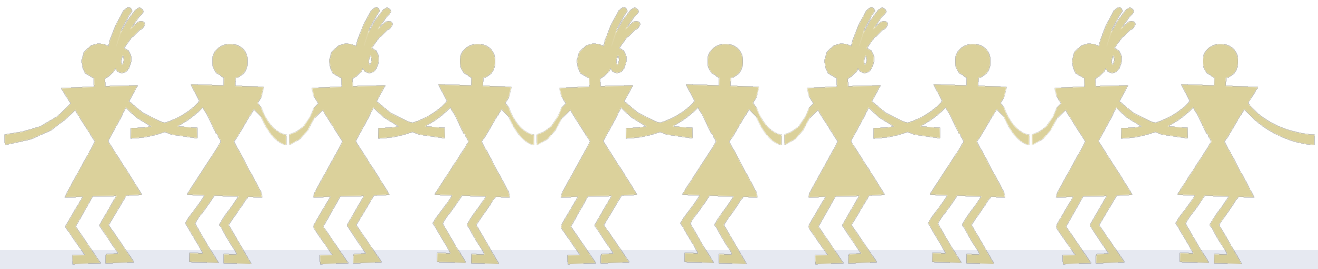
Jharkhand Economic Survey

2025–2026



Centre for Fiscal Studies
Department of Finance, Government of Jharkhand

Jharkhand Economic Survey

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Jharkhand Economic Survey 2025–26

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CHAPTER 12

12 Health and Nutrition

Jharkhand's health infrastructure, disease burden, and nutrition outcomes

12.1 Introduction

Healthcare constitutes a critical pillar in India's journey towards becoming a developed nation ('Viksit Bharat') by 2047. State governments play a pivotal role in this healthcare transformation through implementation of central schemes and state-specific initiatives. Strengthening primary healthcare remains a key focus, alongside improving maternal and child health outcomes across all districts.

Jharkhand, despite being a mineral-rich state, faces significant health and nutrition challenges. Key health issues include inadequate healthcare access particularly in remote and tribal areas, persistent malnutrition, the adverse impacts of poverty and illiteracy, and insufficient health infrastructure. The state confronts considerable malnutrition challenges including stunting, wasting, underweight children, and widespread anaemia among women and children.

The Government of Jharkhand has implemented numerous programmes to address these challenges, including the Integrated Child Development Services (ICDS), National Health Mission (NHM), mid-day meal schemes, and supplementary nutrition programmes. This chapter evaluates Jharkhand's healthcare progress during FY 2025-26, analysing health status of adults and children, health-seeking patterns, disease burden, health insurance coverage, infrastructure, manpower, and expenditure. The Jharkhand Economic Survey 2024-25 had reported a Maternal Mortality Ratio (MMR) of 76 per 100,000 live births and an Infant Mortality Rate (IMR) of 29 per 1,000 live births based on SRS 2020-22 data. Current SRS 2021-23 data shows further improvement, with MMR declining to 54 (a reduction of 29 per cent) and IMR declining to 25 (a reduction of 14 per cent), indicating sustained progress in maternal and child healthcare.

12.2 Health Status of Adults in Jharkhand

Adult health outcomes shape workforce productivity, maternal care quality, and long-term human capital formation. This section examines nutritional status, anaemia prevalence, and institutional delivery patterns in Jharkhand, drawing primarily on NFHS-5 (2019-21) data and departmental records for FY 2024-25.

According to NFHS-5, 26.2 per cent of women in Jharkhand have a Body Mass Index (BMI) below normal ($<$18.5 kg/m^2), compared to 17.1 per cent of men. The female underweight rate exceeds the national average of 18.7 per cent by 7.5 percentage points. Rural-urban disparities are pronounced: 28.4 per cent of rural women are underweight compared to 17.8 per cent in urban areas, a gap of 10.6 percentage points that is consistent with differential access to dietary diversity and healthcare services.

Anaemia remains a critical public health concern, affecting 65.3 per cent of women aged 15-49 years in Jharkhand, which is 8.3 percentage points above the national average of 57 per cent. Among pregnant women, anaemia prevalence stands at 62.6 per cent, with implications for birth weight, neonatal mortality, and maternal complications. The co-occurrence of undernutrition and anaemia among women of reproductive age underscores

the need for integrated nutrition and health interventions targeting this demographic.

12.2.1 Institutional Deliveries by Type

Institutional deliveries are critical for reducing maternal and neonatal mortality. Safe deliveries in health facilities ensure access to skilled birth attendants, emergency obstetric care, and immediate newborn care. According to NFHS-5, 62.4 per cent of deliveries in Jharkhand occur in health facilities.

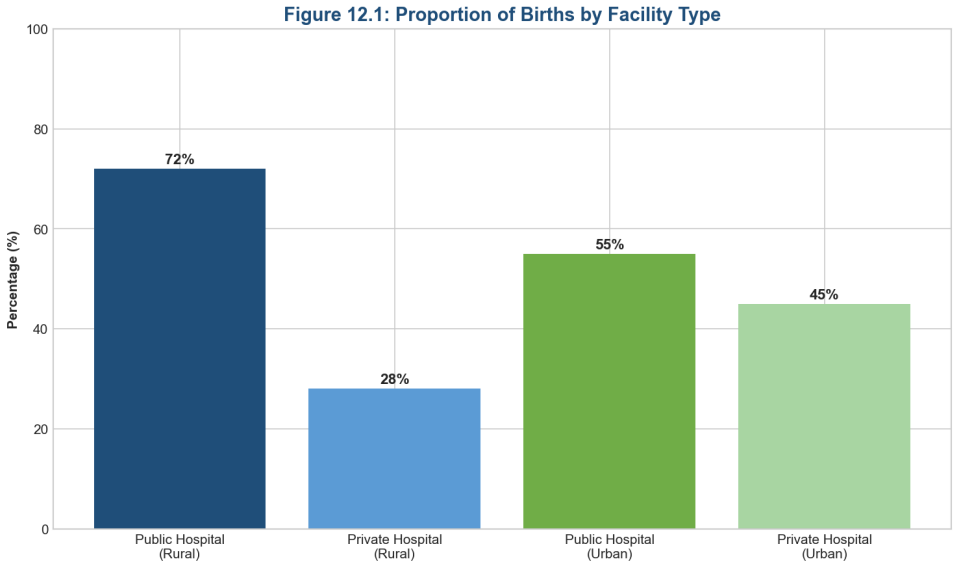

Figure 12.1. Proportion of births in public and private hospitals during 2020-21 to 2024-25

Source: National Family Health Survey (NFHS-5), 2019-21. Data period: 2019-21.

In rural areas, approximately 72 per cent of institutional deliveries occur in public hospitals, while in urban areas this proportion is 55 per cent. The higher reliance on public facilities in rural areas reflects both the limited availability of private healthcare and the success of government programmes such as JSY in promoting institutional deliveries.

12.2.2 Births in Health Facilities Receiving Financial Assistance under JSY

The Janani Suraksha Yojana (JSY) is a key initiative under the National Health Mission aimed at reducing maternal and neonatal mortality by promoting institutional deliveries among poor pregnant women. Under this scheme, eligible women receive cash incentives for delivering in government health facilities. Accredited Social Health Activists (ASHAs) play a crucial role in identifying pregnant women and facilitating their access to healthcare facilities.

The state recorded 5,50,897 institutional deliveries under JSY in FY 2024-25, an increase from approximately 5.2 lakh deliveries reported in the Jharkhand Economic Survey 2024-25

for FY 2023-24. This represents a growth of approximately 5.8 per cent year-on-year. District-wise analysis reveals significant variations. Garhwa district recorded the highest coverage with 41,419 deliveries, followed by Dumka (37,633), Palamu (35,017), and Ranchi (34,067). Districts with lower JSY coverage include Khunti (8,831), Saraikela (10,239), and Lohardaga (10,424), requiring focused attention to improve outreach.

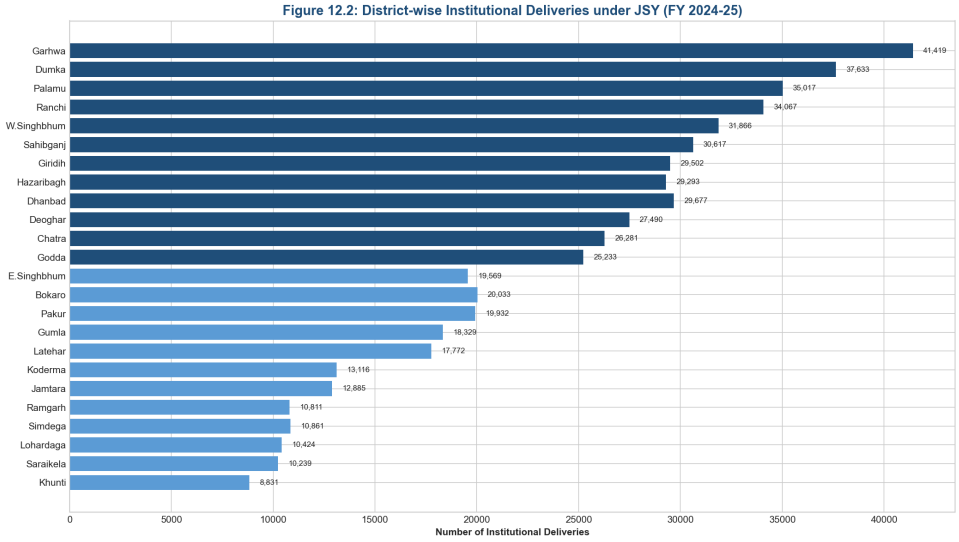

Figure 12.2. District-wise coverage of institutional deliveries under Janani Suraksha Yojana during 2020-21 to 2024-25

Source: National Health Mission, Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data period: FY 2020-21 to FY 2024-25.

12.3 Health Status of Children in Jharkhand

Children's health serves as a key indicator of overall state development. Multiple factors influence child health including maternal health status, nutritional intake, healthcare access, educational attainment, and socio-economic conditions.

Key mortality indicators from SRS 2022 reveal encouraging progress:

- **Infant Mortality Rate (IMR):** 25 per 1,000 live births (India: 28)
- **Neonatal Mortality Rate (NNMR):** 17 per 1,000 live births (India: 19)
- **Under-Five Mortality Rate (U5MR):** 27 per 1,000 live births (India: 32)

However, nutritional status according to NFHS-5 indicates persistent challenges:

- **Stunting** (low height-for-age): 39.6 per cent (India: 35.5%)
- **Wasting** (low weight-for-height): 22.4 per cent (India: 19.3%)
- **Underweight** (low weight-for-age): 39.4 per cent (India: 32.1%)
- **Anaemia** among children (6-59 months): 67.5 per cent (India: 67.1%)

12.3.1 Immunisation Levels

Full immunisation coverage is critical for protecting children from vaccine-preventable diseases. The Universal Immunisation Programme covers multiple antigens including BCG, Hepatitis B, OPV, Pentavalent, Rotavirus, PCV, Measles-Rubella, and DPT boosters. Jharkhand's immunisation performance has improved steadily, with full immunisation coverage rising from 84.6 per cent in FY 2023-24 to 86.2 per cent in FY 2024-25 according to departmental records, and further to 89.7 per cent as of December 2025.

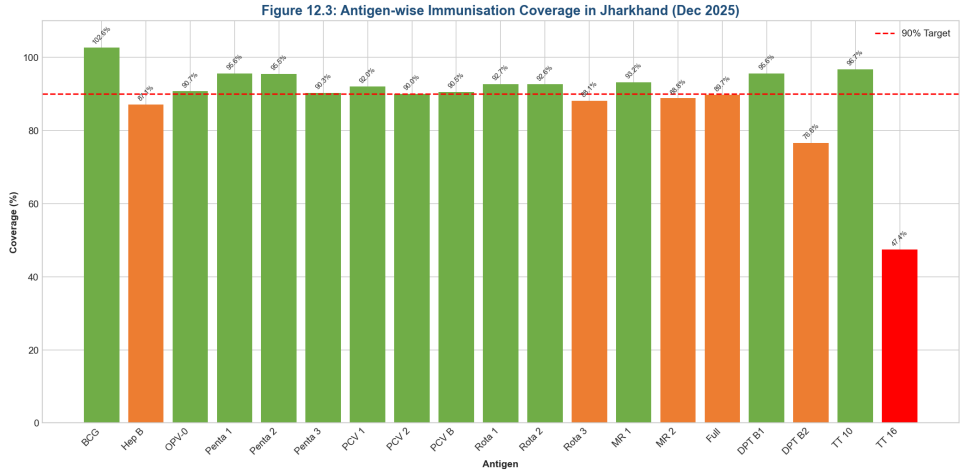

Figure 12.3. Full Immunisation among children at critical age months during 2020-21 to 2025-26

Source: Immunisation Division, Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

Figure 12.3 presents antigen-wise achievement as of December 2025. BCG coverage stands at 102.6 per cent, indicating immunisation is reaching children beyond the estimated birth cohort. Among individual antigens, MR-1 coverage improved from 94.2 per cent in FY 2023-24 to 95.1 per cent in FY 2024-25, while MR-2 rose from 86.4 per cent to 88.3 per cent over the same period. However, certain antigens require attention: TT coverage at 16 years stands at only 47.4 per cent and DPT Booster 2 at 76.6 per cent. The gap between primary doses (above 93 per cent) and booster doses (below 80 per cent) points to dropout during the later stages of the immunisation schedule and suggests a need for school-based immunisation campaigns and adolescent health outreach.

12.4 Health Seeking Pattern in Jharkhand

Healthcare utilisation patterns indicate the extent to which the population accesses available health services and reflect both supply-side capacity and demand-side awareness. In Jharkhand, where 75 per cent of the population is rural and a substantial share resides in forested and tribal areas, geographic accessibility and facility availability are key determinants of health-seeking behaviour. This section examines trends in inpatient and outpatient

utilisation across government hospitals from FY 2018-19 to FY 2024-25, with district-level analysis to identify areas of high and low service uptake.

12.4.1 Number of Inpatients Visiting Government Hospitals

Inpatient admissions serve as a proxy for the utilisation of secondary and tertiary care, reflecting both disease burden and the capacity of the hospital network to provide admission-based treatment. The total number of inpatients in government hospitals increased from 7.71 lakh in FY 2018-19 to 9.17 lakh in FY 2024-25, representing cumulative growth of 18.9 per cent over seven years. The Jharkhand Economic Survey 2024-25 had reported 8.56 lakh IPD admissions for FY 2023-24; the current figure of 9.17 lakh represents a further year-on-year increase of 7.1 per cent.

The COVID-19 pandemic caused a sharp dip to 5.01 lakh in FY 2020-21, a decline of 35 per cent from the pre-pandemic level. However, admissions recovered to 6.24 lakh by FY 2021-22 and have exceeded pre-pandemic levels since FY 2022-23. This recovery trajectory is consistent with the expansion of Ayushman Bharat cashless treatment, addition of new facility capacity, and increased outreach through mobile health units in remote populations.

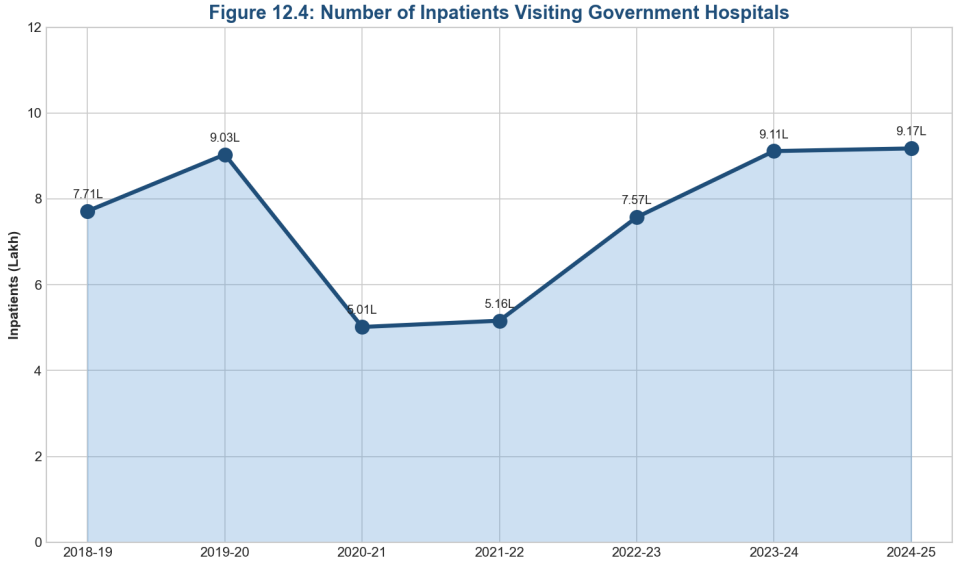

Figure 12.4. Number of inpatients visiting government hospitals during 2018-19 to 2024-25

Source: Health Management Information System (HMIS), Government of Jharkhand. Data period: FY 2018-19 to FY 2024-25.

