Public Financing for Nutrition in Bihar

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Challenges in Analysing Public Expenditure for Nutrition in Bihar

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Errors and omissions, if any, are entirely our own.

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List of Abbreviations

AE	Actual Expenditure
ANC	Ante Natal Check-up
BE	Budget Estimate
CSS	Centrally Sponsored Schemes
DDGs	Detailed Demand for Grants
DHS	District Health Society
DNI	Direct Nutrition Interventions
FMR	Financial Management Report
FY	Financial Year
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IFA	Iron, Folic Acid
IGSMY	Indira Gandhi Matritva Sahyog Yojana
JSSK	Janani Shishu Suraksha Karyakram
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
NFHS	National Family Health Survey
NHM	National Health Mission
NSP	Nutrition Sensitive Programme
OTMS	Online Treasury Management System
PIP	Programme Implementation Plan
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
RE	Revised Estimates
RSOC	Rapid Survey on Children
SC	Scheduled Caste
SHS	State Health Society
SNP	Supplementary Nutrition Programme
ST	Scheduled Tribe
VHND	Village Health and Nutrition Day
WASH	Water, Sanitation and Hygiene

Abstract

Background

Bihar has one of the highest levels of undernutrition in the country. A set of proven direct nutrition interventions (DNIs) and nutrition sensitive actions can lower the undernutrition levels by addressing its immediate and underlying causes. These interventions are delivered through a mix of Centrally Sponsored and state-specific schemes across several departments, making their delivery mechanism complex. This poses several challenges in tracking their budgets in the state. The problem is compounded at the district level, where relevant data is difficult to obtain. In this paper, we documented the challenges confronted while tracking the budgets for nutrition in Bihar at both state and district levels.

Methods

We analysed the nutrition budgets for for four fiscal years viz. 2014-15, 2015-16, 2016-17 and 2017-18. At the state level, we studied the budgets for Direct Nutrition Interventions and Nutrition Sensitive Programmes and at the district level (Purnea district) focus was on maternal nutrition inventions delivered by the health department.

Results

In Bihar, the DNIs are delivered through 4 Centrally Sponsored Schemes (CSS) implemented by two Union Ministries. On the other hand, NSP are delivered through 18 CSS and 30 state level schemes implemented by 9 ministries / departments at the Union Government level and corresponding 16 departments at the state level. In carrying out this analysis we faced a number of challenges pertaining to (i) limited availability of disaggregated budget data at the state and district level; (ii) multiple agencies from where data had to be collected; (iii) difficulty in getting fund utilisation data for DNIs delivered by health department; (iv) non-availability of district-wise budget data in public domain; and (v) difficulties in segregating nutrition budgets in specific sectors due to overlapping objectives. Additionally, while trying to understand the magnitude of undernutrition in the state, we confronted challenges due to differences in definitions and indicators used in different nutrition surveys; and absence of information on nutritional indicators at the sub-district level.

Conclusion

Some of these challenges can be addressed by bringing more transparency in budgetary processes, by making budget information available in the public domain and by improving the data base on nutritional outcomes in the state. Initiating a state level survey customised to Bihar would be helpful in improving need based planning and facilitating informed policy making.

Bihar has high levels of under-nutrition which can be addressed by scaling up a set of proven nutrition interventions.

1 Introduction

Bihar is the third most populous state in India, with high levels of maternal and child undernutrition. Bihar is home to ~16 million children under five years of age (U5), almost half of whom suffer from chronic undernutrition (or stunting – short height for age). As per the NFHS-4, around 48% children U5 in Bihar are stunted (as of 2015-16), considerably higher than the national average of 38.4% (IIPS 2016). Other nutritional indicators for children U5 are equally poor; for example ~44% are underweight, 21% are wasted and 63.5% are anaemic. According to the NFHS-4, in Bihar 60.3% women aged 15-49 years are anaemic and 30.4% women (15-49 years) have a low body mass index (BMI <18.5 kg/m2). Around 58% of the pregnant women (15-49 years) suffer from anaemia – one of the reasons contributing to maternal deaths. To address undernutrition, there are a set of proven nutrition-specific or direct nutrition interventions (DNIs) which address the immediate causes of undernutrition, and nutrition-sensitive

programmes (NSP) that address the underlying and basic causes of undernutrition (Lancet 2013 nutrition series).

