit costs for the programme from September 2017 (PIB, 2017).

The budget outlays for treatment of SAM have increased from FY 2014-15 (INR 6.8 crore) to FY 2017-18 (INR 8.9 crore). The budget outlays however, have remained <INR 10 crore and constitute <1% of the total DNI budget in all the four fiscal years.

The budget outlays for 'Others' first declined from INR 414 crore in FY 2014-15 to INR 360 crore in FY 2015-16, before increasing to INR 434 crore in FY 2016-17 and INR 480 crore in FY 2017-18. JSY, which accounts for the major portion of funds in the group 'Others', experienced budget cuts during the period.

Adequacy of Budget Outlays:

Adequacy of Budget Outlays for ICDS-SNP:



Budget outlays for almost all DNIs increased between FY 2014-15 and FY 2017-18.





There are significant resources gaps for both ICDS-SNP in FY 2015-16 and 2016-17; and for management of SAM children, diarrhoea control and deworming for children in FY 2017-18.

The resource requirement for ICDS-SNP according to scheme norms and stated number of beneficiaries was INR 1,676 crore in both FY 2015-16 and FY 2016-17 (Figure 7.A). The resource gap between the budget outlays (Revised Estimates) and resource requirement is ~31% in FY 2015-16 and ~27% in FY 2016-17.

The resource requirement increases significantly if computed for universalising the scheme in Bihar (figure 7.B). This has been discussed in Discussion section of the paper.

Adequacy of Budget Outlays for Micronutrient Supplementation and Deworming for children and adolescents:

A comparison of budget outlays for FY 2017-18 (Approved Budget) with the cost requirements estimated by Chakrabarty and Menon for year 2017 reveal significant resource gaps for certain interventions, and resource

surplus for some others (figure 7.C).

There is a resource surplus of 30% for IFA and deworming for adolescent girls (budget outlays of INR 30 crore against a requirement of INR 23 crore) and 138% for vitamin A supplementation for children (budget outlays of INR 14.3 crore against a requirement of INR 6 crore) in FY 2017-18. On the other hand there is a resource deficit of 95% for treatment of SAM children, 75% for treatment of diarrhoea, and ~40% for deworming for children. Bihar is close to meeting the resource requirement for paediatric IFA, with resource deficit of only 1% (budget outlay of INR 29.6 crore against a resource requirement of INR 30 crore).

Assessing Fund Utilisation:

Fund Utilisation for SNP and IGMSY under SWD:

The scenario with respect to

utilisation of funds differs significantly between FY 2014-15 and FY 2015-16 (figure 8.A). Under ICDS-SNP, only INR 1,198 crore was spent against budget outlays of INR 2,411 crore (~50%) in FY 2014-15; in FY 2015-16, INR 1,075 crore was spent against the budget outlays of INR 1,158 crore (~93%). Similarly, under IGMSY / PMMVY while the actual expenditure was INR 27 crore against budget outlays of INR 63 crore in FY 2014-15 (~42%), in FY 2015-16 actual expenditure was greater than the budget outlays (budget outlays of INR 42 crore against expenditure of INR 47 crore; i.e. 113%). Fund utilisation on SNP-SABLA has been low in both the years: while INR 116 crore was spent in FY 2014-15 against budget outlays of INR 273 crore (~42%); in FY 2015-16, actual expenditure was INR 15 crore against the budget outlays of INR 25 crore (~59%).

Fund Utilisation for interventions within NHM:

Fund utilisation for most interventions within NHM is low (Figure 8.B). Of the eight schemes / interventions, the expenditure as a proportion of the total funds available is <10% in five schemes / interventions. These include IYCF, paediatric IFA, deworming for children, vitamin A and IFA and deworming for adolescent girls. The utilisations levels are ~40% in treatment of SAM and National Iodine Deficiency Disorders Control Programme (NIDDCP). The highest levels of fund utilisation are visible in *Janani Suraksha Yojana* at ~80%.

Public factors constraining fund utilisation:

Low levels of fund utilisation are often symptoms of larger systemic issues such as poor need assessment, lack of decentralised planning, shortage of human resources and basic infrastructure, delay in fund flows etc. (CBGA 2011). Some of these factors are discussed below.

(i) Weak planning and need

assessment: A joint report by CBGA-UNICEF (2011) had highlighted that ICDS in Bihar did not involve any detailed planning exercise, nor was there any mechanism for involving personnel in project-level planning. The same finding was reiterated by CAG audit in 2017 which noted that inputs of *anganwadi* workers were not considered while making Annual Programme Implementation Plans (APIPs), nor were the planning teams for making APIPs constituted in the state. Similarly, under NHM, CAG (2015) observed that bottom-up approach was not adopted for preparation of plans, as planning teams and committees were not constituted at any level in any test checked districts. The block health action plans (BHAP) for almost half the blocks were prepared without inputs from villages, and for other half, BHAP were not prepared during 2010-15. Consequently, the District/State plans did not contain inputs of all blocks.

(ii) Significant additions through supplementary budgets, constrains the ability of departments to utilise

Fund utilisation is a major issue in Bihar, especially for the DNIs delivered by the health department.

the funds: Analysis reveals that in recent years, initial budget outlays for CSS delivering the DNIs were low, with significant amounts added through supplementary budgets later during the course of the year (Figure 10). For example, SABLA-SNP was not allocated any budget in FY 2015-16 BE, but received close to INR 116 crore through supplementary budget, of which INR 91 crore were added in February 2016 through third supplementary grant. Similarly, ICDS-SNP received ~INR 290 crore through supplementary budgets in FY 2016-17, which were added through third supplementary budget in February 2017. In FY 2017-18, SABLA-SNP got INR 197 crore and IGMSY got INR 50 crore through first supplementary budget. When funds are allocated late in a fiscal year (say last quarter), the department is not left with much time to spend the funds, adversely affecting the utilisation.

(iii) Severe shortage of Human Resources in Health Department:

The Economic Survey of Bihar 2016-17 notes that in 2016-17, there was a vacancy ratio of ~50% for doctors, ~63% for contractual doctors, 45% for regular nurses, 76% for contractual nurses, 41% for regular ANMs and 45% for contractual ANMs (Government of Bihar, 2017).

(iv) Shortage of infrastructure for delivery of DNIs: In Bihar, there is a shortage of *Anganwadi* Centres (AWCs) in the rural areas, with 25% wards without AWCs. Moreover, ~21 thousand AWCs and 1,675 mini

AWCs sanctioned by the Union Government in November 2014 were not operationalised (as on June 2016) (CAG 2017). Similarly, health infrastructure too, is weak in Bihar. According to the Rural Health Survey (2015-16) there was 48% shortfall for sub-centres, 42% shortfall in Primary Health Centres (PHCs) and an 81% shortfall in Community Health Centres (CHCs).