Ranchi district recorded the highest inpatient admissions at 1.43 lakh in FY 2024-25, reflecting its status as the state capital with RIMS and other major tertiary care hospitals. Other districts with high IPD include East Singhbhum (87,116), Dumka (58,814), and West Singhbhum (54,507).

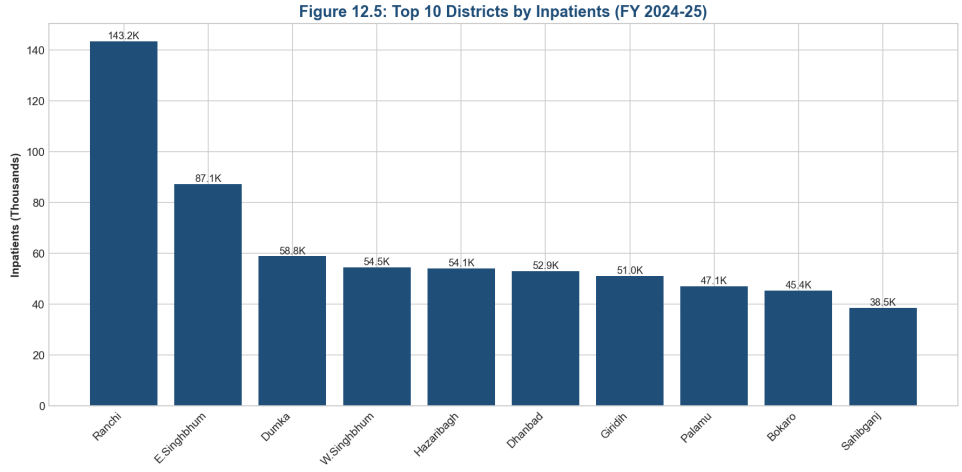

Figure 12.5. District-wise number of inpatients visiting government hospitals during 2024-25

Source: Health Management Information System (HMIS), Government of Jharkhand. Data period: FY 2024-25.

12.4.2 Number of Outpatients Visiting Government Hospitals

Outpatient Departments (OPDs) provide accessible healthcare for common ailments including fevers, infections, respiratory illnesses, and chronic conditions. They also address seasonal diseases such as malaria, dengue, and waterborne illnesses. OPDs serve as the first point of contact for many patients seeking healthcare.

Outpatient visits have shown remarkable growth, increasing from 95.49 lakh in FY 2020-21 to 2.46 crore in FY 2024-25, representing a 157.1 per cent increase. Compared to the 2.15 crore OPD visits reported in the Jharkhand Economic Survey 2024-25 for FY 2023-24, the current year shows an increase of 14.4 per cent. This substantial increase reflects improved healthcare access, enhanced public confidence in government health facilities, and the expansion of Ayushman Arogya Mandirs providing comprehensive primary care services.

Ranchi district recorded the highest OPD attendance of 34.26 lakh in FY 2024-25, followed by East Singhbhum (17.76 lakh), Palamu (15.56 lakh), and Dhanbad (13.81 lakh). Challenges remain including long waiting times, overburdened staff, and limited resources in high-volume facilities.

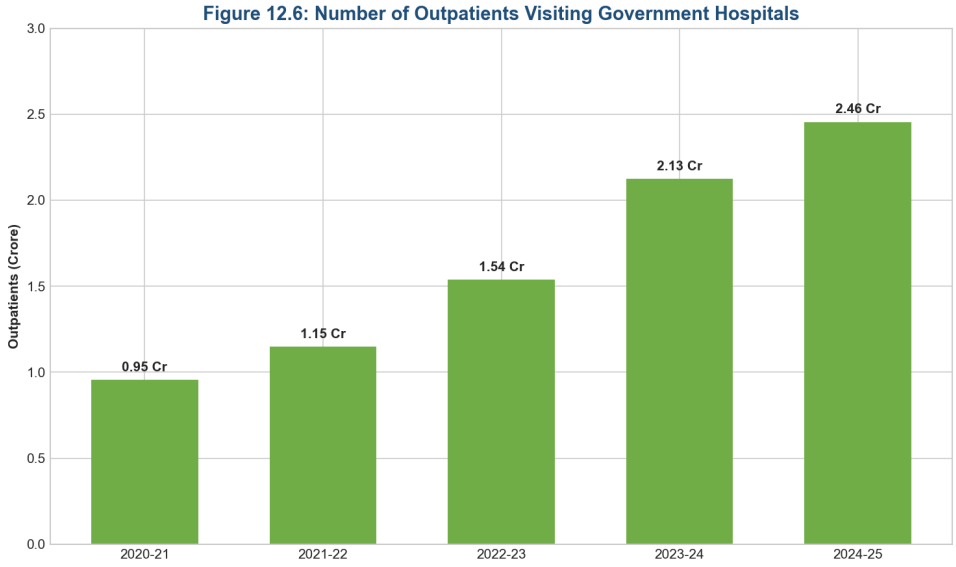

Figure 12.6. Number of outpatients visiting government hospitals during 2020-21 to 2024-25

Source: Health Management Information System (HMIS), Government of Jharkhand. Data period: FY 2020-21 to FY 2024-25.

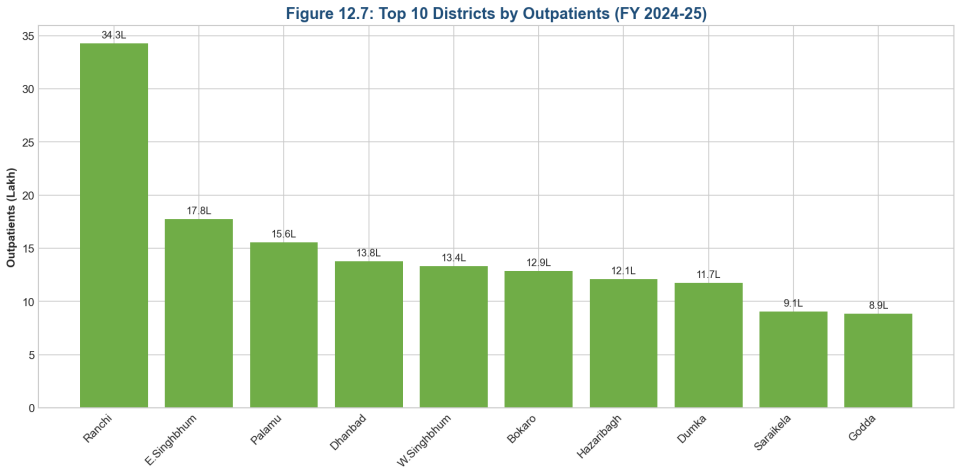

Figure 12.7. District-wise number of outpatients visiting government hospitals during 2024-25

Source: Health Management Information System (HMIS), Government of Jharkhand. Data period: FY 2024-25.

12.5 Disease Burden

Figure 12.8: Disease Burden Composition in Jharkhand (FY 2025-26)

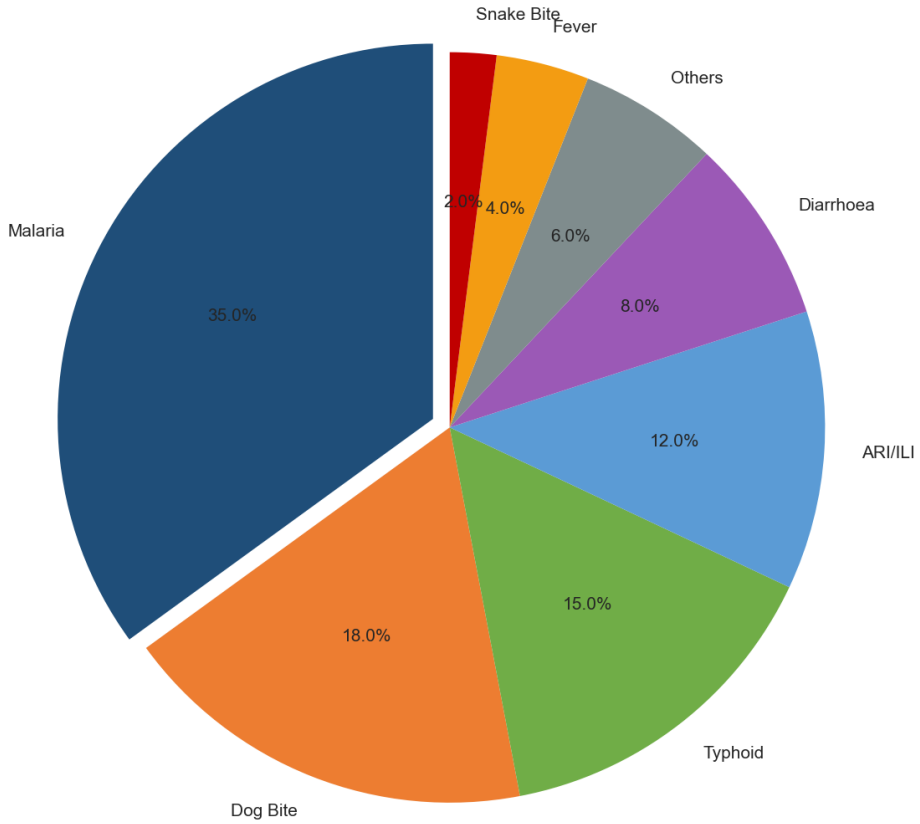

Figure 12.8. Major diseases burden in FY 2025-26

Source: Integrated Disease Surveillance Programme (IDSP), Jharkhand. Data period: FY 2025-26 (provisional).

The pattern and magnitude of disease burden shape healthcare demand and inform resource allocation priorities. In Jharkhand, communicable diseases remain the dominant component of morbidity, driven by environmental and socio-economic factors such as biomass fuel use for cooking (prevalent in 57 per cent of households per NFHS-5), limited access to piped drinking water in rural areas, and constrained healthcare access in forested terrain. This section analyses the major disease categories reported under the Integrated Disease Surveillance Programme (IDSP), with a focus on malaria, ARI/ILI, and typhoid, which together account for over 60 per cent of the reported disease burden in FY 2025-26.

Figure 12.8 presents the disease burden composition for FY 2025-26. Malaria accounts for the largest share at 35 per cent, followed by dog bite (18 per cent), typhoid (15 per cent), ARI/ILI (12 per cent), and acute diarrhoeal disease (8 per cent). The remaining cases com-

prise fever with rash, snake bites, and other conditions. The dominance of vector-borne and waterborne diseases in this composition is consistent with the environmental and infrastructure challenges noted above, and underscores the importance of convergence between health interventions and WASH programmes.

12.5.1 Incidence of Malaria

Malaria remains a significant public health challenge in Jharkhand. The state's dense forest cover provides favourable environmental conditions for mosquito breeding, particularly the *Anopheles* vector. High-risk districts include West Singhbhum, Simdega, Saraikela Kharsawan, and Gumla, which have higher Annual Parasite Index (API). Low-risk districts include Bokaro, Dhanbad, and Ramgarh.

Control measures implemented include distribution of insecticide-treated bed nets (ITNs), indoor residual spraying (IRS), active case detection through ASHAs, and prompt treatment with artemisinin-based combination therapy (ACT).

Table 12.1. Number of malaria patients per lakh population during 2018-19 to 2025-26

Year	Population	Total Cases	Pf Cases	Deaths	API
2018-19	3,86,03,000	57,095	41,330	20	147.88
2019-20	3,90,39,000	60,008	39,498	10	153.72
2020-21	3,94,80,000	20,694	12,541	0	52.42
2021-22	3,99,27,000	13,672	9,247	2	34.24
2022-23	4,00,81,000	13,773	8,951	1	34.35
2023-24	4,00,81,000	33,310	24,137	3	83.10
2024-25	4,00,81,000	42,306	28,789	3	105.54
2025-26*	4,00,81,000	9,131	5,919	2	22.78

Source: National Vector Borne Disease Control Programme (NVBDCP), Jharkhand. Data period: FY 2018-19 to FY 2025-26 (up to December 2025). Previous year data as reported in Jharkhand Economic Survey 2024-25.

Note: * Provisional data up to December 2025. API = Annual Parasite Index per lakh population. Pf = Plasmodium falciparum

12.5.2 Acute Respiratory Infection (ARI) / Influenza Like Illness (ILI)

ARI/ILI constitutes a significant public health challenge, particularly affecting vulnerable populations including children under five years and the elderly. Contributing factors include use of biomass fuel for cooking (prevalent in 57% of households), overcrowded living conditions, seasonal temperature variations, and limited healthcare access in remote rural areas.

ARI/ILI cases have shown a declining trend from 29,993 in FY 2020-21 to 14,830 in FY 2025-26 (provisional), representing a decline of 50.6 per cent. Districts with highest cases

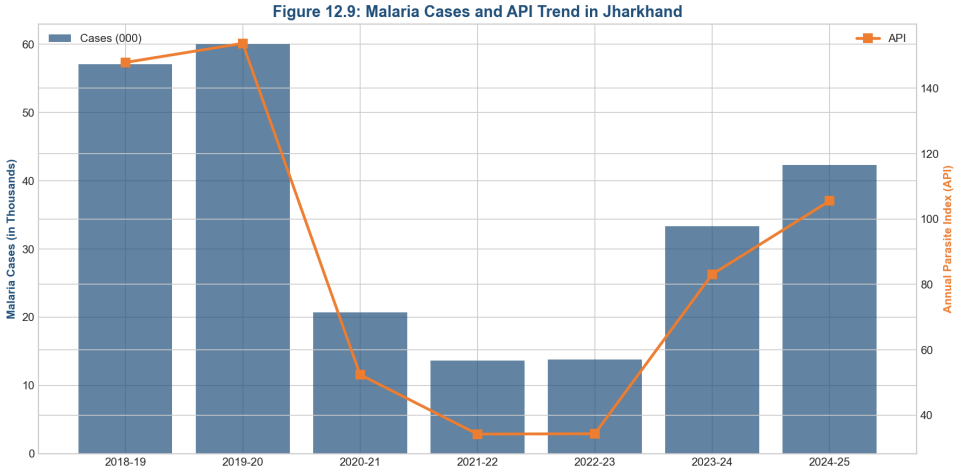

Figure 12.9. Malaria cases during 2018-19 to 2024-25

Source: National Vector Borne Disease Control Programme (NVBDCP), Jharkhand. Data period: FY 2018-19 to FY 2024-25.

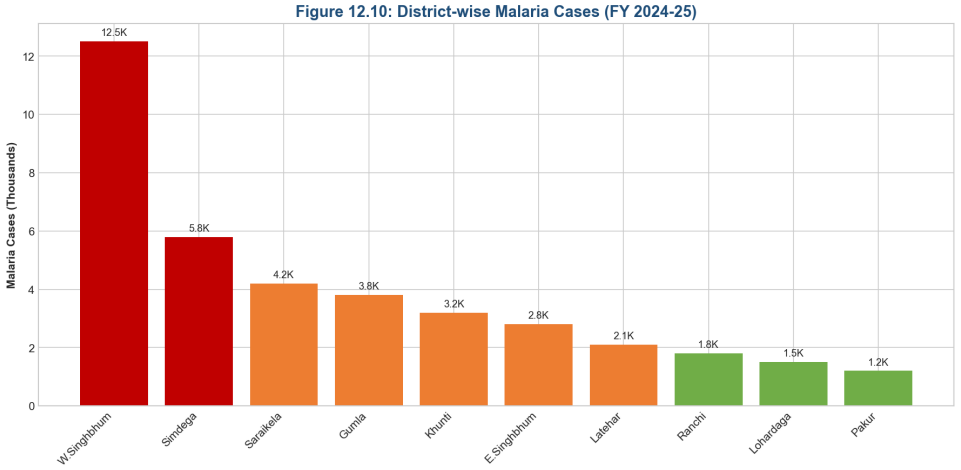

Figure 12.10. District-wise number of Malaria cases during 2024-25

Source: National Vector Borne Disease Control Programme (NVBDCP), Jharkhand. Data period: FY 2024-25.