These interventions are included in the development programmes of Bihar and are delivered by a number of schemes and programmes, implemented by different departments, across various sectors (Sethi et al 2017). Thus the delivery of nutrition interventions is dependent on a complex web of multiple schemes and programmes implemented by a range of departments, with often overlapping functions and issues of coordination. The delivery of these nutrition interventions is through a mix of Centrally Sponsored Schemes (CSS), designed by the Union Government and jointly funded by the Union and state governments, and state-specific schemes, entirely designed and funded by the state governments. The implementation of both these kinds of schemes takes place at the district level and below, often with significant intra-state variations in their performance. While all three tiers are important in the process of delivering nutrition interventions, their roles in planning, budgeting and implementation differ. Moreover, the governance structures and institutions involved, availability and timeliness of budget documents, transparency and accountability mechanisms, etc. also differ at the three levels. Understanding budgets for nutrition interventions at these three levels – Union, state and district – is thus important.

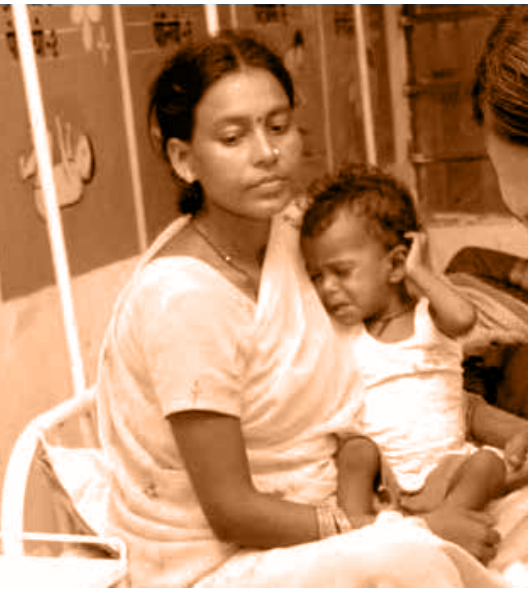
Given this backdrop and understanding of the delivery of nutrition interventions, the present paper attempts to document the challenges faced while tracking budgets for nutrition interventions in Bihar at the state-level and for maternal nutrition interventions at the district level (Purnea district).

Methods

We studied the budgets at the state level and at the district level, for district Purnea in Bihar. In the process of analysing the nutrition budgets, we also gathered insights on the planning, budgeting and implementation of nutrition programmes. For the state-level study, focus was on nutrition-specific and nutrition-sensitive interventions, whereas the district-level study focused on maternal nutrition interventions only.

For the state-level study, departments delivering nutrition-

Delivery of nutrition intervention depends on a complex web of multiple schemes and programmes implemented by various departments.



Both desk and field research were undertaken to collate budgets and understand fiscal bottlenecks in implementation.

specific and nutrition-sensitive programmes were identified, followed by mapping of schemes delivering these interventions. Thereafter, the budget outlays and actual expenditure were collated for nutrition interventions.

For the district-level study, we listed out the set of interventions for pregnant women from UNICEF (2016) report, and selected interventions delivered by the health department. Budget outlays and expenditure for these interventions were collated. In addition, field work was undertaken to understand the fund flow mechanism and identify fiscal challenges in delivering maternal nutrition interventions in the district.

Documents scanned and

Time-line used

The budget outlays and expenditure data was collated from the Detailed Demand for Grants (DDGs) for the relevant departments. For the interventions delivered through the National Health Mission (NHM), budgets were captured through the Programme Implementation Plans (PIPs), Record of Proceedings (ROPs), and the Financial Management Report (FMR) brought out by the Union Ministry of Health and Family Welfare (MoHFW 2014, 2015, 2016, 2017A, 2017B). The district-level budget data was obtained from the District Health Society (DHS), Purnea.

Prior to Fiscal Year (FY) 2017-18 the budget outlays in Bihar were reported under two expenditure

heads – Plan and the Non-Plan expenditure. The plan expenditure reported the budget outlays for schemes being implemented under the ongoing Five Year Plans, while the non-plan expenditure captured the committed expenditure of the government. However, from FY 2017-18, the Union Government merged the plan and non-plan heads of expenditure. Subsequently, Bihar also merged its plan and non-plan heads of expenditure from FY 2017-18, changing the reporting format of budgets in Bihar (Government of Bihar 2017). These changes have been kept in mind while tracking the budget outlays and expenditure data from Bihar Budget 2017-18.