Discussion

Several important findings have emerged from the study, which have implications for DNIs. Some of these are discussed below:

Shift in fiscal priority for DNIs in Bihar:

During the period between FYs 2014-15 and 2017-18, the budgets for social welfare and health departments taken together have increased from INR 8,493 crore in FY 2014-15 to INR 15,482 crore in FY 2017-18. This, however, did not translate for enhanced prioritisation for DNIs in the state. Taken together, the share of social welfare and health departments

There is a severe shortage of basic infrastructure and human resources for delivery of DNIs delivered by the health department in Bihar.

budgets in total state budget declined from 9% in FY 2014-15 to 8.6% in FY 2017-18 (Figure 4). This is also reflected in the share of DNIs budget in the state, which declined from 1.9% of total state budget in FY 2014-15 to 1.5% in FY 2017-18. Moreover, while the increased budget for social welfare department led to proportionate increase in budgets for DNIs delivered by the department, doubling of the health department budget did not translate into higher budgets for DNIs delivered by health department. Budget outlays for DNIs delivered under NHM was INR 440 crore in FY 2014-15, which has declined to INR 432 crore in FY 2017-18 (Figure 6).

Inadequate Budget Outlays for DNIs delivered by health department:

The budget outlays for DNIs delivered by health department are inadequate, with the resource gap being as high as 95% in case of treatment of SAM and 75% for treatment of diarrhoea. According to a recent study, diarrhoea is one of the biggest contributor to deaths in Bihar (ICMR, PHFI and IHME 2017), but the state is not providing enough resources for addressing this problem. Interventions like vitamin A supplementation, paediatric IFA and IFA and deworming for adolescents seem to be better budgeted for, with budget outlays close to the resource

requirements (with resource surplus of ~138% for Vitamin A and 30% for Adolescent IFA and deworming). Most of these DNIs require only small amounts of budgets, (for example deworming for children requires only INR 17 crore, and treatment of diarrhoea (ORS + zinc) requires INR 54 crore)) which too, did not get approved in FY 2017-18 implying low priority for these (figure 7.C).

Budgets for provision of ICDS-SNP are inadequate:

The budget outlays for providing ICDS-SNP are also inadequate. With a resource gap of ~31% in FY 2015-16 and ~27% in FY 2016-17, the state is allocating only two-third of the budget needed for provision of supplementary nutrition to its existing number of beneficiaries. The resource requirement, and hence the resource gap, would be much higher if SNP is universalised in the state² or if the resource requirement is computed using the revised cost norms for the scheme³ (Figure 7.B). Similarly, the gap in provisioning for the scheme is high if one compares the actual expenditure on ICDS-SNP, against the resource requirements (Figure 7.A). The resource inadequacy for SNP needs to be seen in the context of visible gaps in delivery of SNP in the state. The recent CAG performance audit found that none of the test checked AWCs are providing

Doubling of health department's budget did not translate into higher budgets for DNIs delivered by health department.

2. As per current norms in Bihar, one anganwadi centre has a capping of: 40 children (36m –72m), 28 malnourished children (6m – 36m), 12 normal children (6m-36m), and 16 pregnant and lactating women, per day. The Supreme Court directive however, has been to universalise the scheme.

3. As per government order No.CD-I-11 | 21 20t6-CD.r dated October 6, 2017, the unit cost norms under ICDS-SNP have been increased per person per day to INR 8/- for children (6-72 months), INR 12/- for severely underweight children and INR 9.5/- for pregnant and lactating women. These would be applicable from October 2017 (MWCD 2017; http://www.wcd.nic.in/sites/default/files/SNP%20rate%20revision_0.PDF).

supplementary nutrition for stipulated 300 days in a year and ~46% children and ~58% women have been left out of ambit of the programme (CAG 2017).

Issues in fund utilisation for DNIs in Bihar:

Poor fund utilisation in almost all DNIs is a major issue in Bihar. In several instances the amounts proposed by the state government were not fully approved by the union health ministry, citing among other reasons, existing unspent amounts. Similarly, levels of utilisation in social welfare department schemes have also not been satisfactory. Poor fund utilisation should be seen in the context of available human and infrastructure resources, availability of funds vis-à-vis requirement, capacity of staff to undertake an activity and so on. We discuss some of these issues below:

(i) Persistent underfunding in these sectors over a period of time has weakened the resource absorption capacity of the state. This, in turn, leads to a vicious cycle of poor planning, leading to poor budgeting, and hence poor fund utilisation. Underfunding may lead to underspending due to lack of resources for support structures for undertaking an activity. For instance, the provision of hot cooked meal can be undertaken effectively only if the requisite structure, such as kitchen, utensils, oil, gas, etc., is available. In absence of these, funds for the scheme will remain unutilised. Poor fund utilisation also adversely affects

the budget outlays for the subsequent fiscal year.

(ii) Shortages of human resources and infrastructure are both, a result of underfunding, as well as a causal factor constraining the fund utilisation. The Rural Health Survey (2016) found that population burden on health centres in Bihar was much higher than the recommended norms (as of March 31, 2015). For example, ~9,500 persons are covered by a sub-centre, ~51,200 persons are covered by a PHC, and ~6,24,000 persons are covered by a CHC, against a population norm of 5,000, 30,000 and 1,20,000 respectively (Ministry of Health and Family Welfare 2012). Similarly, a government doctor serves a much larger population (for instance, in 8 districts (Bhojpur, Lakhisarai, Patna, Sheohar, Munger, Nalanda, Jehanabad and Sheikhpura), a government doctor serves more than 5 lakh people) (Government of Bihar 2017: 272).

(iii) The extent of fund underutilisation for social welfare department schemes may be much higher than the numbers given in Figure 8.A. This is because the numbers reported in Figure 8.A are assessed against Revised Estimates for both FY 2014-15 and 2015-16. However, the additional funds added through second and third supplementary grants are not reflected in Revised Estimate figures. If we add these numbers to initial allocations and then compare against actual expenditure figures, the extent

Persistent underfunding over time has weakened the resource absorption capacity of the state, leading to vicious cycle of poor planning, leading to poor budgeting, and poor fund utilisation.



of fund utilisation might be even lower.

Paucity of data constrains the analysis:

Apart from issues that affect service delivery and budgeting for schemes, schemes' evaluation remains a weak spot due to limited data availability. These include:

(i) While the data on actual expenditure for schemes implemented by social welfare department is available after a one year time lag, data on health related DNIs are not reported in the budget books of the health department. To collate data on actual expenditure for health DNIs, we had to rely on the FMR compiled by the Union MoHFW, which was available only for one year at the time of this study. Hence, expenditure trend analysis for DNIs is difficult. Also, the data from ROPs and the FMR for a year are not strictly comparable as the data on approved budget in ROPs and the FMR for 2016-17 did not match for some of the

DNIs studied. For example, according to the ROP 2016-17, under FMR code B.1.1.3.2.5 'Incentive for follow up of discharge SAM children from NRCs', no amount was proposed by the state or approved by MoHFW. However, in the FMR for FY 2016-17, INR 12.86 crore is shown as approved by the MoHFW (Ministry of Health and Family Welfare 2017).

(ii) The information on physical coverage of the schemes is not readily available. For example, the number of beneficiaries under SNP-ICDS, SNP-SABLA or IGMSY / PMMVY is not in the public domain (online). The data on number of beneficiaries for ICDS-SNP was obtained from the ICDS Directorate, Government of Bihar. For health related DNIs in Bihar such data is not available in public domain and one has to use estimates given by independent agencies / organisations.

Issues for further research:

The present paper focuses on tracking

Apart from issues that affect service delivery and budgeting for schemes, schemes' evaluation remains a weak spot due to limited data availability.