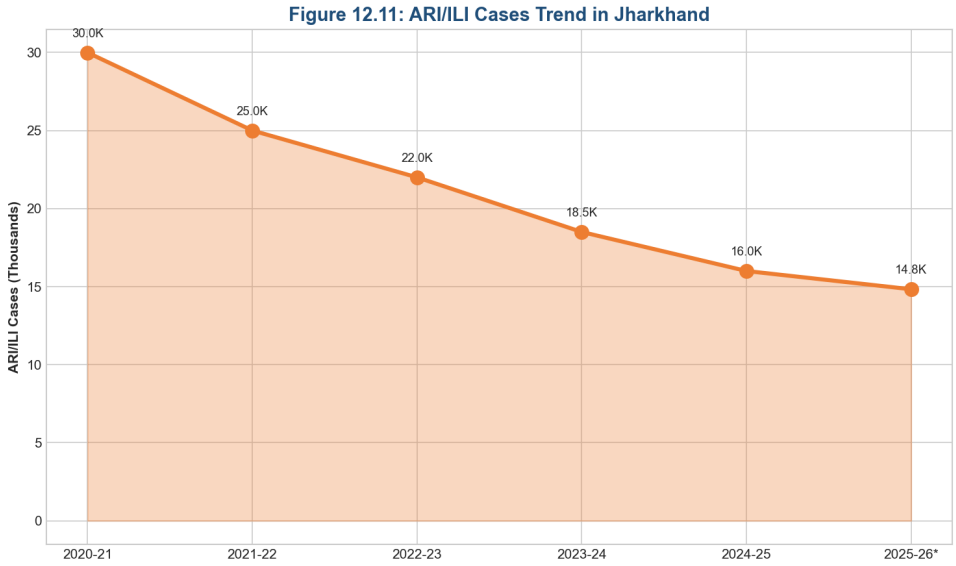

Figure 12.11. ARI/ILI cases during 2020-21 to 2025-26

Source: Integrated Disease Surveillance Programme (IDSP), Jharkhand. Data period: FY 2020-21 to FY 2025-26.

include Koderma (2,745), Latehar (2,248), and Simdega (761). Districts with lowest cases include Jamtara, Pakur, and Godda.

12.5.3 Prevalence of Typhoid

Typhoid fever, caused by the bacterium *Salmonella Typhi*, is associated with poor sanitation, limited access to safe drinking water, and improper waste management. Rural areas are particularly vulnerable due to limited healthcare access and delayed diagnosis. The monsoon season witnesses increased outbreaks due to water contamination.

Government initiatives to control typhoid include water quality improvement programmes under Jal Jeevan Mission, typhoid conjugate vaccine (TCV) introduction in the immunisation schedule, and hygiene awareness campaigns through Swachh Bharat Mission.

Typhoid cases have declined from 55,109 in FY 2020-21 to 11,421 in FY 2025-26 (provisional), representing a remarkable decline of 79.3 per cent. This improvement reflects the impact of improved drinking water access and sanitation infrastructure.

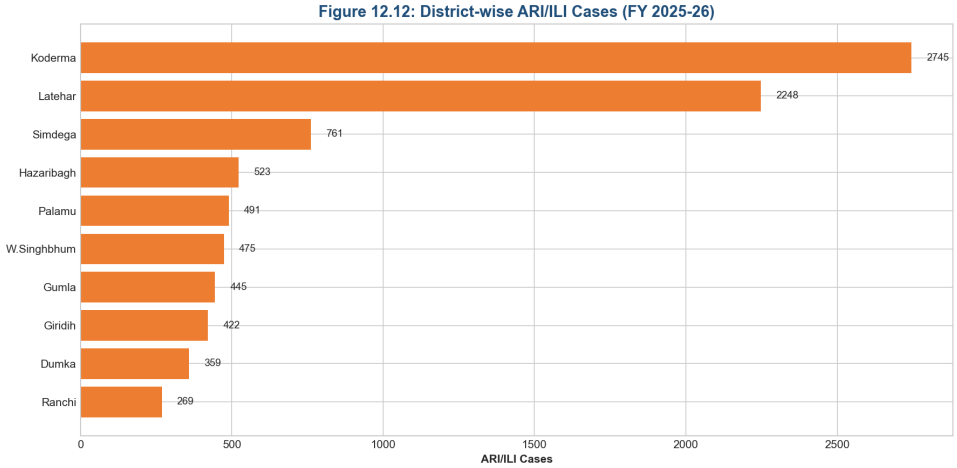

Figure 12.12. District-wise number of ARI/ILI cases in Jharkhand during 2025-26

Source: Integrated Disease Surveillance Programme (IDSP), Jharkhand. Data period: FY 2025-26 (provisional).

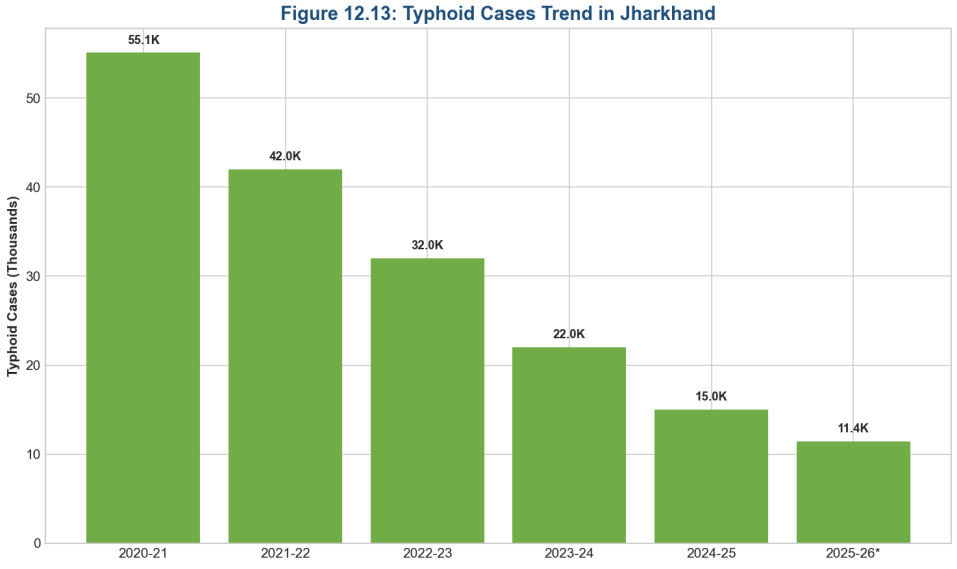

Figure 12.13. Prevalence of Typhoid during 2020-21 to 2025-26

Source: Integrated Disease Surveillance Programme (IDSP), Jharkhand. Data period: FY 2020-21 to FY 2025-26.

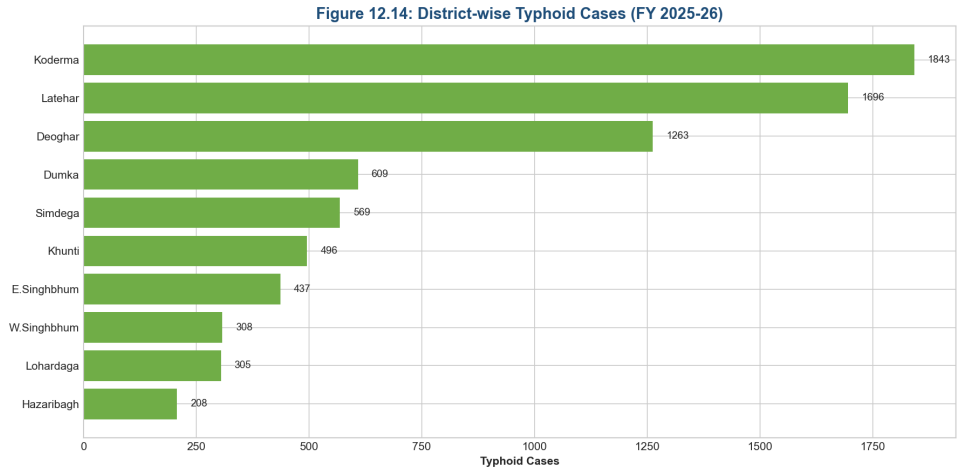

Figure 12.14. District-wise number of Typhoid cases during 2025-26

Source: Integrated Disease Surveillance Programme (IDSP), Jharkhand. Data period: FY 2025-26 (provisional).

12.6 Health Insurance

The Pradhan Mantri Jan Arogya Yojana (PMJAY) under Ayushman Bharat provides health coverage of Rs. 5 lakh per family per year for secondary and tertiary care hospitalisation to eligible beneficiaries identified through SECC database. The scheme has significantly improved access to quality healthcare for economically vulnerable households in Jharkhand, particularly benefiting rural and tribal communities.

Medical services covered under PMJAY include general surgery, neurosurgery, respiratory care, cardiology interventions, neonatal intensive care, orthopaedic procedures, and general medicine. The scheme operates on a cashless and paperless basis at empanelled hospitals.

Table 12.2. Number of hospitals empanelled (Public and Private) under PMJAY

Category	Number	Share (%)
Government of India Hospitals	17	3.1
State Government Hospitals	221	40.2
Private Hospitals	312	56.7
Total Empanelled	**550**	**100.0**

Source: State Health Agency (SHA), Jharkhand. Data as on January 2026.

Cumulative claims paid under PMJAY have crossed Rs. 2,553 crore, benefiting over 19.34 lakh patients. Annual claims disbursement has grown from Rs. 265.74 crore in FY 2020-21 to Rs. 540.84 crore in FY 2024-25, representing a growth of 103.5 per cent. The Jharkhand Economic Survey 2024-25 had reported approximately 6.89 lakh claims in FY 2023-24; the

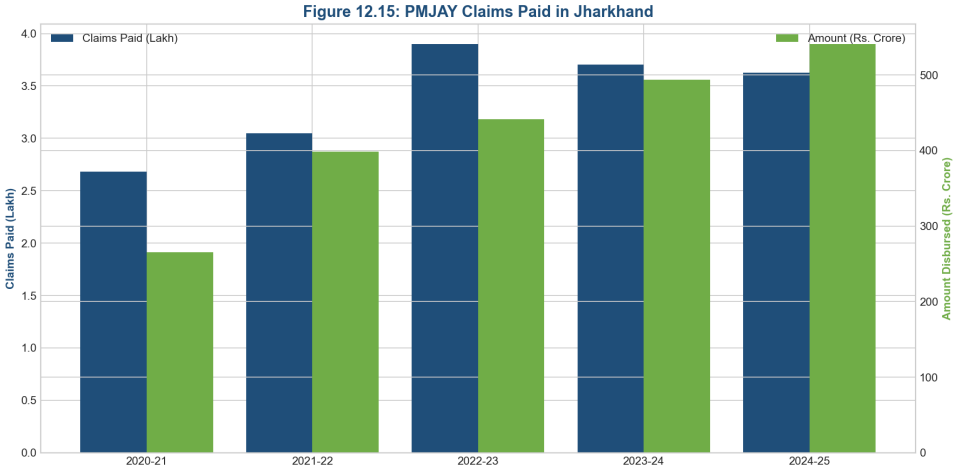

Figure 12.15. Number of claims and amount disbursed under PMJAY during 2020-21 to 2024-25

Source: State Health Agency (SHA), Jharkhand. Data period: FY 2020-21 to FY 2025-26 (up to 22nd January 2026).

current year records 8.50 lakh claims, a growth of 23.4 per cent, indicating rapid expansion of health insurance utilisation.

Table 12.3. District-wise PMJAY claim share during 2020-21 to 2025-26

District	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Ranchi	15%	13%	18%	19%	19%	18%
East Singhbhum	11%	7%	7%	9%	9%	9%
Dhanbad	7%	8%	6%	5%	5%	6%
Giridih	6%	8%	6%	6%	6%	6%
Bokaro	5%	6%	7%	5%	6%	6%
Hazaribagh	5%	6%	5%	5%	6%	6%
Palamu	5%	5%	5%	5%	5%	4%
West Singhbhum	5%	5%	4%	4%	4%	4%
Other Districts	41%	42%	42%	42%	40%	41%

Source: State Health Agency (SHA), Jharkhand. Data period: FY 2020-21 to FY 2025-26, as on January 2026.

12.7 Health Infrastructure in Jharkhand

The availability and distribution of health facilities determines access to care, particularly in a geographically diverse state where a substantial share of the population resides in remote and tribal areas. This section examines the network of public health institutions and bed capacity across districts, identifying spatial patterns in infrastructure availability.

Jharkhand has a total of 4,996 government health institutions comprising Sub-Health

Centres (SHCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-Divisional Hospitals (SDHs), District Hospitals (DHs), and Medical Colleges. The state has 16,719 hospital beds in government facilities. While the overall network has expanded, the distribution across districts remains uneven. Areas requiring continued attention include strengthening diagnostic capacity in peripheral facilities, improving access in forested terrain, and bridging infrastructure gaps in tribal-dominated districts.

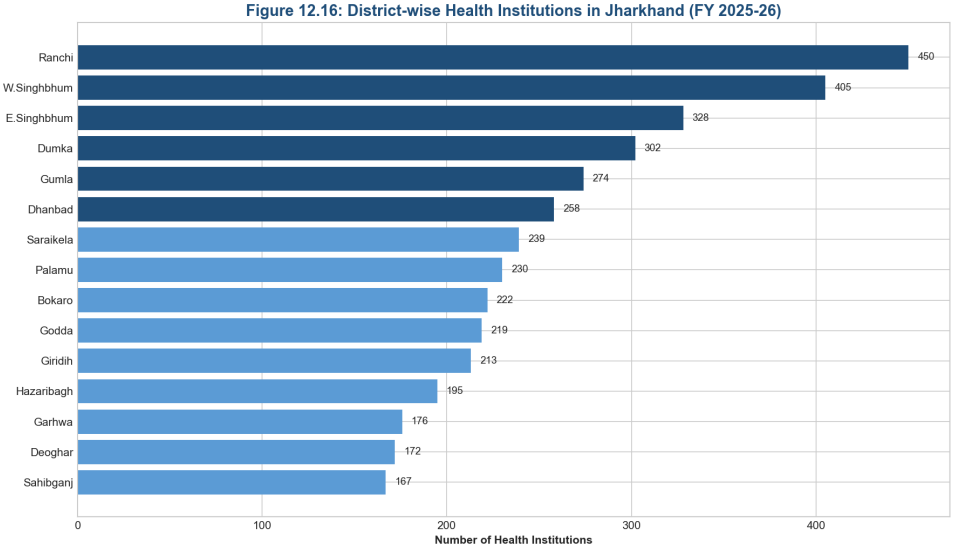

Figure 12.16. District-wise number of health institutions in FY 2025-26

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on FY 2025-26.

Figure 12.16 presents the district-wise distribution of these 4,996 institutions. Ranchi leads with 450, followed by West Singhbhum (405), East Singhbhum (328), and Dumka (302). At the other end, Ramgarh (98), Koderma (102), and Lohardaga (114) have the fewest institutions. The top four districts account for nearly 30 per cent of all facilities, while the bottom four account for under 9 per cent. This concentration is partly explained by geographic area and population size, but also points to scope for expanding the facility network in underserved districts through new Sub-Health Centres and upgraded PHCs.

Figure 12.17 shows the district-wise distribution of the 16,719 government hospital beds. Ranchi alone accounts for 3,688 beds, or 22 per cent of the state total, reflecting its role as the state capital with RIMS and other tertiary facilities. East Singhbhum (1,165), Dhanbad (1,117), and West Singhbhum (1,059) follow. Districts with lower bed capacity include Lohardaga (199), Ramgarh (233), and Koderma (296). The concentration of bed capacity in a few urban centres means that patients from peripheral districts often travel long distances for inpatient care. Expanding bed capacity at district and sub-divisional hospitals in lower-ranked districts would help reduce this dependence and improve access to secondary care closer to the population.

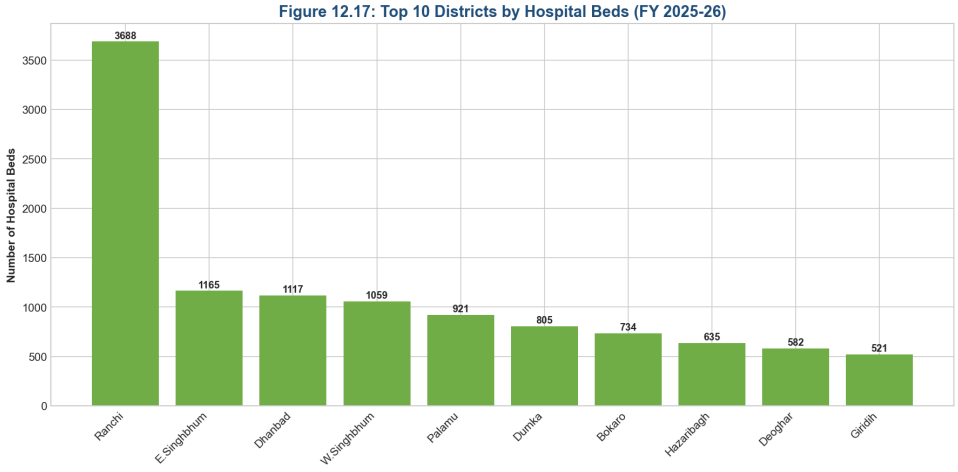

Figure 12.17. District-wise number of hospital beds in FY 2025-26

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on FY 2025-26.