The budget was collated for four fiscal years viz. 2017-18 (Budget Estimates), 2016-17 (Revised Estimates), 2015-16 (Actuals) and 2014-15 (Actuals). Bihar had presented its first supplementary budget for FY 2017-18 in August, 2017, which has been added to the Budget Estimates of FY 2017-18 (Government of Bihar 2017). The reason to compare actual expenditure with budget expenditure could be explained by the usual practice followed by the state finance department to refer to the actual expenditure of the previous years while determining allocations for the ensuing fiscal years. Therefore, comparing BE figures with AE figures would enable us to clearly identify the priorities of the state finance department.

We identified the budget heads[1] for the respective schemes, and tracked the budgets for nutrition interventions within the schemes.

Results

3.1 Delivery platforms for nutrition interventions in Bihar

The two types of nutrition interventions - Direct Nutrition Interventions (DNIs) and Nutrition Sensitive Programmes (NSP) in Bihar are delivered through set of Centrally Sponsored Schemes and state specific schemes. The DNIs in Bihar are delivered through 4 CSS namely Integrated Child Development Services (ICDS), SABLA, Indira Gandhi Matritva Sahyog Yojana (IGMSY) / Pradhan Mantri Matru Vandana Yojana (PMMVY) and National Health Mission (NHM); there are no state specific schemes for

DNIs and NSP in Bihar are delivered through set of Centrally Sponsored Schemes and state specific schemes.

1. The budget in India largely follow a six-tier classification – Major Head, Sub-Major Head, Minor Head, Sub-Minor head, Detailed Head and Object Head. The scheme level budget outlays are generally reported at the level of Minor Head or Sub-Minor Head.

DNIs and NSPs in Bihar are delivered through set of CSSs. There are no state specific DNIs in Bihar. Specific components under schemes deliver DNIs.

delivering the DNIs in Bihar. However, it is not the entire schemes, rather specific components within them that deliver the DNIs. These schemes are implemented by two Union ministries – Ministry of Health and Family Welfare (MoHFW) for National Health Mission and Ministry of Women and Child Development (MWCD) for ICDS, SABLA, and IGMSY / PMMVY at the Union level, and the corresponding departments – health and social welfare – at the state level.

The NSP in Bihar are delivered through a set of 18 CSS and 30 state level schemes spread across six sectors, making the delivery process complex. The CSS are delivered through 9 ministries / departments at the Union Government level and corresponding 16 departments at the state level. These departments at the state level include Agriculture; Fisheries and Animal Husbandry; Building Construction; Cooperative; Education; Industries; Public Health and Engineering; Rural Development; Urban Development; Health; Food and Consumer Protection; Labour Resource; Information and Public Relations; Social Welfare; Disaster Management; Planning and Development.

The health related maternal nutrition interventions are implemented by the District Health Society, which is the nodal agency for implementing NHM. The nutrition

interventions for pregnant women are largely delivered through fixed-day outreach activities of the health department. These include Village Health and Nutrition Day (VHND) and Pradhan Mantri Surakshit Matritva Abhiyaan (PMSMA). In addition, pregnant women can access these services at the nearest health centres.

3.2 Budget outlays for DNIs and NSP in Bihar

The total budget outlays for DNIs in Bihar was INR 1,778 crore in FY 2014-15, which declined to INR 1,540 crore in FY 2015-16, before increasing to INR 1,990 crore in FY 2016-17 and INR 2,695 crore in FY 2017-18. In all the four fiscal years under scrutiny, shares of DNIs budget has remained <2% of the total state budget, with a decline from 1.9% in FY 2014-15 to 1.5% in FY 2017-18. Within the total DNIs budget in FY 2017-18, ~76% budget was for supplementary feeding, ~18% for conditional cash transfers, and the remaining ~5-6% for behaviour change counselling, micronutrient supplementation and treatment of children with severe acute malnutrition. Due to lack of disaggregated budget data, it was not possible to collate budget outlays for maternal calcium, deworming and IFA supplementation.