The state departments of social welfare and health should significantly increase the budgets for DNIs delivered through their respective schemes and address factors constraining their fund utilisation.

budgets, assessing their adequacy and analysing the extent of fund utilisation for DNIs in Bihar. This analysis is important for informing the discourse on public financing for DNIs at the state level, and advocate with the government for increasing the budgets or the DNIs in Bihar.

Analysis can be deepened further by looking into questions pertaining to quality of fund utilization (when and on what are funds being spent) and delving deeper into factors constraining fund utilisation and delivery of DNIs in the state. Research can also focus on analysing the design of nutrition budgets, i.e. is the state budgeting appropriately to address the specific factors contributing to undernutrition in the state. The analysis can be further strengthened by undertaking primary, field based surveys to document the state-specific issues better.

the interventions to prevent undernutrition are known and are part of the government interventions in the state. However, as has been highlighted in the paper, the investment for delivering these interventions is low (1.5% of total state budget in FY 2017-18) and inadequate. The problem is further compounded by the low levels of fund utilisation in schemes delivering the DNIs.

In this context, is it important that the state departments of social welfare and health significantly increase the budget outlays for DNIs delivered through their respective schemes. At the same time, government needs to provide for shortfalls in basic infrastructure and human resources of the two departments. The planning and budgeting processes in the state should be strengthened to ensure needs-based budgeting and improve utilisation of allocated funds. The state should also take initiative to make data on budget outlays and actual expenditure for all DNIs, as well as data on physical coverage of their schemes and programmes, available in public domain in a timely manner.

The Bihar government recently came up with '7 *Nishchay*' of the Bihar CM, but these do not include any point relating to addressing undernutrition. Including "ending all forms of undernutrition" as an eighth '*nishchay*' in state government's policy framework may be a good starting point for this.

Conclusion

While Bihar has high levels of child and maternal undernutrition,

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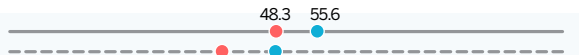
Figure 1: Nutritional Indicators and Coverage of Essential Nutrition Interventions in Bihar (Values in %)

Indicators / Coverage of DNI

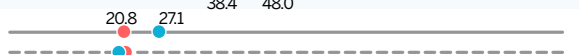
— Bihar — All India ● NFHS 3 ● NFHS 4

Children

Children under 5 years who are stunted (height-for-age)



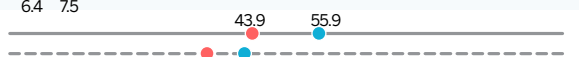
Children under 5 years who are wasted (weight-for-height)



Children under 5 years who are severely wasted (weight-for-height)



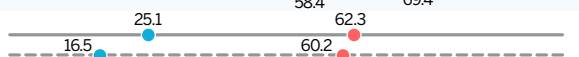
Children under 5 years who are underweight (weight-for-age)



Children age 6-59 months who are anaemic (<11.0 g/dl)



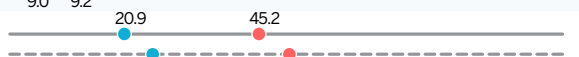
Children age 9-59 months who received a vitamin A dose in last 6 months



Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey



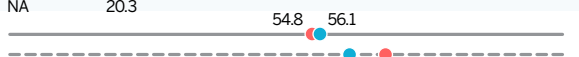
Children with diarrhoea in the last 2 weeks who received oral rehydration salts



Children with diarrhoea in the last 2 weeks who received zinc



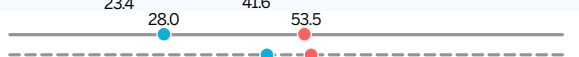
Children with diarrhoea in the last 2 weeks taken to a health facility



Children under age 3 years breastfed within one hour of birth



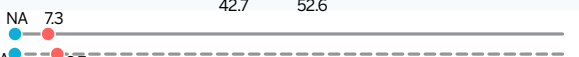
Children under age 6 months exclusively breastfed



Children age 6-8 months receiving solid or semi-solid food and breastmilk



Breastfeeding children age 6-23 months receiving an adequate diet



Non-breastfeeding children age 6-23 months receiving an adequate diet



Total children age 6-23 months receiving an adequate diet



Women

Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2)



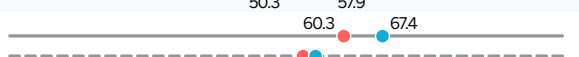
Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl)



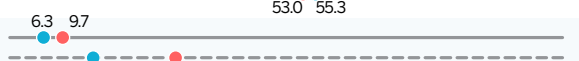
Pregnant women age 15-49 years who are anaemic (<11.0 g/dl)



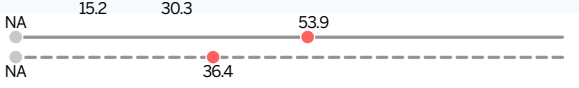
All women age 15-49 years who are anaemic



Mothers who consumed iron folic acid for 100 days or more when they were pregnant



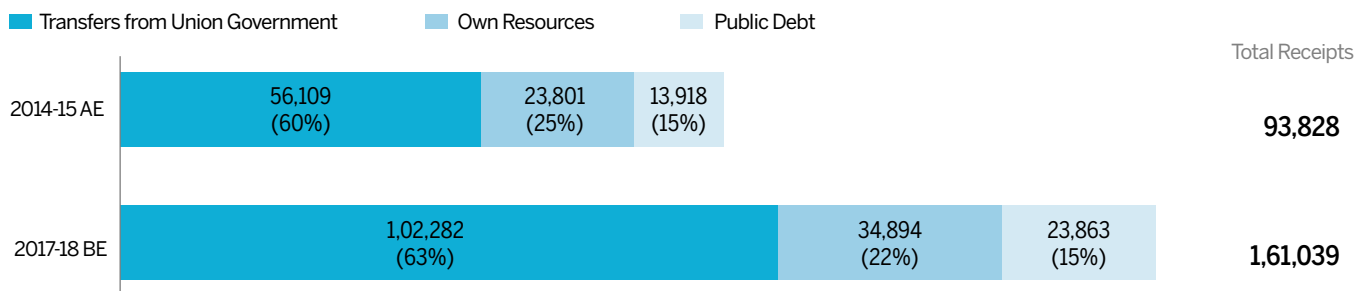
Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution



Note: NA: Not Available Source: NFHS-4; IIPS 2016

Figure 2: Break-up of Receipts in Bihar's State Budget

Receipts in INR Crore. Figures in parenthesis show figures as proportion of total receipts.