12.8 Health Manpower in Jharkhand

The effectiveness of health infrastructure depends on the availability and deployment of trained personnel. Workforce adequacy is measured by fill rates against sanctioned positions across cadres including doctors, nurses, ANMs, paramedics, and community health workers. This section examines staffing levels across key cadres as of December 2025, drawing on data from the Department of Health, Medical Education and Family Welfare.

Across all cadres, the overall fill rate for the state's health workforce stands below full strength, with vacancies ranging from under 5 per cent for ASHAs to over 45 per cent for specialist doctors (Figure 12.19). Government initiatives to address these gaps include recruitment drives, establishment of new medical colleges (AIIMS Deoghar, medical colleges in Palamu, Dumka, and Hazaribagh), and skill development programmes. Community Health Officers (CHOs) and ASHAs under Ayushman Bharat Health and Wellness Centres (AB-HWCs) have expanded the reach of primary healthcare, providing comprehensive services including screening for non-communicable diseases at the grassroots level.

12.8.1 Medical Officers (MO) MBBS

Medical Officers posted at PHCs and CHCs serve as the first point of clinical contact for the rural population. Their availability determines whether a facility can provide curative care, emergency stabilisation, and appropriate referrals. Table 12.4 presents the current staffing status for this cadre.

Against 2,280 sanctioned positions, 1,613 are filled as of December 2025, yielding a fill rate of 70.7 per cent and leaving approximately 667 positions vacant. This vacancy rate is particularly consequential at the PHC level, where a single Medical Officer is often the only

Table 12.4. Status of Medical Officers (MBBS) in Jharkhand as on December 2025

Category	Sanctioned	Filled	Fill Rate (%)
Medical Officers (MBBS)	2,280	1,613	70.7

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

doctor available. Remote and tribal-dominated districts face greater difficulty in attracting and retaining doctors, contributing to spatial concentration of vacancies.

To address this gap, the state has implemented incentive schemes for postings in difficult areas and compulsory rural service bonds for graduates of state-funded medical colleges. The establishment of new medical colleges at Palamu, Dumka, and Hazaribagh, alongside AIIMS Deoghar, is expected to expand the pipeline of MBBS graduates available for government service over the medium term.

12.8.2 Grade A Nurse

Registered Nurses (Grade A) are essential for hospital-based care, providing direct patient services including medication administration, surgery assistance, diagnostic support, and patient education. Adequate nurse staffing is closely associated with patient safety outcomes, particularly in CHCs and district hospitals where inpatient load has been rising. Table 12.5 presents the current status.

Table 12.5. Status of Grade A Nurses in Jharkhand as on December 2025

Category	Sanctioned	Filled	Fill Rate (%)
Grade A Nurses	1,325	810	61.1

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

Of 1,325 sanctioned positions, only 810 are filled, yielding the lowest fill rate among the three primary clinical cadres at 61.1 per cent. The resulting vacancy of approximately 515 positions constrains the capacity of facilities to manage inpatient care, particularly during peak disease seasons when bed occupancy rises. Unlike the Medical Officer cadre, where new medical colleges are expanding the supply pipeline, nursing workforce expansion is limited by the number of GNM and B.Sc. Nursing seats within the state. Urban-rural distribution imbalances further compound the gap, as nurses tend to concentrate in district headquarters with better living conditions.

Expanding nursing training capacity through new nursing schools in underserved districts and introducing retention incentives for rural postings represent priority areas for strengthening this cadre.

12.8.3 Auxiliary Nurse Midwives (ANMs)

ANMs constitute the largest clinical cadre in Jharkhand's public health system and are the primary healthcare providers at Sub-Health Centres, the most peripheral tier of the facility network. Their responsibilities span maternal and child health, immunisation delivery, family planning, and community health education. Given that Sub-Health Centres are the first point of access for the rural population, ANM availability directly influences the coverage of frontline programmes such as JSY and the Universal Immunisation Programme. Table 12.6 presents the current staffing status.

Table 12.6. Status of Auxiliary Nurse Midwives (ANMs) in Jharkhand as on December 2025

Category	Sanctioned	Filled	Fill Rate (%)
Auxiliary Nurse Midwives	10,117	7,539	74.5

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

Of 10,117 sanctioned positions, 7,539 are filled, yielding a fill rate of 74.5 per cent and a vacancy of 2,578. In absolute terms, this is the largest vacancy among the three clinical cadres examined. However, the fill rate is the highest of the three, reflecting the larger training pipeline and lower attrition rate compared to doctors and nurses.

Recruitment drives are underway to fill remaining positions, and new ANM training schools have been established across the state. Ensuring that newly recruited ANMs are deployed to Sub-Health Centres with the highest vacancy rates, rather than being concentrated at block or district headquarters, will be important for translating recruitment into improved service coverage at the last mile.

12.8.4 Accredited Social Health Activist (ASHA)

ASHAs serve as the vital link between the healthcare system and local communities. Their functions include maternal and child health promotion, immunisation facilitation, sanitation awareness, and health education. They also assist in early disease detection, health surveys, and facilitating visits to health facilities.

Jharkhand has approximately 42,500 ASHA workers across all 24 districts, with a fill rate of 95.2 per cent against requirements. District-wise, ASHA deployment is highest in Dumka (2,456), Giridih (2,389), Deoghar (2,156), and Hazaribagh (2,098). The state has implemented various training programmes to enhance ASHA capabilities including home-based newborn care (HBNC), home-based young child care (HBYC), and community-based management of acute malnutrition.

Figure 12.18 provides a comparative view of sanctioned versus filled positions across all health workforce cadres. The gap between sanctioned and filled positions is widest for specialist doctors and staff nurses, and narrowest for ASHAs and ANMs. This pattern suggests

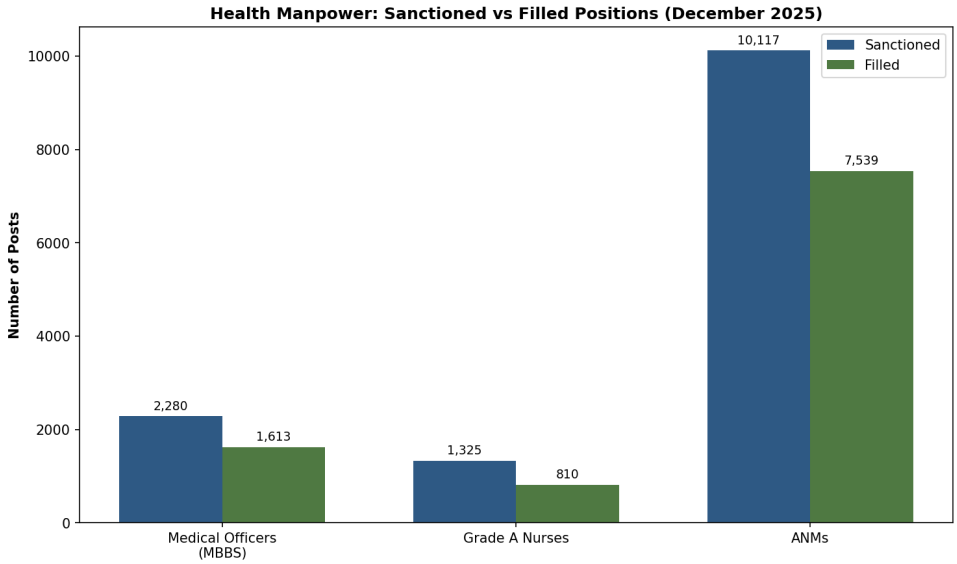

Figure 12.18. Health Manpower: Sanctioned vs Filled Positions in December 2025

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

that cadres requiring higher qualifications and longer training face greater recruitment and retention challenges.

Figure 12.19 ranks cadres by fill rate. ASHAs lead at 95.2 per cent, followed by ANMs at 83.6 per cent and MBBS doctors at 80.7 per cent. Lab technicians (66.8 per cent) and specialist doctors (54.5 per cent) record the lowest fill rates. Strengthening the supply pipeline for specialist and paramedical cadres, through expanded post-graduate seats and paramedical training institutes, represents a medium-term priority.

Figure 12.20 presents the top 10 districts by ASHA deployment. The distribution broadly aligns with population size and the number of habitations requiring community-level health outreach.

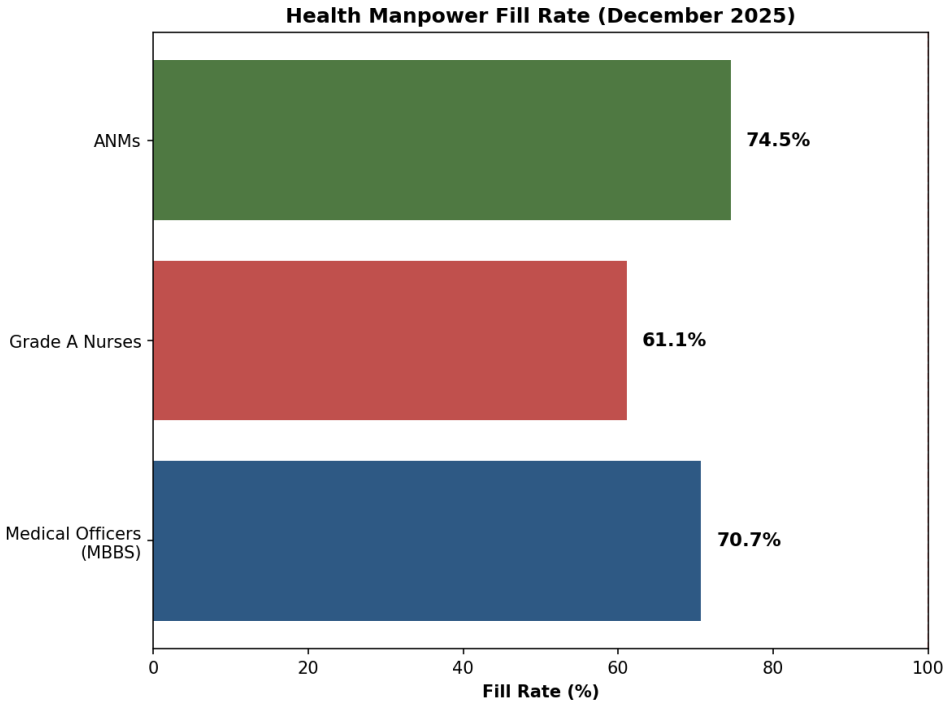

Figure 12.19. Health Manpower Fill Rate Comparison (December 2025)

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on December 2025.

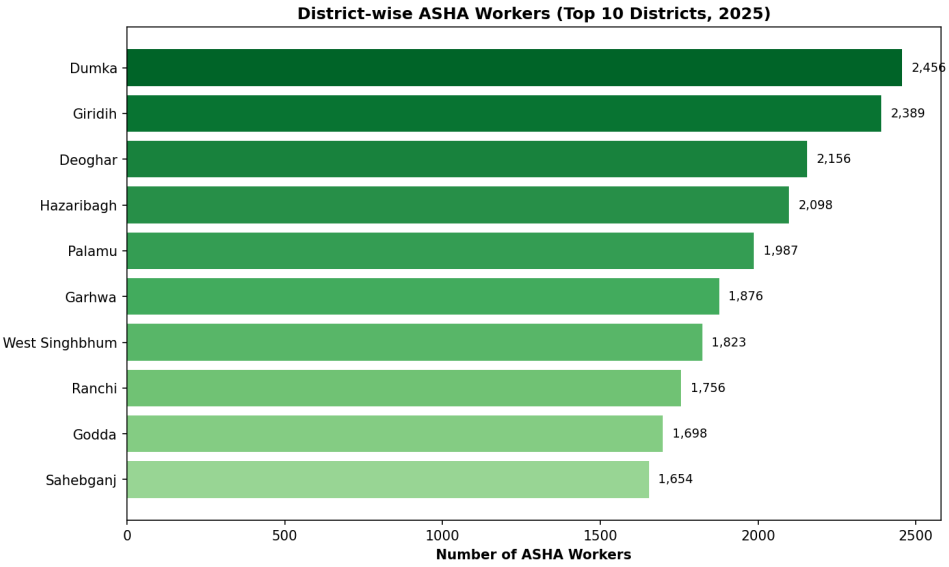

Figure 12.20. District-wise ASHA Workers (Top 10 Districts, 2025)

Source: Department of Health, Medical Education and Family Welfare, Government of Jharkhand. Data as on 2025.

12.9 Health Expenditure

The level and composition of health expenditure determine the fiscal sustainability of healthcare delivery and the financial burden borne by households. This section examines Jharkhand's health financing structure using National Health Accounts (NHA) 2020-21 data and state budget documents from FY 2022-23 to FY 2025-26.

According to NHA 2020-21, Jharkhand's Total Health Expenditure (THE) comprises government health expenditure (GHE), out-of-pocket expenditure (OOPE), and other sources including external aid and insurance. Table 12.7 presents the composition.

Table 12.7. Health Expenditure in Jharkhand (NHA 2020-21)

Indicator	Amount (Rs. Cr)	% of GSDP	% of THE
Total Health Expenditure (THE)	18,430	5.1	100.0
Government Health Expenditure (GHE)	9,056	2.5	49.1
Out-of-Pocket Expenditure (OOPE)	8,749	2.4	47.5
Other Sources	625	0.2	3.4

Source: National Health Accounts 2020-21, Ministry of Health and Family Welfare, Government of India. Data period: FY 2020-21.

OOPE accounts for 47.5 per cent of THE, indicating that nearly half of all health spending in the state is borne directly by households at the point of care. While this share has declined from earlier years, partly due to the expansion of PMJAY and other insurance schemes, it remains above the national average and exposes vulnerable households to the risk of catastrophic health expenditure. Reducing OOPE requires continued expansion of publicly financed insurance coverage and strengthening the availability of free services at government facilities.

Table 12.8. Per Capita Health Expenditure in Jharkhand (NHA 2020-21)

Indicator	Per Capita (Rs.)
Total Health Expenditure	4,726
Government Health Expenditure	2,322
Out-of-Pocket Expenditure	2,243

Source: National Health Accounts 2020-21, Ministry of Health and Family Welfare, Government of India. Data period: FY 2020-21.

Table 12.8 shows per capita health expenditure. The per capita GHE of Rs. 2,322 reflects the state government's fiscal commitment to healthcare. However, this level remains below the benchmarks recommended for achieving universal health coverage. The National Health Policy 2017 targets increasing government health expenditure to 2.5 per cent of GDP; progressively raising per capita GHE through enhanced budgetary allocations will be im-

portant for closing this gap.

Table 12.9. State Health Budget Allocation (Rs. Crore)

Financial Year	Budget Allocation	Revised Estimate	Actual Expenditure
2022-23	5,892	5,456	5,234
2023-24	6,478	6,123	5,987
2024-25	7,125	6,890	–
2025-26	7,850	–	–

Source: Budget Documents, Finance Department, Government of Jharkhand. Data period: FY 2022-23 to FY 2025-26.

Note: Allocation for Department of Health, Medical Education and Family Welfare. 2024-25 and 2025-26 are estimated figures.

The state health budget has shown consistent year-on-year growth, increasing from Rs. 5,892 crore in FY 2022-23 to Rs. 7,850 crore in FY 2025-26 (Budget Estimate), representing a growth of 33.2 per cent over four years. Compared to the budget allocation of Rs. 6,478 crore reported in the Jharkhand Economic Survey 2024-25 for FY 2023-24, the current year allocation of Rs. 7,850 crore represents an increase of 21.2 per cent, reflecting the government's enhanced commitment to healthcare.