The total budget for NSP was INR 11,272 crore in FY 2014-15 Actual Expenditure (AE), which increased to INR 23,759 crore in FY 2017-18 Budget Estimates (BE), an increase of 111%. The share of NSP budget in state's total budget, ranged between 12% and 14% during this period, showing a consistent increase since FY 2014-15 AE till FY 2016-17 Revised Estimates (RE), with a decline in current fiscal year. In FY 2017-18, food security and social safety nets sector had the highest share in the total NSP budget (34%), followed by education sector (20.9%), WASH sector (15.7%), poverty alleviation sector (14.4%), health sector (9.1%) and agriculture sector (6.5%).

3.3 Budget outlays for health related maternal nutrition interventions in Purnea:

Total budget for the maternal nutrition interventions included in our study was INR 2,504.6 lakh in FY 2014-15. This decreased to INR 2,083 lakh in FY 2015-16 and remained unchanged in FY 2016-17. Within maternal interventions budget, the component of safe delivery has the highest share (more than 90%) and this has increased in the last 3 years.

Budget outlay for the ANC component was INR 84.8 lakh for both FY 2015-16 and FY 2016-17. Both these values were less than half from that of FY 2014-15 (INR 198.2 lakh). The per capita spending on maternal interventions for 2014-15, 2015-16 and 2016-17 was INR 1,462, INR 1,748 and INR 1,431, respectively. Budget outlays for supplements (IFA tablet, Folic Acid, and Calcium) could not be obtained separately.

3.4 Challenges in tracking nutrition budgets at the state and district level:

Food security and social safety nets sector has the highest share in the total budget for NSPs in Bihar followed by education and WASH sector.

Multiple agencies delivering nutrition interventions, consulting a range of documents to collate information and different reporting format is a challenge in collating budget for nutrition in Bihar.

(i) Multiplicity of agencies adds to complexity in budget tracking at the state and district level:
Given the multiplicity of agencies / departments involved in the delivery of nutrition interventions, the process of budget tracking is very complex. The budget outlays and expenditure data have to be computed from across a range of departments, amounting to 16 departments for NSP alone. At the district level, the budget data has to be obtained from the nodal implementing agencies in respective sectors.

(ii) The data sources for collating budgets vary across interventions:
A range of documents were consulted to obtain budget outlays for nutrition interventions. The reporting format for each of these documents, and types of information they present differs considerably. For example, the DDGs follow a six-tier budget structure given by the CAG of India and present Actual Expenditure, Revised Estimates and Budget Estimates. On the other hand the ROPs under NHM do not report these values and instead report Proposed Outlays and Approved Outlays. In order to compile data on Actual Expenditure for health interventions, we had to use FMRs, which are not publically available in a regular and timely manner. District analysis was based entirely on the FMRs shared by the DHS. Thus, understanding the different documents, and collating these figures to arrive at nutrition budgets is another challenge that we confronted.

In addition to the above mentioned challenges relating to multiple departments and different data sources for tracking nutrition budgets, we faced several other challenges that are important to highlight. These are related to the analysing budgets for nutrition in Bihar, assessing their adequacy and tracking fund utilisation as well as availability of nutrition outcomes data at the state and district levels. These challenges have been discussed in the subsequent section.

Discussion

Some of these challenges such as the absence of a standard set of nutrition interventions, interventions being scattered across departments and schemes, differences in the framework followed by nutritionists and budget analysts, issues of assigning weights, etc. were highlighted by Sethi et al (2017). We also encountered these challenges while analysing public investment in nutrition for Bihar, however; in addition, there are other challenges that are discussed below.

1. Disaggregated budget outlays for maternal supplements are not available: Budgets for maternal IFA, calcium and deworming are reported under the budgets for *Janani Shishu Suraksha Karyakram* (JSSK), a programme under NHM. However, the disaggregated budget data for supplements under JSSK could not be accessed for FY 2017-18 at the state level[2] and for any study year at the district level. Also, even at the state level, we get combined budgets for IFA and Calcium supplementation, and not separate budgets for each. This makes it very difficult to know about the budgets for these interventions by the state government or the district.

2. Non-availability of beneficiary-wise disaggregated budget outlays: Most nutrition interventions, especially DNIs, are for different population groups such as children (0-6 years), adolescent girls, pregnant and lactating women, etc. However, the budgets for the schemes are not presented beneficiary-wise. As a result, it is not always possible to obtain population-wise disaggregated budget data for different interventions. For example, while studying budgets for Supplementary Nutrition Programme (SNP), it is

Non-availability of disaggregated data for maternal supplements and for various beneficiaries is a challenge in doing nuance analysis of the nutrition sector.