Source: State Budget Documents of 2016-17, 2017-18; Govt. of Bihar

Figure 3: Fund flow structure for DNI in Bihar

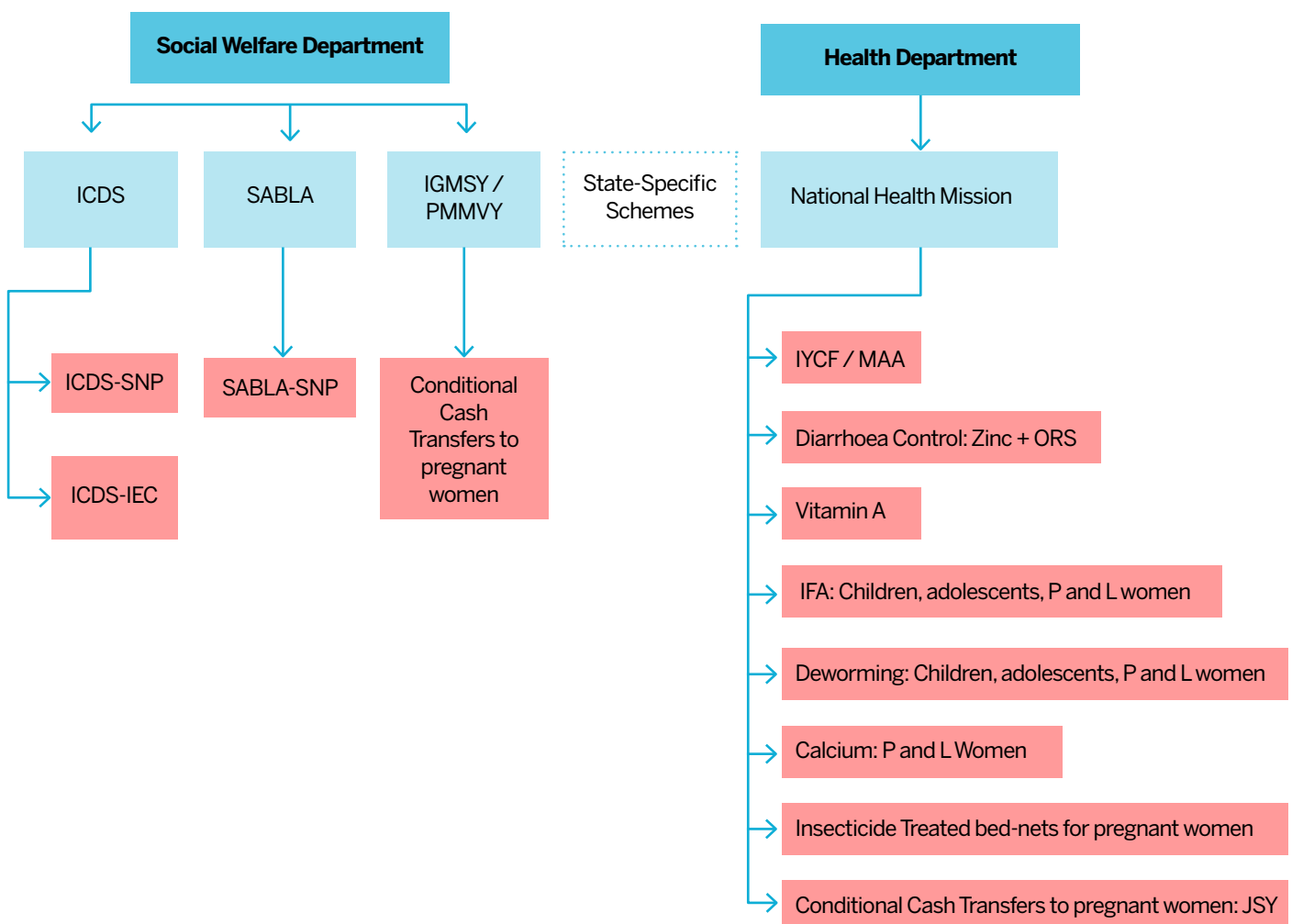
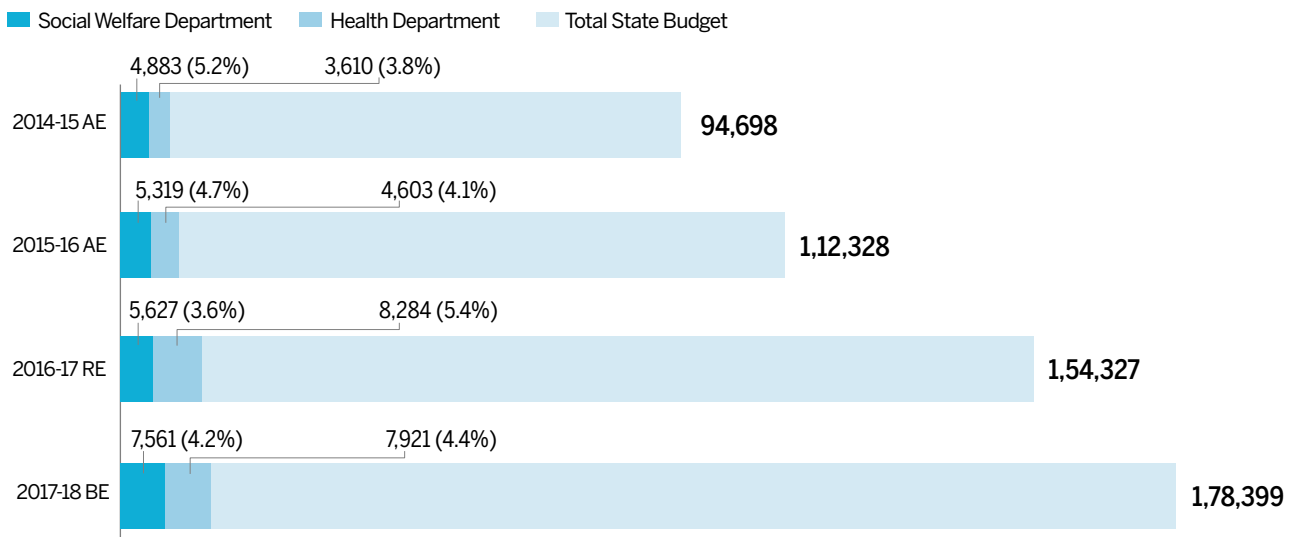


Figure 4: Budget Outlays for Nodal Departments delivering DNIs in Bihar

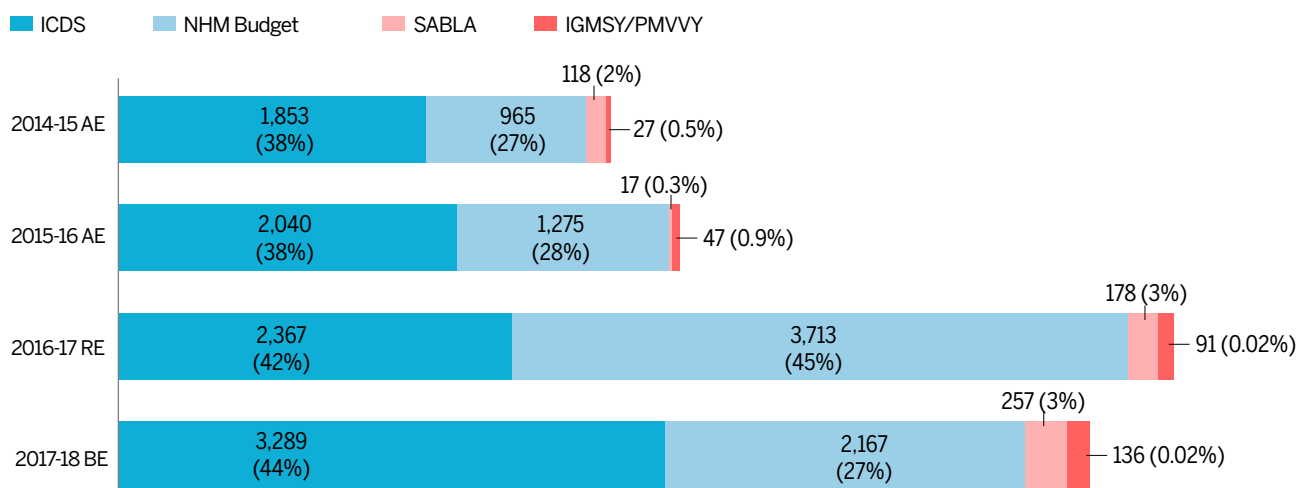
Outlays in INR Crore. Figures in parenthesis show department budgets as a proportion of total state budget