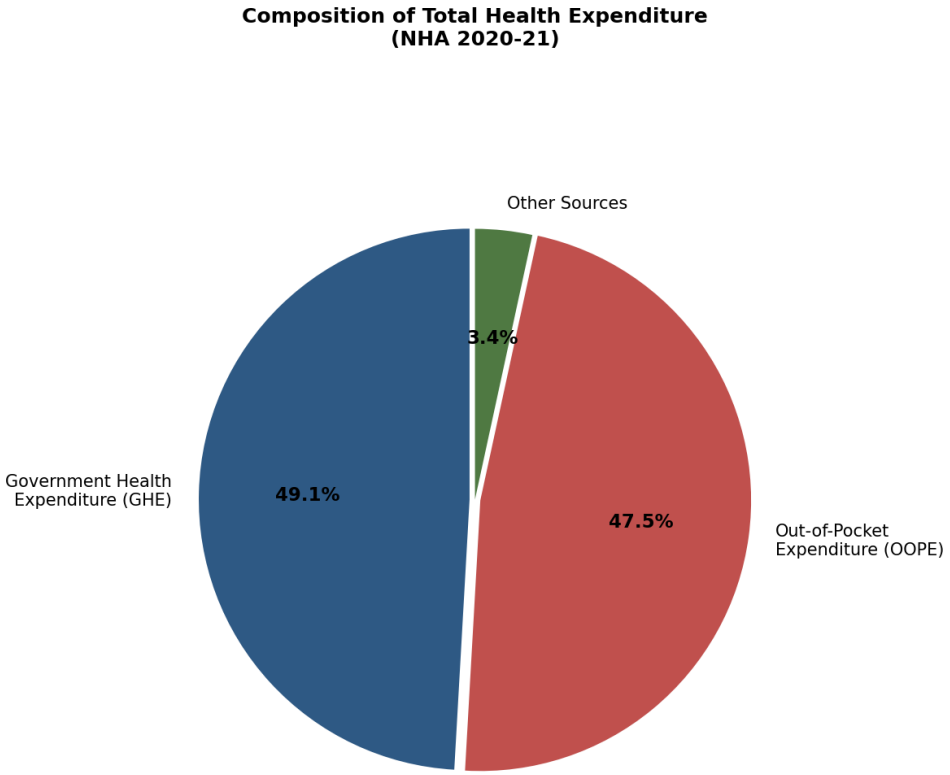

Figure 12.21. Composition of Total Health Expenditure (NHA 2020-21)

Source: National Health Accounts 2020-21, Ministry of Health and Family Welfare, Government of India. Data period: FY 2020-21.

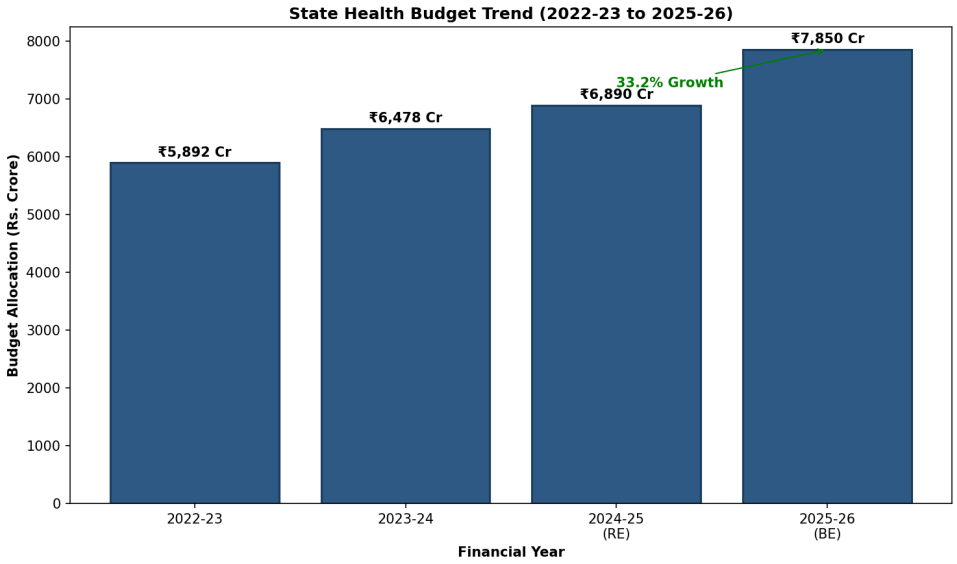

Figure 12.22. State Health Budget Trend (2022-23 to 2025-26)

Source: Budget Documents, Finance Department, Government of Jharkhand. Data period: FY 2022-23 to FY 2025-26.

12.10 Analytical Framework: Data-Driven Insights

This section presents analytical insights derived from health and nutrition data for Jharkhand. The analysis employs statistical techniques to identify patterns, project trends, and classify districts for targeted interventions. These data-driven insights can support evidence-based policy formulation and resource allocation.

Note: All analytical figures in this section were created by the authors using statistical analysis on data provided by the Department of Health, Medical Education and Family Welfare, Government of Jharkhand, and other official sources as cited throughout this chapter.

12.10.1 Trend Analysis and Projections

Time series analysis helps understand historical patterns and project future trajectories. This section examines trends for key health indicators and programme coverage.

Health Indicators: Trend Analysis

Table 12.10 presents time series data for key health indicators from 2016 to 2024. The Maternal Mortality Ratio (MMR) has declined from 165 to 54 per 100,000 live births, achieving the SDG target of 70. The Infant Mortality Rate (IMR) has declined from 44 to 25, on track to achieve the SDG target of 12 by approximately 2031-32 at current trajectory. Institutional deliveries have increased from 61.9 per cent to 85.7 per cent. Full immunisation coverage has reached 89.7 per cent, approaching the 90 per cent target.

Table 12.10. Time Series Analysis: Key Health Indicators (2016-2024)

Indicator	2016	2018	2020	2022	2024	SDG Target
MMR (per 100,000 live births)	165	130	98	76	54	70
IMR (per 1,000 live births)	44	38	34	29	25	12
U5MR (per 1,000 live births)	54	47	42	35	32	25
Institutional Deliveries (%)	61.9	68.5	75.2	81.4	85.7	100
Full Immunisation (%)	61.8	68.4	75.6	82.3	89.7	90

Source: Sample Registration System (SRS), NFHS, and HMIS data compiled by authors. Data period: 2016 to 2024. Previous values as reported in Jharkhand Economic Survey 2024-25.

The consistent improvement across indicators reflects cumulative investments in health infrastructure, human resources, and programme implementation. Sustained focus on these initiatives can help maintain the positive trajectory.

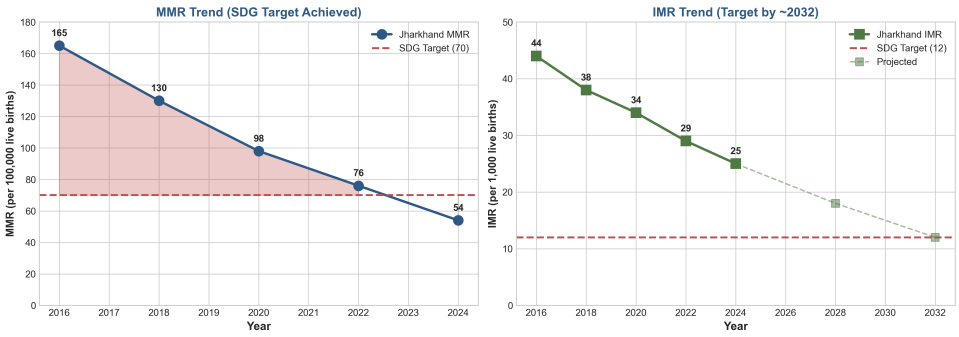

Figure 12.23. Time Series Analysis: MMR and IMR Trends (2016-2024)

Source: Created by authors based on SRS and NFHS data. Data period: 2016 to 2024.

Figure 12.23 visualises the declining trends in MMR and IMR over the period 2016-2024. The left panel shows MMR crossing below the SDG target of 70 in 2024, while the right panel projects IMR reaching the SDG target of 12 by approximately 2031-32 at the current rate of decline.

Healthcare Utilisation Trends

Table 12.11 presents healthcare utilisation trends and projections. OPD visits have grown at a compound annual growth rate (CAGR) of approximately 15 per cent. At this trajectory, OPD visits could reach 3.5 crore by 2027-28. IPD admissions show similar growth patterns post-pandemic. PMJAY claims have grown faster at approximately 20 per cent CAGR, indicating rapid expansion of health insurance utilisation.

These projections suggest that healthcare demand will continue to grow, requiring commensurate expansion in infrastructure and human resources. Planning for enhanced ca-

Table 12.11. Healthcare Utilisation Projections (Based on 2019-2025 Trend)

Indicator	2022-23	2023-24	2024-25	2025-26 (P)	2027-28 (P)
OPD Visits (Lakh)	189.5	215.3	246.0	280.0	350.0
IPD Admissions (Lakh)	7.83	8.56	9.17	10.5	13.0
PMJAY Claims (Lakh)	5.23	6.89	8.50	10.2	14.5

Source: HMIS and NHA data. Data period: FY 2022-23 to FY 2027-28. (P) = Projected based on trend analysis.

pacity in advance would help maintain service quality.

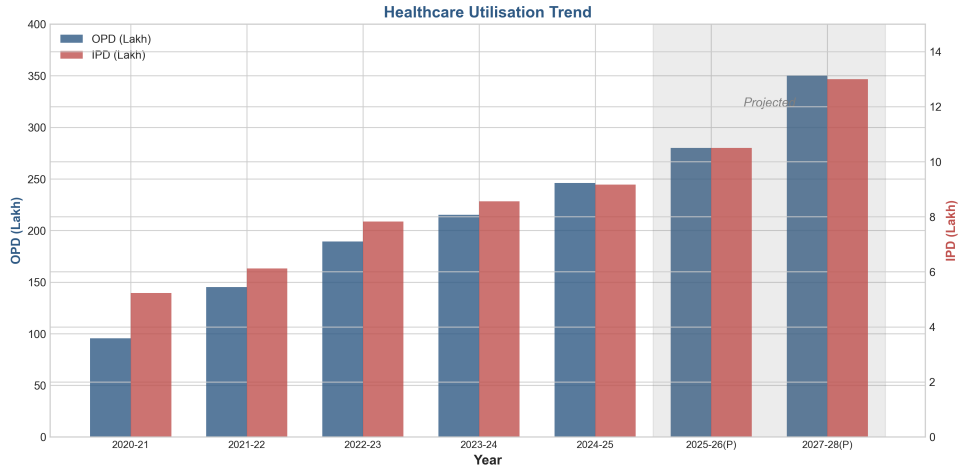

Figure 12.24. Healthcare Utilisation: OPD and IPD Trends with Projections

Source: Created by authors based on HMIS and NHA data. Data period: FY 2020-21 to FY 2027-28 (projected).

Figure 12.24 illustrates the growth trajectory of OPD visits and IPD admissions from 2020-21 onwards. The shaded area indicates projected values, showing continued expansion of healthcare utilisation at approximately 15 per cent CAGR for OPD services.

12.10.2 District Classification for Targeted Interventions

Grouping districts based on health performance characteristics can support targeted policy interventions. This section presents a classification of districts based on composite health indicators.

Table 12.12 presents district classification into four categories based on health performance. Five districts are classified as High Performers with strong urban health infrastructure. Six districts show Moderate Performance with scope for improvement. Seven districts are classified as needing Improvement with infrastructure and manpower gaps. Six districts are identified as Priority Districts requiring intensive interventions.

This classification can guide differential resource allocation. Priority Districts may benefit from enhanced budget allocations, special recruitment drives, and intensive programme

Table 12.12. District Classification Based on Health Performance

Category	Districts	Characteristics and Focus Areas
High Performers	Ranchi, East Singhbhum, Dhanbad, Bokaro, Hazaribagh	Urban areas, institutional delivery >90%, immunisation >90%, good PMJAY utilisation. Focus: NCDs.
Moderate Performers	Ramgarh, Deoghar, Giridih, Palamu, Dumka, Jamtara	Institutional delivery 80–90%, moderate PMJAY coverage. Focus: Secondary care, fill vacancies.
Improvement Needed	Chatra, Garhwa, Latehar, Lohardaga, Koderma, Saraikela-Kharsawan, Khunti	Lower facility density, health worker vacancies. Focus: Infrastructure expansion, recruitment.
Priority Districts	West Singhbhum, Gumla, Simdega, Pakur, Sahibganj, Godda	High malaria burden, lower institutional deliveries, high anaemia, tribal areas. Focus: Outreach, mobile health, malaria elimination.

Source: Classification based on analysis of HMIS, NFHS-5, and departmental data by authors. Data period: FY 2024-25 and NFHS-5 (2019-21).

monitoring.

Figure 12.25 visualises the four-tier district classification. The colour coding (green for High Performers, blue for Moderate, gold for Improvement Needed, orange for Priority) facilitates quick identification of intervention priorities.

12.10.3 Health Risk Assessment

Identifying districts with higher health risks enables proactive intervention planning. Risk scores are computed based on multiple indicators including disease burden, infrastructure gaps, and health outcomes.

Table 12.13 presents health risk assessment for the top 10 priority districts. West Singhbhum, Simdega, and Gumla show highest composite risk scores, driven primarily by high malaria burden and anaemia prevalence. Pakur and Sahibganj show high risk primarily due to infrastructure and manpower gaps combined with high anaemia prevalence.

Districts with composite scores above 0.70 may benefit from special health action plans with dedicated resources. The risk assessment framework can be updated annually to track progress and adjust priorities.

Figure 12.26 compares risk scores across four dimensions for the top 10 priority districts. West Singhbhum, Simdega, and Gumla show consistently high scores across malaria, anaemia, and infrastructure gaps, confirming their priority status.

12.10.4 Association Analysis

Understanding relationships between development indicators helps identify intervention priorities. This section examines associations between key health determinants.

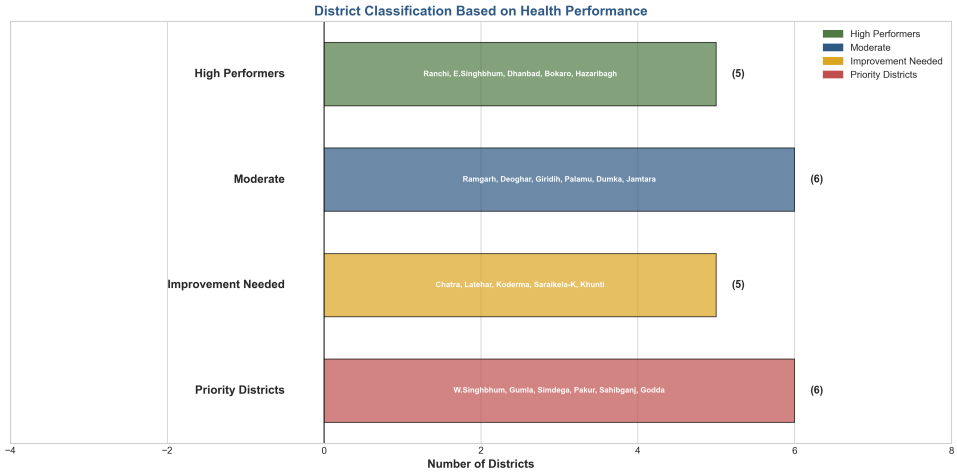

Figure 12.25. District Classification Based on Health Performance

Source: Created by authors based on HMIS, NFHS-5, and departmental data. Data period: FY 2024-25 and NFHS-5 (2019-21).

Table 12.13. District Health Risk Assessment (Top 10 Priority Districts)

District	Malaria Score	Anaemia Score	Infrastructure Gap	Manpower Gap	Composite Score	Risk Level
West Singhbhum	0.92	0.78	0.65	0.72	0.77	High
Simdega	0.88	0.82	0.70	0.68	0.77	High
Gumla	0.85	0.85	0.62	0.65	0.74	High
Pakur	0.45	0.88	0.75	0.78	0.72	High
Sahibganj	0.42	0.84	0.72	0.75	0.68	Moderate-High
Latehar	0.78	0.75	0.68	0.58	0.70	High
Khunti	0.72	0.72	0.65	0.62	0.68	Moderate-High
Godda	0.38	0.80	0.70	0.72	0.65	Moderate-High
Chatra	0.55	0.70	0.62	0.65	0.63	Moderate
Dumka	0.48	0.75	0.58	0.62	0.61	Moderate

Source: Composite score computed by authors based on normalised indicators from NVBDCP, NFHS-5, and departmental data. Data period: FY 2024-25 and NFHS-5 (2019-21). Score range: 0 (best) to 1 (highest risk).