2. The budgets for IFA and calcium supplementation for pregnant women are reported under JSSK for FYs 2014-15, 2015-16 and 2016-17 at the state level. However, this has not been reported for FY 2017-18.

Non-availability of district-wise budget data in public domain constraints nutrition budget analysis at the district level

not possible to obtain segregated budget outlays for providing SNP to normal children (6 months to 6 years), severely underweight children (6 months to 6 years) and pregnant and lactating women. Hence, in our analysis we included the combined budget for these three interventions. Similarly, there are schemes promoting secondary education which are included as NSP in our analysis. This is because promotion of secondary education for girl child is an important nutrition sensitive intervention (Mebrahtu and Sethi 2016). However, these schemes are for both boys and girls and it is not possible to obtain budgets for promotion of secondary education among girls alone. As a result, the entire budget outlays are considered for our analysis, leading to overestimation of resources for a given intervention in some cases.

3. Non-availability of district-wise budget data: A major challenge in the context of Bihar is the non-availability of district-wise budget data in public domain. As a result, to analyse district budgets for any sector, one has to obtain the relevant information from the nodal agency / departmental unit. While states such as Maharashtra make these district budget books available in public domain (Government of Maharashtra, 2017a), Bihar does not do this. Availability of sector / scheme specific budget data is entirely

The Online Treasury Management System (OTMS) can be an important source of budget data at the district level. Most states have started putting the treasury data in the public domain. For example, the OTMS for Maharashtra, which is called Koshwahini (https://koshwahini.mahakosh.gov.in/kosh/kosh/ provides disaggregated budget data up to the district and object head level. It can be easily accessed by anyone and is a hands-on data source for district level budget tracking for various sectors.

contingent upon the concerned nodal authority, some of which do make such data available. For example, the State Health Society has uploaded the District FMRs on its website till FY 2015-16 but were not accessible on the website at the time of this study (State Health Society, Bihar 2017). However, from FY 2016-17 the FMRs have not been uploaded by SHS.

In our analysis of budgets for nutrition interventions for pregnant women in Purnea, data had to be obtained from the DHS, Purnea. If one wants to study the budgets for various districts in Bihar, one would have to collect the data from the departmental offices of various districts. This process of data collection is tedious and led to delay in our analysis. The state / district treasury, which can be an important source for such data, does not provide open access to general public (Government of Bihar 2017). This constrains the analysis at the district level significantly. This is in contrast with states like Uttar Pradesh and Maharashtra, which have Online Treasury Management Systems, open to public (Government of Uttar Pradesh, 2017; Government of Maharashtra, 2017b).

4. Data on fund utilisation for interventions contained in NHM is not easily available: Fund utilisation for interventions within NHM is reported in the FMR. These documents are not easily available in public domain. At the time of analysis, the state level expenditure data was available only for one year – FY 2016-17 – and therefore a trend analysis of expenditure for health DNIs was not possible. Moreover, the numbers reported in FMR are not audited figures, as compared to those reported (for other schemes) in the DDGs of the state departments.

5. Segregation of schemes in a specific nutrition-sector is difficult: Several schemes that are included in this analysis of nutrition budgets have multiple objectives, which correspond to one or more nutrition-sensitive sectors. Segregating these schemes into a particular nutrition-sensitive sector is thus difficult. Inclusion of these schemes in any one sector may also undermine importance of the scheme in addressing other

In Maharashtra, district budget books are available in public domain, Bihar does not do this. Its availability is entirely contingent upon the concerned nodal authority.

development issues. For example, MGNREGA is a wage employment scheme which has been considered under poverty alleviation sector of the NSP budget. But this scheme also contributes to the agriculture sector in facilitating a number of land development activities and has been critical in empowering women through its gender-sensitive components. Hence, drawing a clear boundary for the schemes, to be categorised under different sectors of NSP, poses a challenge. This in turn, leads to overestimation of the budget for a particular sector vis-à-vis other sectors.

Inability to define the nutrition-components within programmes, and segregate specific budgets leads to an overestimation of the nutrition budgets.