Source: State Budget Documents of 2016-17, 2017-18; Govt. of Bihar

Figure 5: Budget Outlays for CSS Delivering the DNIs in Bihar

Values in INR crore; Figures in parenthesis show budget outlays for scheme as a proportion of total departmental budgets



Source: Detailed Demand for Grants for Social Welfare Department 2016-17, 2017-18; Govt. of Bihar

Note: NHM Budget has been computed as a proportion of the health department’s budget; budgets for IGMSY, SABLA and ICDS have been computed as proportions of social welfare department’s budget.

Figure 6: Budget outlays for Direct Nutrition Interventions in last four fiscal years**Direct Nutrition Interventions**

(Values in INR crore; figures in parenthesis indicate sectoral share in total DNIs budget)

	2014-15	2015-16	2016-17	2017-18
I. Behaviour Change Interventions	5.4 [0.3%]	17 [1.1%]	63 [3.2%]	86.4 [3.2%]
Combined budget outlays for three interventions:				
1. Counselling for mothers during pregnancy				
2. Counselling for optimal breastfeeding to caregivers of children 0–6months		IYCF / MAA		
	1	0	1	4.4
3. Counselling for complementary feeding and hand washing to caregivers of children 6 -23 months, under schemes IYCF and IEC-ICDS.		IEC-ICDS		
	4.4	17	62	82
II. Micronutrient Supplementation and Deworming Interventions	45.4 [2.5%]	78 [5.0%]	79.9 [4.0%]	74.5 [2.8%]
4. Vitamin A supplementation for children 6–59 months	8.2	10	6.5	14.3
5. ORS for treatment of diarrhoea for children under 5 years	0	11.7	9.3	9.3
6. Therapeutic zinc supplements for treatment of diarrhoea for children under 5 years	0	1.6	1.8	1.8
Intensified Diarrhoea Control Fortnight (IDCF)	0	1.1	0	2.6
7. Deworming for children 12–59 months	0.9	5.7	2.9	3.3
8. Deworming for adolescents 10–19 years	2.7	2.8	4.4	4.4
National Deworming Day (NDD)	0	0.5	2.7	6.7
9. Deworming for pregnant women	NA	NA	NA	NA
10. Iron folic acid supplements (IFA) for children 6–59 months	9.9	10.7	14.5	29.6
11. Iron-folic acid supplements (IFA) for adolescents 10-19 years	15.4	22.2	26.5	0.1
12. Iron folic acid supplements for pregnant women and breastfeeding mothers of children 0-6 months	8	11.2	11.2	NA
13. Calcium supplementation for pregnant women and breastfeeding mothers				
14. Salt iodization for general population	0.3	0.5	0.1	2.4
III. Supplementary Feeding	1314.4 [73.6%]	1090 [70.3%]	1397 [70.5%]	2037 [75.8%]
15. Complementary food supplements for children 6-36 months				
16. Supplementary food for pregnant and lactating women for 6 months after delivery	1198.4	1075	1226	1787
17. Additional food ration for severely underweight (WAZ< -3) children 6-59 months				
18. Supplementary food rations for adolescent girls 11-18 years	116	15	171	250
State-funded scheme: Spot feeding for pregnant and lactating mothers	NA	NA	NA	NA

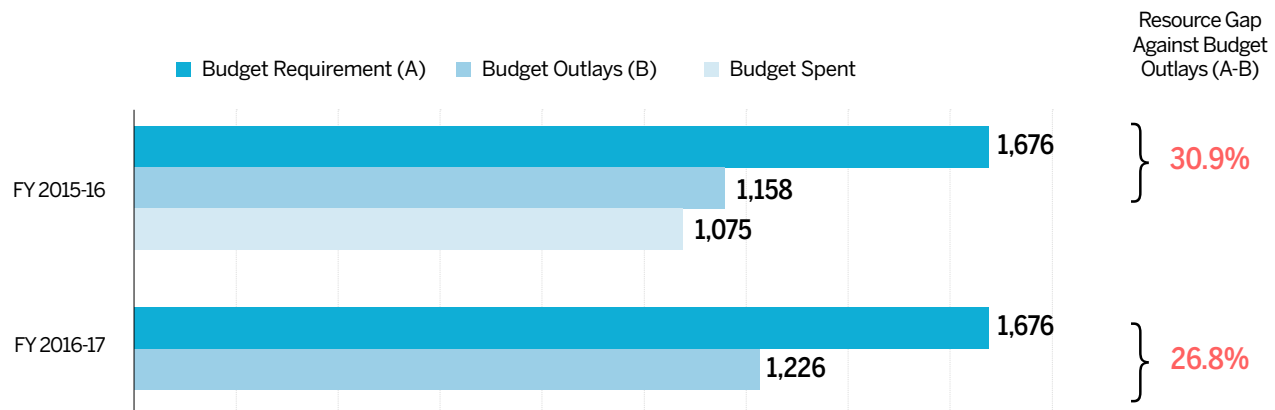
Figure 6: Budget outlays for Direct Nutrition Interventions in last four fiscal years**Direct Nutrition Interventions**

	Values in INR crore; figures in parenthesis indicate sectoral share in total DNI budget			
	2014-15	2015-16	2016-17	2017-18
IV. Severe Acute Malnutrition Treatment	6.8 [0.4%]	6.3 [0.4%]	7.4 [0.4%]	8.9 [0.3%]
19. Facility-based treatment for children 6-59 months for children with severe acute malnutrition	6.82	6.28	7.4	8.9
V. Others	414 [23.2%]	359.8 [23.2%]	434 [21.9%]	480.1 [17.9%]
20. Insecticide-treated bed nets for pregnant women in malaria-endemic areas	0	0	0	0
21. Cash transfers to pregnant women and breastfeeding mothers for the first 6 months after delivery				
Indira Gandhi Matritva Sahyog Yojana / PMMVY	27	47	91	136
Janani Suraksha Yojana	387	312.8	343	344.1
Total DNI Budget (I + II + III + IV + V)	1786	1551	1981	2687
Total State Budget	94698	112328	154327	178399
Total DNI budget as a % of Total State Budget	1.9	1.4	1.3	1.5
Per Capita DNI Budget* (in INR)	380	330	422	572

Note: *Per capita figures have been computed by taking the population of children in age group 0-6 years and number of females in age group 11 years to 49 years, from Census of India 2011.