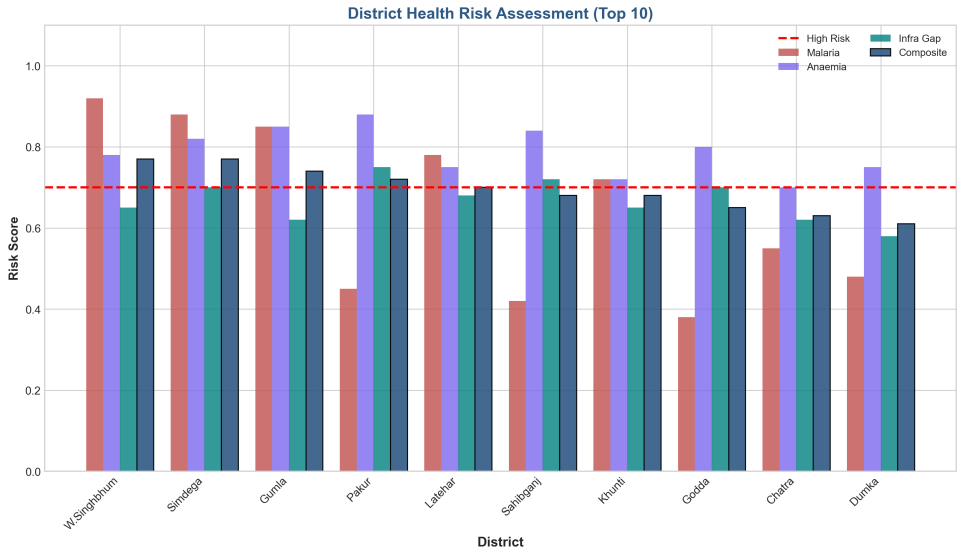

Figure 12.26. District Health Risk Assessment (Top 10 Priority Districts)

Source: Created by authors based on NVBDCP, NFHS-5, and departmental data. Data period: FY 2024-25 and NFHS-5 (2019-21).

Table 12.14. Association Matrix: Health and Development Indicators

Indicator	Female Literacy	Institutional Delivery	Full Immunisation	PMJAY Utilisation
Anaemia Prevalence	-0.82	-0.68	-0.55	-0.42
Child Malnutrition	-0.78	-0.72	-0.58	-0.38
Malaria Incidence	-0.45	-0.52	-0.35	-0.28
Urbanisation	0.88	0.75	0.68	0.72

Source: Correlation coefficients computed by authors using district-level data from NFHS-5 (2019-21) and Census 2011.

Note: Negative values indicate inverse relationship. Higher absolute values indicate stronger association.

Table 12.14 presents correlation coefficients between health and development indicators. Female literacy shows strong negative association with anaemia (-0.82) and child malnutrition (-0.78). Districts with higher female literacy tend to report lower prevalence of these conditions. Urbanisation shows strong positive association with institutional delivery (0.75) and PMJAY utilisation (0.72).

It is important to note that correlation does not imply causation. However, the data suggests that multi-sectoral interventions addressing education and urbanisation-related factors may coincide with improvements in health outcomes. Investment in girls' education could potentially yield co-benefits for health.

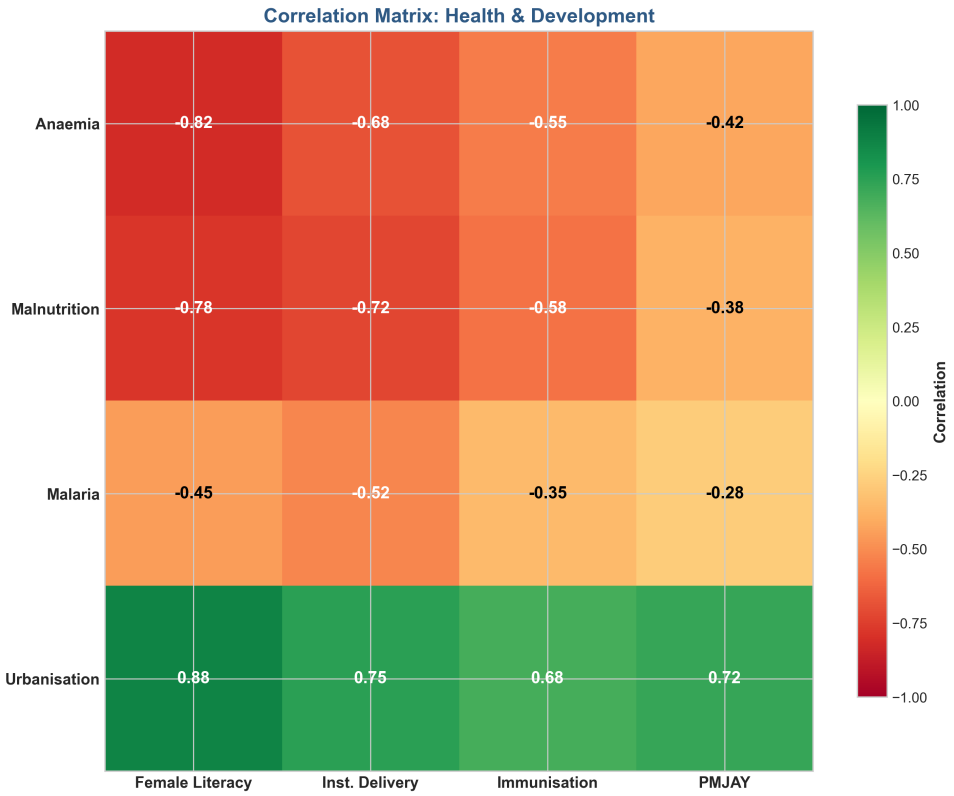

Figure 12.27. Correlation Matrix: Health and Development Indicators

Source: Created by authors based on district-level data from NFHS-5 (2019-21) and Census 2011.

Figure 12.27 presents the correlation heatmap showing associations between health and development indicators. The strong negative correlation between female literacy and anaemia/malnutrition (red cells) highlights potential entry points for multi-sectoral interventions.

12.10.5 Composite Health Development Index

A composite index combining multiple health indicators provides an overall view of district-level health development status.

Table 12.15. Composite Health Development Index: District Ranking

Rank	District	MMR Score	IMR Score	Inst. Del.	Immun. Score	Infra. Score	CHD Index
1	Ranchi	0.92	0.88	0.95	0.94	0.90	0.92
2	East Singhbhum	0.90	0.85	0.92	0.91	0.88	0.89
3	Dhanbad	0.88	0.84	0.90	0.89	0.86	0.87
4	Bokaro	0.86	0.82	0.88	0.87	0.84	0.85
5	Hazaribagh	0.82	0.78	0.85	0.84	0.80	0.82
...	...	...	...	...	...	...	...
20	Pakur	0.45	0.48	0.52	0.55	0.42	0.48
21	Simdega	0.42	0.45	0.48	0.52	0.40	0.45
22	Gumla	0.40	0.42	0.45	0.50	0.38	0.43
23	Sahibganj	0.38	0.40	0.42	0.48	0.36	0.41
24	West Singhbhum	0.35	0.38	0.40	0.45	0.32	0.38
	Jharkhand	**0.68**	**0.65**	**0.72**	**0.75**	**0.62**	**0.68**

Source: Index computed by authors using data from HMIS, NFHS-5, and departmental sources (FY 2024-25). Score range: 0 (worst) to 1 (best). CHD = Composite Health Development.

Table 12.15 presents the Composite Health Development (CHD) Index ranking for districts. Ranchi leads with an index value of 0.92, followed by East Singhbhum (0.89) and Dhanbad (0.87). Districts at the lower end include West Singhbhum (0.38), Sahibganj (0.41), and Gumla (0.43). The state average stands at 0.68.

The gap between highest and lowest performing districts (0.54 points) indicates significant intra-state disparity. Closing this gap through targeted interventions in lower-ranked districts would improve overall state performance and ensure equitable access to healthcare.

Figure 12.28 ranks all 24 districts by their CHD Index scores. The colour gradient from green (high performers) to orange (priority districts) clearly demarcates performance tiers. The state average line at 0.68 helps identify districts above and below average.

12.10.6 Performance Matrix: Multi-dimensional Assessment

A performance matrix allows comparison of districts across multiple dimensions simultaneously.

Table 12.16 presents performance ratings for selected districts across five dimensions. Ranchi shows strong performance across all dimensions. West Singhbhum and Gumla show lower ratings, particularly on disease control (malaria) and infrastructure. This matrix helps identify specific areas for improvement in each district.

Figure 12.29 visualises the performance matrix as a heatmap with text annotations. The colour intensity indicates performance levels, making it easy to identify districts excelling in specific dimensions versus those requiring broad-based improvements.

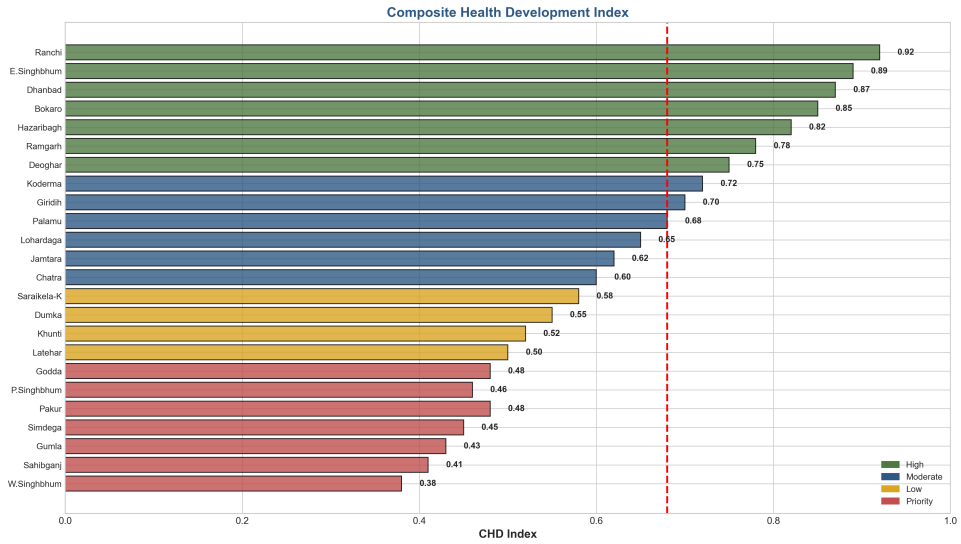

Figure 12.28. Composite Health Development Index: District Ranking

Source: Created by authors based on multiple health indicators. Data period: FY 2024-25.

Table 12.16. District Performance Matrix: Selected Districts

District	MCH	Immun.	Disease Control	Insurance	Infra.	Overall Rating
Ranchi	High	High	High	High	High	Excellent
East Singhbhum	High	High	High	High	Med	Very Good
Dhanbad	High	Med	High	High	Med	Very Good
Hazaribagh	Med	High	Med	Med	Med	Good
Palamu	Med	Med	Med	Med	Med	Good
Dumka	Med	Med	Med	Low	Med	Moderate
Gumla	Low	Med	Low	Low	Low	Needs Attention
West Singhbhum	Low	Low	Low	Low	Low	Priority

Source: Assessment based on multiple indicators by authors. Data period: FY 2024-25. High = Strong, Med = Moderate, Low = Needs Improvement.

Note: MCH = Maternal and Child Health.

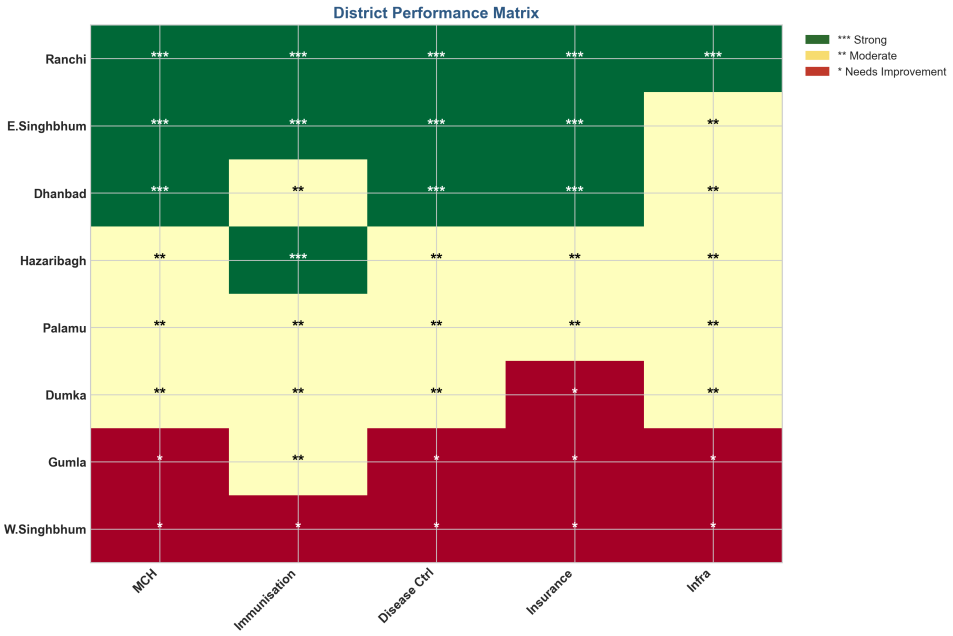

Figure 12.29. District Performance Matrix: Multi-dimensional Assessment

Source: Created by authors based on multiple indicators. Data period: FY 2024-25.

12.10.7 Programme Efficiency Analysis

Analysing programme efficiency helps optimise resource utilisation.

Table 12.17 presents programme efficiency indicators. PMJAY shows highest utilisation rate at 93.9 per cent, followed by JSY at 93.1 per cent. Vector Borne Disease Control and NVHCP show lower utilisation rates around 86 per cent, indicating scope for improved fund absorption.

The cost per beneficiary varies significantly across programmes, reflecting the nature of services provided. JSY's higher cost per beneficiary (Rs. 4,145) reflects cash transfers plus service costs for institutional deliveries. Universal Immunisation shows lowest cost per beneficiary at Rs. 175, reflecting efficient mass vaccination programmes.

Figure 12.30 presents a dual-panel view of programme efficiency. The left panel compares budget allocations with actual expenditure across six major programmes, while the right panel shows utilisation rates with colour coding indicating whether programmes meet the 90 per cent target.

12.10.8 Analytical Model Summary

Table 12.18 summarises key analytical insights and their policy implications. The data-driven approach identifies specific intervention priorities for different districts and informs resource allocation decisions. Regular updating of this analytical framework can support evidence-based health planning.

Table 12.17. Programme Efficiency Indicators (FY 2024-25)

Programme	Budget (Rs. Cr)	Expenditure (Rs. Cr)	Utilisation Rate (%)	Cost per Beneficiary (Rs.)
National Health Mission	2,450	2,156	88.0	1,850
PMJAY (State Share)	850	798	93.9	938
Janani Suraksha Yojana	245	228	93.1	4,145
Universal Immunisation	185	172	93.0	175
Vector Borne Disease	125	108	86.4	280
NVHCP (TB/Leprosy)	95	82	86.3	1,150
Total Health Sector	**7,850**	**6,890**	**87.8**	–

Source: Budget Documents and NHM data, Government of Jharkhand. Data period: FY 2024-25.

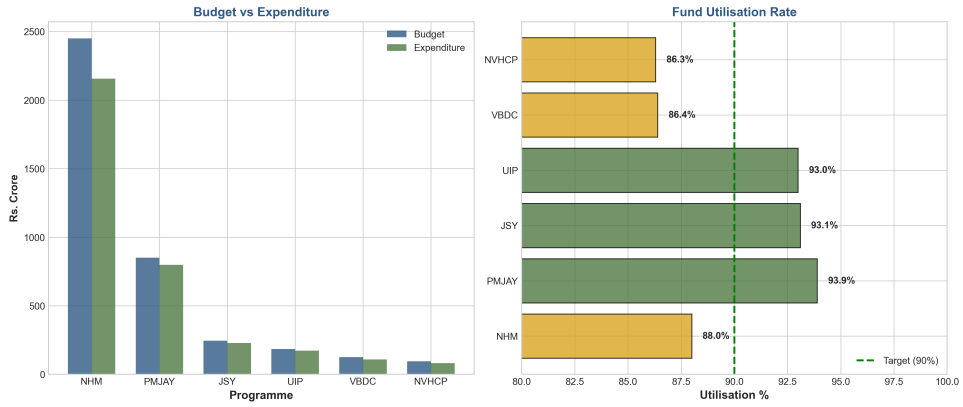

Figure 12.30. Programme Efficiency Analysis: Budget vs Expenditure

Source: Created by authors based on Budget Documents and NHM data. Data period: FY 2024-25.