6. Assessing the quantum of nutrition-sensitive budgets is difficult: To analyse the budgets for NSP in Bihar, budgets were collated for schemes and programmes that are relevant from a nutrition perspective. These comprise the large social sector programmes across 6 sectors. Due to the inability to define the nutrition-components within these programmes, and segregate their specific budgets from the total scheme budgets, the entire budgets for the programmes and schemes were included in the NSP budget. Such an approach leads to an over-estimation of the nutrition budgets.

7. Information on physical coverage of schemes not available in public domain: In addition to analysing the budget outlays for nutrition interventions, an assessment of their physical outreach is an important indicator of the scheme performance. In our analysis, we attempted to access the Monthly Progress Reports for ICDS, which provide the number of ICDS beneficiaries for each category and the amount of SNP provided to them. This document was published regularly till FY 2015 (Ministry of Women and Child Development 2017). However, presently this information is not being provided in the public domain and we were unable to obtain the document from the department.

8. Non-availability of NFHS-4 nutritional indicators and budget data for different socio-economic groups: It is well-recognised that marginalised people from the Scheduled Tribes (STs)/Scheduled Caste (SCs) communities and the religious minorities have poorer nutritional status than the general population. Since the state-level reports for NFHS-4 (2015-16) are not yet available, we had to use RSOC (2013-14) for nutritional status of SCs and STs and NFHS-3 (2005-06) for religious minorities. The analysis of nutrition budgets specific to these communities cannot be done due to the paucity of disaggregated community-wise budget data for the schemes analysed in this study.

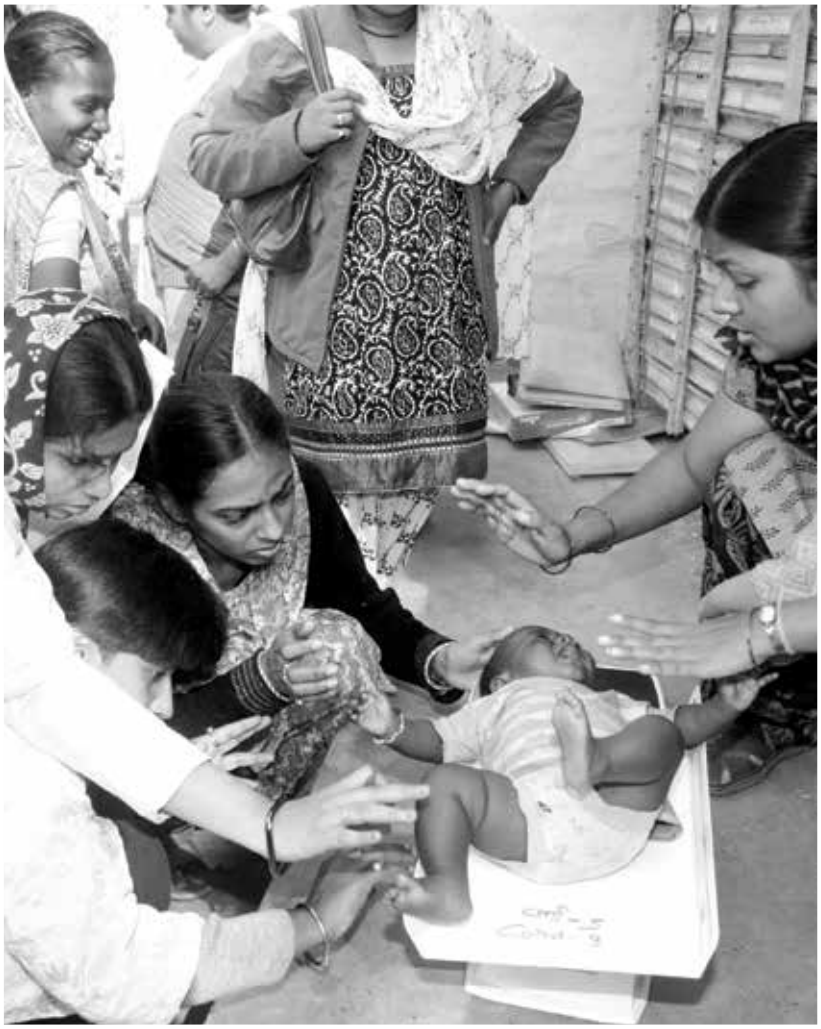
9. Challenges with data sources to track nutritional status and related indicators: Access to "regularly updated, readily accessible and comparable data sources on nutrition" are "essential both to understand the level of malnutrition in a country and to develop strategies to address it" (John et al. 2015, p 1). While John et al.