Source: Compiled by authors from Detailed Demand for Grants for Social Welfare Department 2016-17, 2017-18, Govt. of Bihar and Record of Proceedings 2014-15, 2015-16, 2016-17, and 2017-18; National Health Mission, Govt. of India

Figure 7.A: Resource Gap Analysis for SNP-ICDS in Bihar for FY 2015-16 and FY 2016-17 as Per Existing Scheme Coverage



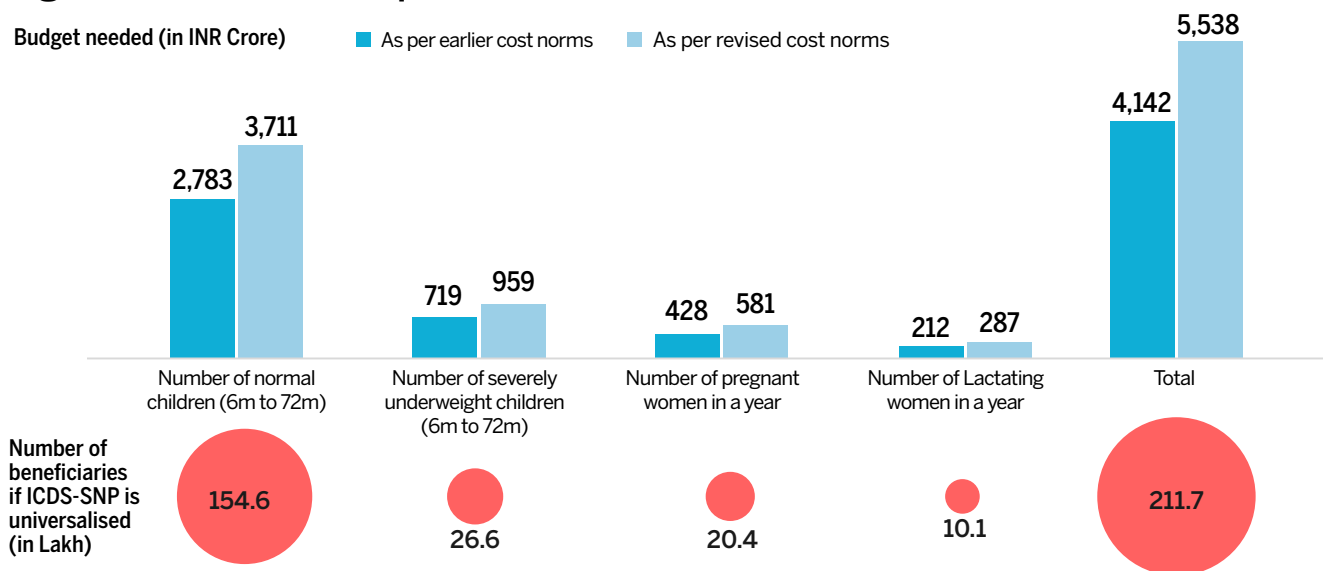
Existing Number of beneficiaries

- (i) Normal children (6m to 72m): **60,49,076**
- (ii) Severely underweight children (6m to 72m): **10,67,484**
- (iii) Pregnant and Lactating Women: **14,23,312**

Values in INR Crore

Source: For number of beneficiaries: Directorate of ICDS, Government of Bihar. (ii) For budget outlays: Detailed Demand for Grants for Social Welfare Department 2016-17 and 2017-18, Government of Bihar.

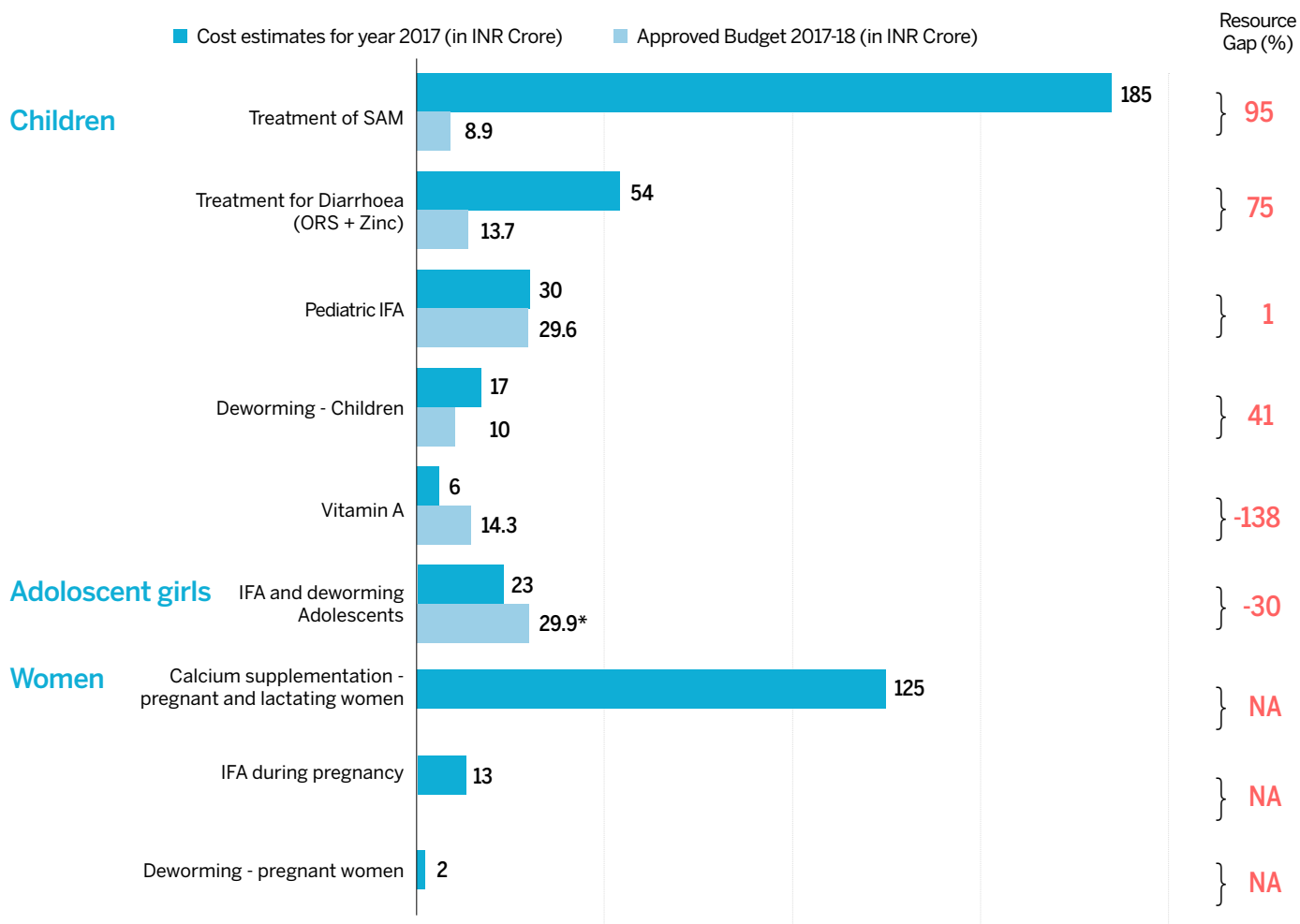
Figure 7.B Resource requirement for universalisation of ICDS-SNP in Bihar



- Notes:
- (i) Earlier Unit Costs: (per person per day): INR 6/- for normal children (6m-72m); INR 9/- for severely underweight children (6m – 72m); INR 7/- for P and L women
Revised Unit Costs: (per person per day): INR 8/- for normal children (6m-72m); INR 12/- for severely underweight children (6m – 72m); INR 9.5/- for P and L women
 - (ii) Number of children in age group 6-12 months has been computed by taking half of the number of children in age group 0-12 months, as per Census 2011
 - (iii) Number of severely underweight children have been computed from total children in age group 6-72 months by taking proportion of severely underweight children from RSOC 2013-14, which is 14.7%
 - (iv) Number of pregnant women have been computed using the number of women in reproductive age-group (15y to 49y) from Census 2011, and Gross Fertility rates in Bihar as per HMIS 2016
 - (v) Number of lactating women have been assumed to be equal to half the number of children in age group 0-12 months, as per Census 2011

Source: Census of India 2011, Rapid Survey on Children 2013-14, Ministry of Women and Child Development 2012 and Press Information Bureau 2017.