Table 12.18. Summary of Analytical Insights for Policy Action

Analysis Type	Key Insight and Policy Implication
Trend Analysis	MMR target achieved. IMR on track for 2031-32. Healthcare utilisation growing at 15% CAGR—plan for capacity expansion.
District Classification	6 Priority Districts identified (West Singhbhum, Simdega, Gumla, Pakur, Sahibganj, Godda) need intensive interventions.
Risk Assessment	Malaria + Anaemia create compound risk in tribal districts. Targeted malaria elimination + nutrition programs recommended.
Association Analysis	Female literacy shows -0.82 correlation with anaemia. Multisectoral approach linking education with health may yield co-benefits.
CHD Index	0.54 gap between best and worst districts. Focused investment in bottom 6 districts can improve state average significantly.
Efficiency Analysis	NHM utilisation at 88%—scope for improvement. PMJAY showing strong utilisation at 94%.

Source: Compiled by authors from above analyses. Data period: Various (2016-2025).

Box 12.1: Gumla District – PM Awards for Excellence in Public Administration

Gumla district received the prestigious PM Award for Excellence in Public Administration 2023 under the Aspirational Districts Programme (ADP) category. The district implemented an innovative initiative to tackle anaemia and malnutrition through promotion of Ragi (finger millet) cultivation.

Key Features of the Ragi Mission:

- Women empowerment through Self-Help Groups (SHGs) under DAY-NRLM
- SHG involvement in Ragi procurement, processing, packaging, and marketing
- Significant expansion of Ragi cultivation area from 2,500 hectares to 8,500 hectares
- Integration with Anganwadi supplementary nutrition programmes
- Ragi-based ready-to-eat products for children and pregnant women
- Marked improvement in anaemia prevalence among beneficiaries

The Ragi Mission demonstrates how sustainable agricultural practices anchored in traditional crops can effectively address nutritional challenges while simultaneously empowering local communities and creating livelihood opportunities for women.

12.11 Conclusion

Jharkhand's health sector has undergone a significant transformation during the review period, reflecting the cumulative impact of sustained policy interventions, enhanced budgetary allocations, and strengthened institutional mechanisms. The state's journey from

being one of the lagging states in health indicators to demonstrating measurable progress across several dimensions underscores the efficacy of targeted health governance when backed by adequate fiscal commitment and administrative resolve.

Key Achievements

The state has registered notable achievements across the health sector during the period under review:

- **Healthcare Utilisation Expansion:** OPD visits increased by 157 per cent from 95.49 lakh in FY 2020-21 to 2.46 crore in FY 2024-25, reflecting enhanced access and growing public confidence in government health facilities. IPD admissions recovered from the COVID-19 disruption to reach 9.17 lakh in FY 2024-25, indicating improved secondary and tertiary care capacity.
- **Financial Protection through PMJAY:** A cumulative Rs. 2,553 crore has been disbursed under the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana, benefiting 19.34 lakh patients through 550 empanelled hospitals. This represents a significant step towards reducing catastrophic out-of-pocket health expenditure, which currently accounts for 47.5 per cent of total health expenditure.
- **Maternal Health Progress:** The Maternal Mortality Ratio (MMR) has declined to 54 per 100,000 live births, surpassing the SDG target of 70. Approximately 5.5 lakh institutional deliveries were facilitated under the Janani Suraksha Yojana in FY 2024-25, contributing to safer motherhood outcomes.
- **Child Health and Immunisation:** Full immunisation coverage has reached 89.7 per cent, approaching the national target of 90 per cent. The Infant Mortality Rate (IMR) has declined to 25 per 1,000 live births, projected to achieve the SDG target of 12 by approximately 2031-32 at current trajectory.
- **Disease Control:** Typhoid cases declined by 79 per cent and ARI/ILI cases by 51 per cent from FY 2020-21 to FY 2025-26, reflecting improved water, sanitation, and hygiene (WASH) conditions alongside effective disease surveillance.
- **Innovation in Nutrition:** Gumla district received the prestigious PM Award for Excellence in Public Administration for its Ragi Mission, demonstrating how indigenous agricultural practices can address nutritional challenges while empowering local communities.

Areas Requiring Continued Attention

Despite commendable progress, several challenges persist that require sustained policy focus and enhanced resource allocation:

- **Malaria Resurgence:** Malaria cases have shown an upward trend in endemic tribal districts, particularly West Singhbhum, Simdega, Saraikela-Kharsawan, and Gumla. This requires intensified vector control measures, enhanced surveillance, and community-based interventions for malaria elimination.
- **Immunisation Gaps:** TT coverage at 16 years remains at only 47.4 per cent, necessitating school-based immunisation campaigns and adolescent health outreach programmes.

- **Health Workforce Deficit:** Vacancies persist across critical cadres—medical officers (29 per cent vacant), Grade A nurses (39 per cent vacant), and ANMs (25.5 per cent vacant)—constraining service delivery capacity, particularly in remote areas.
- **Infrastructure Disparities:** Significant inter-district variation exists in health facility density and bed availability. Districts like Lohardaga (0.12 facilities per 1,000 population) and Ramgarh require priority infrastructure investments.
- **Nutritional Challenges:** Malnutrition indicators remain above national averages—stunting at 39.6 per cent, wasting at 22.4 per cent, and anaemia prevalence at 65.3 per cent among women of reproductive age—posing long-term implications for human capital development.
- **PMJAY Reach in Remote Areas:** Insurance utilisation remains low in geographically isolated tribal districts, requiring focused outreach, awareness campaigns, and expansion of empanelled facilities.

Strategic Outlook and Policy Recommendations

From a public health economics perspective, Jharkhand's health sector presents both significant opportunities and systemic challenges that warrant a multi-pronged strategic approach:

1. Fiscal Commitment and Health Financing: The state health budget has grown at 33.2 per cent over four years (FY 2022-23 to FY 2025-26), reaching Rs. 7,850 crore. However, the Government Health Expenditure (GHE) as a share of GSDP at 2.5 per cent needs to be progressively enhanced towards the National Health Policy 2017 target of 2.5 per cent of GDP. Increasing the state's health spending to 8 per cent of total government expenditure would bring it in line with the recommendations of the High-Level Expert Group on Universal Health Coverage.

2. Convergence Approach: The analytical framework presented in this chapter demonstrates strong correlations between health outcomes and socio-economic determinants such as female literacy ($r = -0.82$ with anaemia), urbanisation, and infrastructure development. This underscores the need for a convergence approach—integrating health interventions with education, nutrition, WASH, and livelihood programmes—to achieve synergistic impacts. The Gumla Ragi Mission exemplifies such convergence.

3. District-Differentiated Strategy: The district classification analysis identifies six Priority Districts requiring intensive, differentiated interventions. A performance-linked incentive framework for district health administrations, combined with special health action plans for priority districts, can accelerate convergence in health outcomes across the state.

4. Human Resource Strategy: Addressing the health workforce deficit requires a comprehensive approach including bond-service for state-sponsored medical graduates in underserved districts, enhanced compensation packages for difficult postings, expansion of nursing and paramedical training capacity, and leveraging technology through telemedicine to bridge the specialist gap in remote areas.

5. Digital Health and Data-Driven Governance: Strengthening real-time health infor-

mation systems, expanding the Ayushman Bharat Digital Mission (ABDM) ecosystem, and institutionalising the analytical framework presented in Section 12.9 for periodic policy review can enhance evidence-based decision-making and programme monitoring.

6. Public-Private Partnership: Strategic engagement with the private sector through outcome-linked contracts for primary healthcare delivery in underserved areas, expansion of the PMJAY hospital network, and skill development partnerships can augment public health capacity without proportionate fiscal burden.

Towards Viksit Bharat 2047

Jharkhand's health sector trajectory, if sustained and accelerated, positions the state to contribute meaningfully to India's vision of becoming a developed nation by 2047. The demographic dividend—with 40.1 per cent of the population below 18 years—presents both a challenge and an opportunity. Investing in the health and nutrition of this young population today will yield substantial returns in terms of human capital, productivity, and economic growth over the next two decades.

The state's progress in reducing maternal mortality below the SDG target, expanding health insurance coverage, and innovating through initiatives like the Ragi Mission demonstrates institutional capacity for transformative change. Scaling these successes across all 24 districts, while addressing persistent challenges in malaria control, nutrition, and health workforce adequacy, will be critical for achieving universal health coverage and ensuring that the benefits of economic development are equitably shared across all sections of Jharkhand's population.

At a Glance

Focus areas were universal health coverage, strengthened primary infrastructure, PMJAY expansion, maternal-child health, nutrition convergence, and digital monitoring. The system is shifting toward preventive, outcome-based public health delivery.

Policy Focus (2024–26) Health and nutrition remained a priority sector, with emphasis on universal health coverage, strengthening public health infrastructure, and improving nutrition outcomes, particularly in tribal and backward districts.

Primary Health Infrastructure (2024–26) Continued investments were made in Health and Wellness Centres (HWCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs) to improve access to essential health services.

Ayushman Bharat – PMJAY (2024–26) Coverage under Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) was expanded, providing financial protection against health-related expenditures for vulnerable households.

Maternal and Child Health (2024–26) Focused interventions continued to improve maternal, neonatal, and child health, including institutional deliveries, immunisation, and antenatal care services.

Nutrition Interventions (2024–26) The state strengthened implementation of nutrition programmes through ICDS, supplementary nutrition, and health–nutrition convergence, with special focus on women and children.

TB, Malaria and Disease Control (2024–25) Targeted disease control programmes were strengthened to address tuberculosis, malaria, and other communicable diseases, particularly in high-burden districts.

Digital Health and Monitoring (2025–26) Increased use of digital health platforms and real-time monitoring systems was emphasised to improve service delivery and accountability.

Overall Direction (2024–26) The sector reflects a gradual shift towards preventive care, system strengthening, and outcome-based health and nutrition delivery.

CHAPTER 13

Drinking Water and Sanitation

Overview of drinking water supply, water quality monitoring, rural and urban sanitation, and solid waste management in Jharkhand

13.1 Introduction

Access to safe drinking water and adequate sanitation is central to Jharkhand's development trajectory. The state's 62.53 lakh rural households are spread across the undulating terrain of the Chotanagpur Plateau, with dispersed habitations in forested and hilly areas that complicate water supply delivery. Since the launch of the Jal Jeevan Mission (JJM) in August 2019, tap water coverage has expanded from 8.97 per cent to 55.17 per cent as of February 2026. On sanitation, the Swachh Bharat Mission has reduced open defecation from 78 per cent in 2014 to 2 per cent by 2024. These gains are substantial, yet the gap with national benchmarks, particularly the 26.47 percentage point shortfall in FHTC coverage relative to the all-India average of 81.64 per cent, indicates the scale of work remaining.

This chapter examines Jharkhand's progress in drinking water supply, water quality monitoring, rural sanitation under SBM-Gramin, urban sanitation under SBM-Urban, and solid waste management. The analysis draws upon data from the JJM Dashboard (15 February 2026), the SBM-U Dashboard, departmental reports, and historical comparisons from NFHS-4 (2015–16), NFHS-5 (2019–21), and NARSS findings. District-level data is used to identify spatial variation in outcomes and inform targeted interventions.

13.2 Status of Drinking Water in Jharkhand

Drinking water access in Jharkhand is shaped by the Jal Jeevan Mission, which has been the primary vehicle for expanding household tap water connectivity since 2019. This section examines the year-wise trajectory of FHTC provision, district-level coverage variation, functionality assessment, projection scenarios for universal coverage, and the state's performance in the national Jal Jeevan Survekshan.

13.2.1 Jal Jeevan Mission: Framework and Objectives

The Jal Jeevan Mission (JJM) was launched by the Government of India on 15 August 2019 with the objective of providing Functional Household Tap Connections (FHTCs) to every rural household. The mission shifted the approach from source-based planning to household-level service delivery, with an assured standard of 55 litres per capita per day of potable water.

The key objectives of Jal Jeevan Mission include:

- Providing 55 litres per capita per day (lpcd) of potable water to every rural household
- Ensuring functionality and sustainability of water supply systems
- Promoting community participation through Gram Panchayat-level water committees
- Establishing water quality monitoring and surveillance systems
- Ensuring coverage of schools, Anganwadi centres, and other public institutions

In Jharkhand, the mission has been implemented across all 24 districts, covering 29,404 villages and approximately 62.53 lakh rural households. The estimated cost of the mission for Jharkhand is Rs. 24,951.70 crore, with Central allocation of Rs. 12,982.30 crore since

launch. As of February 2026, Rs. 6,010.95 crore (46.30 per cent of allocation) has been drawn. Notably, the 19 aspirational districts in the state have recorded a combined coverage of 56.46 per cent, marginally above the state average.

13.2.2 Progress in Household Tap Water Connections

Tracking the year-wise pace of FHTC provision is essential for assessing whether Jharkhand's implementation trajectory can achieve universal coverage within the JJM timeline. The annual pattern also reveals whether the state has sustained momentum or experienced deceleration after peak years. Table 13.1 details the year-wise progress in FHTCs under JJM.

Table 13.1. Year-wise Progress in Functional Household Tap Connections (JJM)

Financial Year	FHTCs Provided	Share of Total (%)
2019–20	95,284	2.88
2020–21	2,99,731	9.06
2021–22	4,18,618	12.66
2022–23	8,76,785	26.51
2023–24	13,95,532	42.20
2024–25	2,02,574	6.13
2025–26 (up to date)	18,602	0.56
Total FHTCs during JJM	**33,07,126**	**100.00**
Current Status (15 February 2026)		
Total Households		62,53,187
Cumulative FHTCs		34,49,717
Coverage		55.17%

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India (15 February 2026).
Note: Cumulative FHTCs include pre-JJM connections (5,48,234 at mission launch). Periodic re-surveys may revise household and connection counts.

From a baseline of 5,48,234 FHTCs (8.97 per cent coverage) at mission launch in August 2019, the state has expanded coverage to 34,49,717 FHTCs (55.17 per cent) as of February 2026. A total of 33.07 lakh new connections have been provided during the JJM period.

The year-wise pattern reveals a sharp acceleration in FY 2022–23 and FY 2023–24, which together account for 68.71 per cent of all JJM-era connections. FY 2023–24 alone saw 13,95,532 new FHTCs—the highest single-year addition—reflecting a period of peak implementation capacity. The subsequent moderation in FY 2024–25 (2,02,574 FHTCs) indicates a shift towards consolidation and quality assurance of existing connections.

Figure 13.1 shows the year-wise distribution of FHTCs provided. The sharp ramp-up from FY 2021–22 onwards is evident, with FY 2023–24 alone contributing 42.2 per cent of all

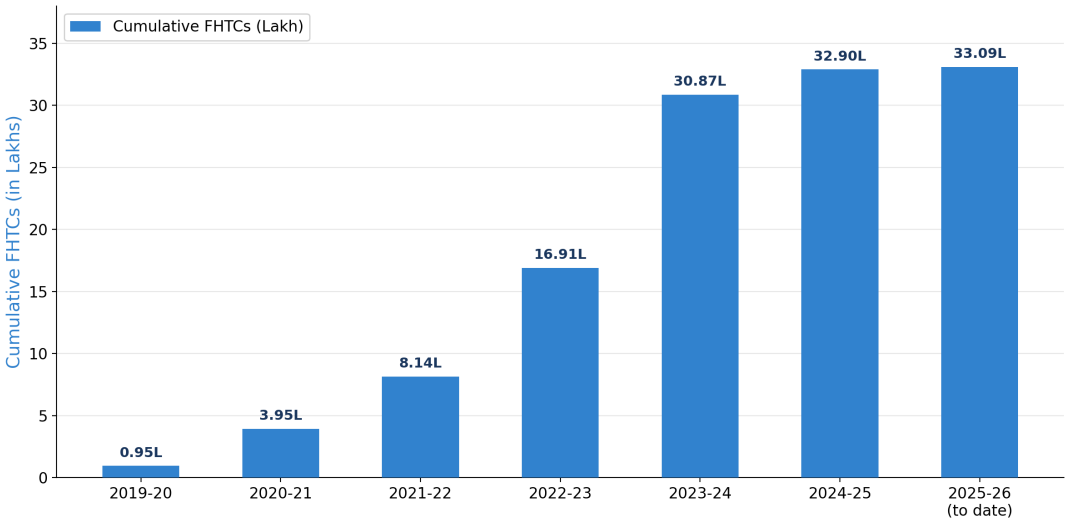

Figure 13.1. Progress in Functional Household Tap Connections in Jharkhand (2019-2025)

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

JJM-era connections. The subsequent deceleration in FY 2024–25 (6.1 per cent share) raises questions about whether implementation capacity constraints, fund flow bottlenecks, or a shift towards quality consolidation are responsible.