(2015) have assessed the geographic scope, frequency, availability, content, and comparability of data from major nutrition surveys in India, we encountered some additional gaps during our analysis at the state and district level, which have been described below:

i) Data sets are not uniform and comprehensive across all surveys (Figure 1). For example, RSOC 2013-14 reports information on severely stunted and severely underweight children, but this data is not available in NFHS-4. Similarly, these surveys do not capture data on anaemia among girls, women's height, childhood obesity, etc. Similarly the Health Management Information System (HMIS) (MoHFW 2015), which is the department generated data, does not collect information on nutritional status.

ii) Another challenge is that the indicators and definitions used in different surveys as well as the computation methods differ. For example, NFHS-4 provides proportion of women who 'consumed' IFA during pregnancy (9.7%), while the HMIS provides proportion of women who 'received' IFA during pregnancy (45.4%), which restricts a comparison. Similarly, the number

Indicators & definitions used and the computation methods differ in different surveys. Data sets are also not uniform and comprehensive across surveys.



Information on nutritional indicators is not available at the sub-district level affecting analysis at the sub-district level.

of home deliveries attended by a skilled birth attendant is computed from 'total deliveries' in the NFHS-4 and from 'total home deliveries' in HMIS 2015 reports. These issues make it difficult to compare the findings of different surveys, even for same indicators. At the same time, information on ANC services, such as checking of blood pressure, haemoglobin for anaemia and the ultra sound services is not captured by HMIS, which collects information for the health department delivering the ANC services. For interventions such as maternal calcium and deworming, no data is available from surveys or the HMIS.

iii) Absence of information on nutritional indicators at the sub-district level. While NFHS-4 gives data on nutritional indicators for national, state and district levels, block-wise variations in nutritional outcomes are not captured by this survey. Similarly, RSOC only provided the national and state level data; it does not collect data at the district level or below (Ministry of Women and Child Development 2015).

Lack of data on outcome indicators limits the understanding

on the scale of the problem in a state or district. Analysis on nutrition financing draws from the severity and nature of the problem (undernutrition or over-nutrition). Data on nutrition indicators help identify the target groups (children, women, adolescents etc.) and the type and scale of interventions required thereof. Therefore data on outcome indicators is important to develop an informed discourse on nutrition in general, and nutrition financing in particular.

Conclusion

Tracking budget outlays and expenditure for nutrition at the state and district level presents a range of challenges. These pertain to unavailability of relevant data as well as quality of the available data. Most of these challenges can be addressed by bringing more transparency to the process of budget preparation and implementation of various schemes and programmes. In addition, the data base on nutritional outcomes in the state also needs to be improved.

The paucity of relevant budget data is greater at district level than the state level in Bihar. The state or / and the district administrations should make budget data publically available at the district and sub-district level. This should be updated at regular intervals and in a timely manner. In this respect Bihar can learn from states such as Uttar Pradesh and Maharashtra, which have open access online treasuries being updated on a real-time basis. For the CSS, the Public Finance Management System, which has the budget and fund flow information for these schemes at all levels of governance, can also be tapped. The line departments too, should provide the schematic financial data in public domain.

At the same time, physical data on most schemes in Bihar is missing from the public domain. This restricts an independent assessment of the outreach and efficacy of schemes. Thus, various line departments should make the physical data of their schemes and programmes available in public domain, in a timely manner.

This will not only facilitate better analysis of the government's efforts in public provisioning of important services, but also improve the transparency and accountability of the government systems.

While availability of financial and physical data can solve a major part of the problem, it is also important to strengthen our data collection

Need to make budget preparation and implementation processes more transparent for addressing some of these data challenges

Bihar can initiate a state level survey customised to the state's context to capture the intra-state differentials in nutritional outcomes and outreach of government interventions

systems capturing information on nutritional and health outcomes. The difference in various surveys with regards to definitions, periodicity, methods, indicators captured, etc. need to be addressed. In this context, developing a basic standard set of indicators, which should be captured by various surveys, would be important. These should include indicators relevant for achieving the nutritional goals set by the government, and outreach of essential services. This would help streamline the surveys and ensure comparability in their findings.