Figure 7.C: Resource Requirement for DNIs delivered by Health Department as Per Cost Estimates of Chakrabarti and Menon (2017)



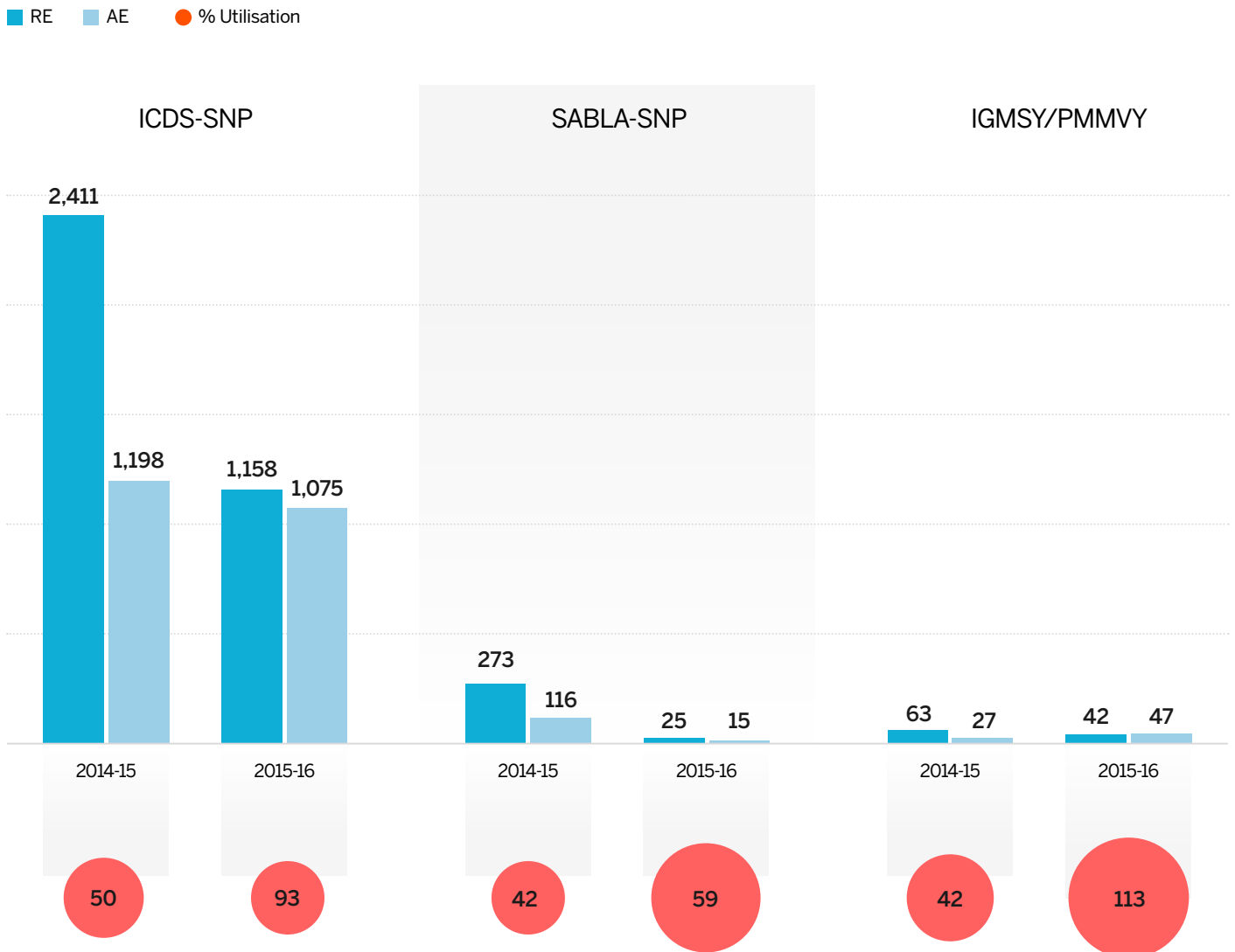
Note:

*In FY2017-18 the amount allocated for IFA and deworming for adolescents was INR 4.4 crore. However in addition to this, the state was asked to use committed unspent amount of INR 25.49 crore from previous year, making it a total of INR 29.9 crore

Figures in negative indicate outlays greater than cost estimates.

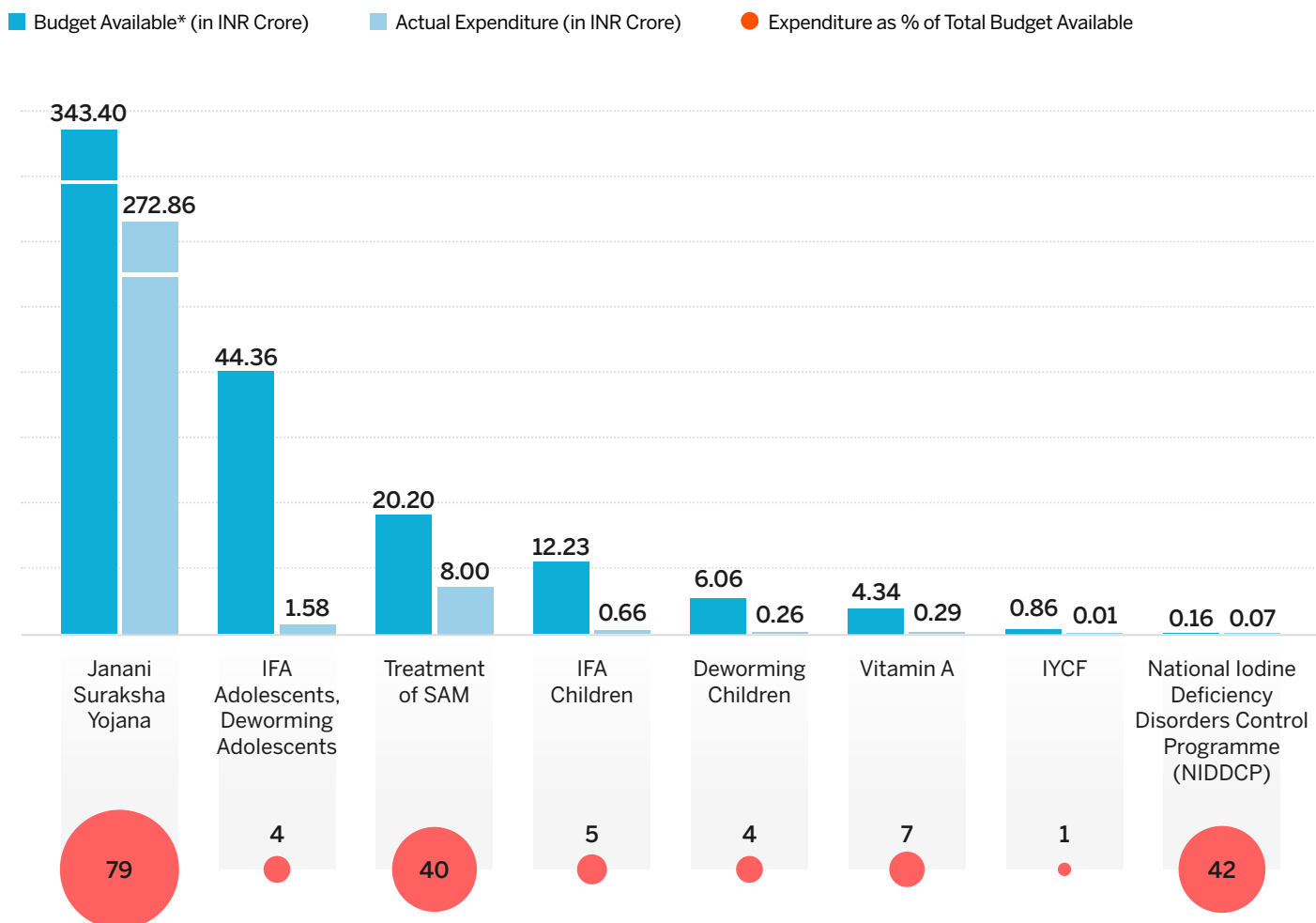
Source: Cost Estimates from Chakrabarti and Menon (2017); Budget Outlays from ROPs for FY 2017-18, Ministry of Health and Family Welfare