In absence of such an effort at the national level, the Government of Bihar can initiate a state level survey in this domain, to capture the intra-state differentials in nutritional outcomes and outreach of government interventions. This would be customised to the state's context and can be conducted more regularly, compared to national surveys whose longer periodicity can be an issue. This would in turn, improve need based planning and facilitate informed policy making.

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Table 1: Reporting of indicators on nutritional status and coverage of essential nutrition interventions in different surveys

✓ Given indicator is being reported in the survey ✗ Given indicator not being reported in the survey

Indicator	NFHS-4: 2015-16			AHS 2012-13		HMIS 2015 (Annually)		RSOC 2013-14	
	National	State	District	State	District	State	District	National	State
ANC									
Currently Married Pregnant Women aged 15-49 years registered for ANC (%)	✗	✓	✓	✓	✓	✓	✓	✓	✓
Mothers who had antenatal check-up in the first trimester (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mothers who received any Antenatal Check-up (%)	✗	✗	✗	✓	✓	✗	✗	✓	✓
Mothers who had at least 3 antenatal care visits (%)	✗	✗	✗	✓	✓	✓	✓	✓	✓
Mothers who had at least 4 antenatal care visits (%)	✓	✓	✓	✗	✗	✗	✗	✓	✓
Mothers who had full antenatal care (%)	✓	✓	✓	✓	✓	✗	✗	✓	✓
Mothers who received at least one Tetanus Toxoid	✗	✗	✗	✓	✓	✓	✓	✗	✗
Received two or more Tetanus Toxoid (TT) injections	✗	✗	✗	✗	✗	✗	✗	✓	✓
Mothers whose last birth was protected against neonatal tetanus (%)	✓	✓	✓	✗	✗	✗	✗	✗	✗
Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	✓	✓	✓	✗	✗	✗	✗	✓	✓
Mothers whose Blood Pressure (BP) taken (%)	✗	✗	✗	✓	✓	✗	✗	✗	✗
Mothers whose Blood taken for Hb (%)	✗	✗	✗	✓	✓	✗	✗	✗	✗
Mothers who underwent Ultrasound (%)	✗	✗	✗	✓	✓	✗	✗	✗	✗
Number of Pregnant women given 100 IFA tablets	✗	✗	✗	✗	✗	✓	✓	✓	✓
Mothers who consumed IFA for 100 days or more when they were pregnant (%)	✓	✓	✓	✓	✓	✗	✗	✓	✓
Health and Nutritional Indicators for women and adolescent girls									
Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	✓	✓	✓	✗	✗	✗	✗	✗	✗
MMR (Maternal Mortality Ratio/ 1 lakh live births)	✗	✗	✗	✗	✗	✗	✗	✗	✗
Women (15-49 yrs) whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2) (%)	✓	✓	✓	✗	✗	✗	✗	✗	✗
Girls' between 15-18 years whose BMI is below normal (BMI < 18.5 kg/m2)(%)	✗	✗	✗	✗	✗	✗	✗	✗	✗
Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%)	✓	✓	✓	✗	✗	✗	✗	✗	✗
All women age 15-49 years who are anaemic (%)	✓	✓	✓	✗	✗	✗	✗	✗	✗

Table 1 (Continued)

Indicator	NFHS-4: 2015-16			AHS 2012-13		HMIS 2015 (Annually)		RSOC 2013-14	
	National	State	District	State	District	State	District	National	State
Deliveries									
Institutional births (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓
LBW									
Children with birth weight less than 2.5 Kg. (%)	✗	✗	✗	✗	✗	✓	✓	✓	✓
Nutrition interventions for children below 5 years									
Children age 9-59 months who received a vitamin A dose in last 6 months (%)	✓	✓	✓	✓	✓	✗	✗	✓	✓
Percentage of children aged 6-59 months who received IFA supplements in six months prior to survey	✗	✗	✗	✗	✗	✗	✗	✓	✓
Children under age 3 years breastfed within one hour of birth	✓	✓	✓	✓	✓	✓	✓	✗	✗
Children under age 2 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	✓	✓	✓	✗	✗	✗	✗	✗	✗

Notes:

AHS is Annual Health Survey being conducted by Registrar General of India

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