Figure 8.A: Fund utilisation under schemes implemented by Social Welfare Department for FY 2014-15 and FY 2015-16 (Values in INR Crore unless mentioned otherwise)



Source: Detailed Demand for Grants for FY 2016-17 and FY 2017-18, Government of Bihar

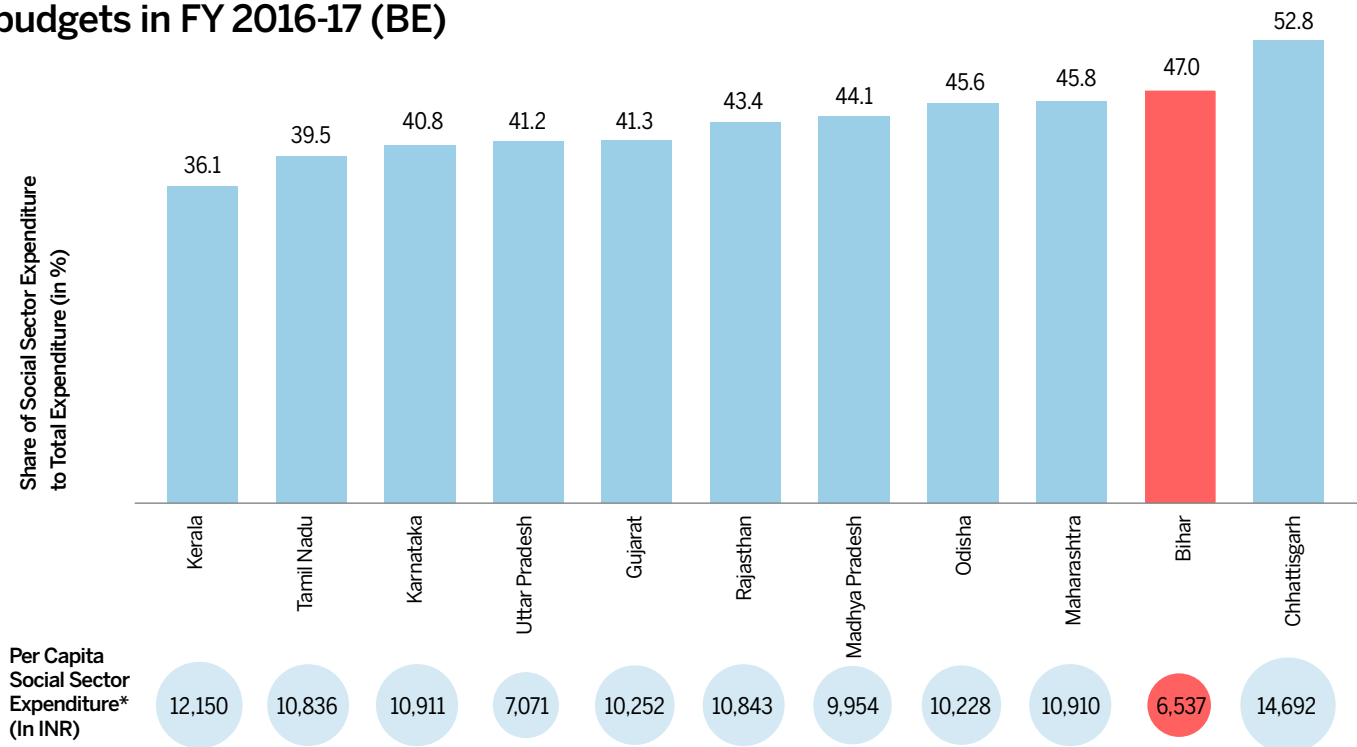
Figure 8.B: Fund Utilisation Under Scheme Implemented by Health Department for FY 2016-17



Note: *Includes budget outlays for FY 2016-17 and committed unspent balance from previous fiscal

Source: ROP and FMR for FY 2016-17; Ministry of Health and Family Welfare, 2017

Figure 9: Priority to Social Sector Expenditure in overall state budgets in FY 2016-17 (BE)



"Note: Per capita social Sector Expenditure has been computed using the Total Social Sector Figures from RBI State Finances 2016-17 and Population data from Census of India 2011

Source: RBI State Finances 2016-17, Reserve Bank of India, Government of India and Registrar General of India, Government of India. "

Figure 10: Supplementary Grants in FY 2015-16, 2016-17 and 2017-18 (in INR Crore)

Month of presentation of Supplementary Budget		ICDS-SNP	SABLA-SNP	IGMSY
Mar-15	2015-16 BE	1,058	0	34
Aug-15	1st SB 2015-16	499	25	35
Dec-15	2nd SB 2015-16	0	0	0
Feb-16	3rd SB 2015-16	100	91	28
2015-16 (BE+SB)		1,656	116	98
Feb-16	2016-17 BE	1,273	130	71
Jul-16	1st SB 2016-17	0	41	20
Nov-16	2nd SB 2016-17	0	0	0
Feb-17	3rd SB 2016-17	289	0	0
2016-17 (BE+SB)		1,562	171	91
Feb-17	2017-18 BE	1,787	53	86
Aug-17	1st SB 2017-18	0	197	50
2017-18 (BE+SB)		1,787	250	136

Source: Compiled by authors from Detailed Demand for Grants for Social Welfare Department 2016-17, 2017-18, Govt. of Bihar



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