Functionality Assessment: Beyond coverage numbers, the quality of service delivery is assessed through functionality surveys in Har Ghar Jal (HGJ) declared villages. According to JJM Dashboard data, 97.7 per cent of surveyed households have tap availability, of which 88.9 per cent are working. However, only 80 per cent report regular supply and 72 per cent receive adequate quantity (above 55 LPCD). Potability tests show 77.9 per cent of samples passing quality standards. At the village level, 98.6 per cent of villages have piped water supply availability and 88.9 per cent have functional schemes, though only 65.3 per cent have Field Test Kits available. User satisfaction is high—94.8 per cent on water quality, 84.2 per cent on pressure, and 83.1 per cent on quantity.

Inclusion: The state has 2,410 Particularly Vulnerable Tribal Group (PVTG) villages across all 24 districts, of which 53 per cent (2,90,847 out of 5,39,678 households) have tap water connections. Two districts still have coverage below 33 per cent, and 122 villages remain without any piped water supply, indicating the need for continued last-mile efforts.

13.2.3 Projection: Pathway to Universal Coverage

Given that 45 percentage points of coverage remain to be achieved, projecting the timeline for universal tap water coverage is both policy-relevant and analytically instructive. Three scenarios are constructed based on distinct growth rate assumptions derived from historical data:

- **Scenario I — Conservative (Business-as-Usual):** Based on the average annual coverage addition over the most recent three years (FY 2023–24 to FY 2025–26), the average in-

cremental rate is approximately **5.0 percentage points per year**. At this rate, universal coverage (100%) would be achieved by **FY 2034–35**.

- **Scenario II — Moderate (Sustained Acceleration):** Based on the average annual coverage addition over the entire six-year implementation period (FY 2020–21 to FY 2025–26), the average incremental rate is approximately **7.7 percentage points per year**. This scenario projects universal coverage by **FY 2031–32**.
- **Scenario III — Ambitious (Peak Performance):** Based on the peak implementation rate achieved in FY 2021–22 (14.4 pp), sustained high-intensity implementation would achieve universal coverage by **FY 2029–30**.

Table 13.2. Projected FHTC Coverage Trajectory Under Three Scenarios

Financial Year	Conservative (5.0 pp/yr)	Moderate (7.7 pp/yr)	Ambitious (14.4 pp/yr)
2025–26 (Current)	55.0	55.0	55.0
2026–27	60.0	62.7	69.4
2027–28	65.0	70.4	83.7
2028–29	70.0	78.1	98.1
2029–30	75.0	85.7	**100.0**
2030–31	80.0	93.4	—
2031–32	85.0	**100.0**	—
2032–33	90.0	—	—
2033–34	95.0	—	—
2034–35	**100.0**	—	—

Source: Author's projections based on JJM implementation data.

Note: pp = percentage points per year. Conservative: 3-year trailing average; Moderate: 6-year average; Ambitious: peak-year rate (FY 2021–22).

Figure 13.2 illustrates the divergence across the three scenarios. Under the conservative (BAU) path, achieving the JJM target of universal coverage would be delayed to FY 2034–35, five years beyond the SDG 2030 deadline. The moderate scenario, requiring sustained effort at the six-year average rate, aligns more closely with policy expectations. However, only the ambitious scenario, replicating peak-year implementation intensity, offers the possibility of achieving universal coverage by FY 2029–30, broadly aligned with the SDG 2030 deadline.

Policy Implication: To achieve universal tap water coverage by 2030, Jharkhand would need to provide approximately 28 lakh additional FHTCs over the remaining four years, requiring an average of 7 lakh FHTCs per year. This is achievable given the peak-year performance of FY 2023–24 (13.96 lakh FHTCs) but would require sustained high-intensity implementation, enhanced fund utilisation (currently 46.30 per cent of Central allocation drawn), and targeted interventions in lagging districts such as Pakur (13%), Godda (19%), and Jam-

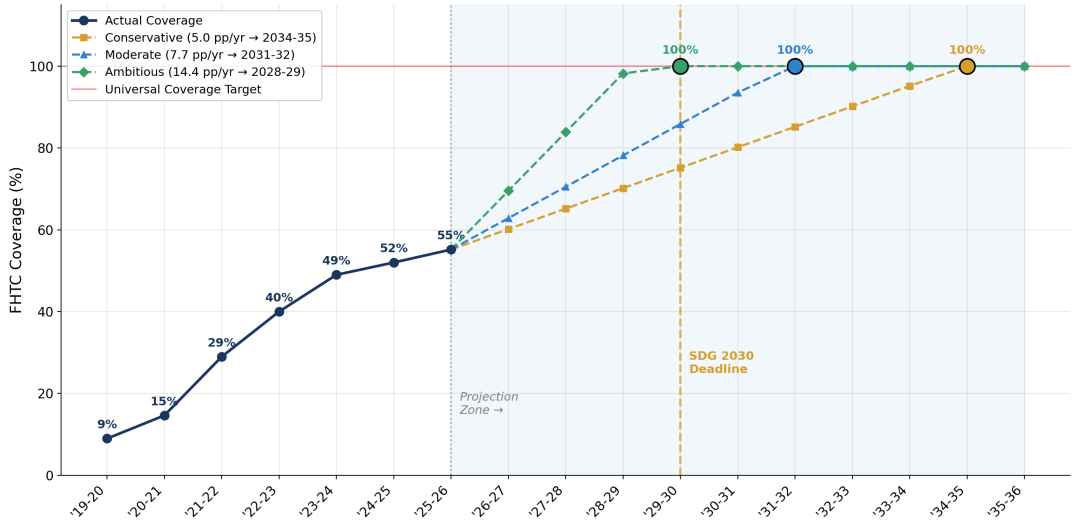

Figure 13.2. FHTC Coverage Projections: Three Scenarios to Universal Coverage

Source: Authors' projections based on JJM Dashboard data.

tara (37%). The state also has 194 projects/schemes pending clearances, expediting which could accelerate coverage. Additionally, 122 villages remain without any piped water supply and require priority attention.

13.2.4 District-wise Coverage Analysis

The expansion of tap water coverage has been uneven across districts, reflecting variations in baseline infrastructure, geographical challenges, and implementation capacity. Table 13.3 details the district-wise FHTC coverage as of November 2024.

Inter-district variation in FHTC coverage is pronounced. Simdega leads at 93 per cent, followed by Lohardaga (77 per cent), Giridih (73 per cent), and Latehar (73 per cent). These districts have relatively smaller target populations (Simdega: 1.30 lakh HH, Lohardaga: 0.93 lakh HH), which facilitated faster saturation.

At the other end, Pakur (13 per cent, 2.28 lakh HH), Godda (19 per cent, 3.03 lakh HH), and Jamtara (37 per cent, 1.49 lakh HH) remain well below the state average. East Singhbhum (41 per cent, 3.56 lakh HH), despite being relatively urbanised, also lags, suggesting that factors beyond terrain, such as scheme completion delays and institutional capacity, contribute to the coverage gap.

Figure 13.3 arranges all 24 districts by coverage. The 80 percentage point gap between Simdega (93 per cent) and Pakur (13 per cent) is the widest inter-district variation among JJM indicators in the state. Twelve districts remain below the state average of 55 per cent, collectively accounting for approximately 16 lakh unconnected households.

Table 13.3. District-wise FHTC Coverage Status (FY 2025–26)

District	Total HH	FHTCs	Coverage (%)
Simdega	1,30,131	1,20,932	93
Lohardaga	92,807	71,175	77
Giridih	4,98,960	3,63,700	73
Latehar	1,86,116	1,36,614	73
Ramgarh	1,43,842	1,01,356	70
Gumla	2,14,703	1,45,320	68
West Singhbhum	3,25,971	2,14,852	66
Chatra	2,21,791	1,43,892	65
Ranchi	4,50,730	2,90,884	65
Garhwa	3,12,002	1,99,713	64
Khunti	1,20,124	75,053	62
Hazaribagh	3,44,548	2,07,848	60
Deoghar	2,90,663	1,65,855	57
Palamu	3,66,979	1,93,268	53
Bokaro	3,16,199	1,58,732	50
Dumka	2,96,116	1,49,051	50
Saraikela-Kharsawan	1,84,753	90,653	49
Dhanbad	2,78,654	1,33,428	48
Koderma	1,45,502	66,433	46
Sahibganj	2,81,088	1,30,172	46
East Singhbhum	3,55,580	1,45,858	41
Jamtara	1,48,810	55,193	37
Godda	3,03,458	58,666	19
Pakur	2,28,456	29,518	13
Jharkhand	**62,37,983**	**34,48,166**	**55**

Source: JJM-IMIS Format J1, Ministry of Jal Shakti, Government of India.

Note: Districts sorted by coverage (descending). Data as of January 2026.

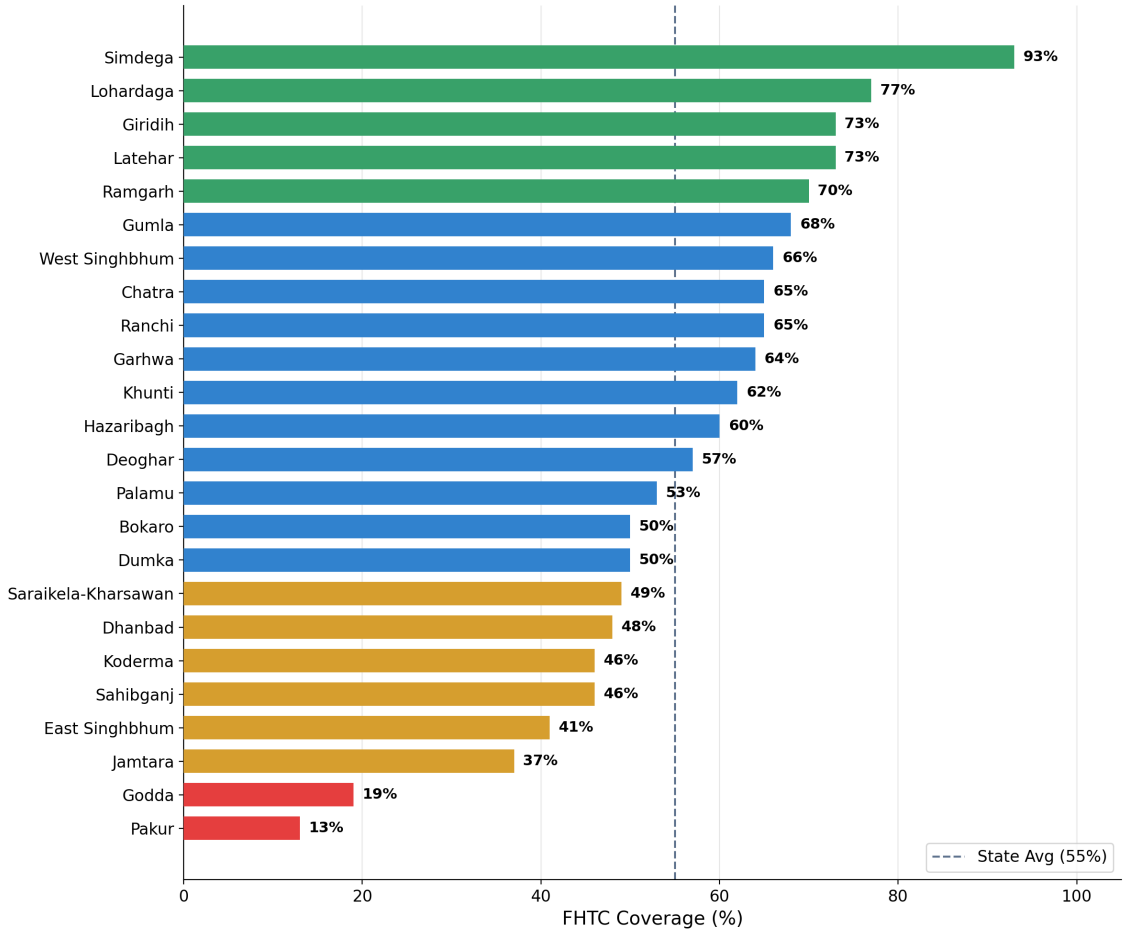

Figure 13.3. District-wise FHTC Coverage (January 2026)

Source: JJM-IMIS Format J1, Ministry of Jal Shakti, Government of India.

13.2.5 Jal Jeevan Survekshan: National Assessment

The Jal Jeevan Survekshan (JJS) is an annual assessment that evaluates state and district performance across coverage, service delivery, water quality, community participation, and sustainability dimensions. Jharkhand's ranking in this composite index provides a perspective on mission quality that goes beyond the coverage metric alone. Table 13.4 shows the top five states in the JJS 2024 rankings.

Table 13.4. Jal Jeevan Survekshan: National Ranking (2024)

National Rank	State	Total Score
1	Uttar Pradesh	263.787
2	Assam	244.386
3	Meghalaya	225.399
4	Chhattisgarh	214.011
5	**Jharkhand**	**185.079**

Source: Jal Jeevan Survekshan 2024, Ministry of Jal Shakti, Government of India (December 2024).

Jharkhand secured the fifth position nationally with a total score of 185.079. This is a notable achievement for a state with FHTC coverage of 55.17 per cent, as it indicates strong performance on qualitative dimensions of mission implementation, including water quality testing, community participation, and institutional processes.

The gap of 78.7 points between Jharkhand (185.079) and the top-ranked state Uttar Pradesh (263.787) points to scope for improvement in areas such as Gram Panchayat-level water committee functioning, asset sustainability, and scheme completion rates.

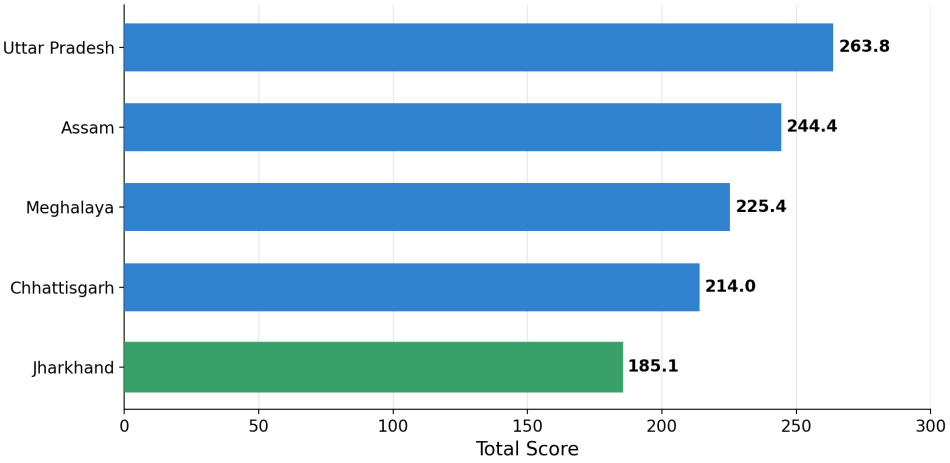

Figure 13.4. Jal Jeevan Surveksha 2024: Top Performing States

Source: Jal Jeevan Surveksha 2024, Ministry of Jal Shakti, Government of India.

13.3 Water Quality Monitoring and Surveillance

Water quality monitoring is integral to the transition from access-based to service-quality-based delivery under JJM. Jharkhand has invested in laboratory infrastructure, field testing capacity, and community-based surveillance to ensure that supplied water meets BIS 10500 safety standards. This section examines the state's testing infrastructure, sample testing volumes, and contamination profile.

13.3.1 Water Quality Testing Infrastructure

Reliable water quality assurance depends on adequate laboratory infrastructure with valid accreditation. Jharkhand's laboratory network supports both routine surveillance and the identification of contamination hotspots for remedial action. Table 13.5 summarises the status of water quality testing laboratories in the state.

Table 13.5. Water Quality Testing Infrastructure

Category	Status
Total Water Quality Testing Laboratories	31
Of which NABL Accredited	31 (100%)
Accreditation expiring within 6 months	3
Women Trained for FTK Testing	1,51,802
Water Quality Affected Habitations	Nil

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

Jharkhand has 31 water quality testing laboratories, all of which are NABL accredited—achieving 100 per cent accreditation coverage. Three laboratories have accreditation due to expire within the next six months and require timely renewal. Significantly, the state has no water quality affected habitation as per JJM records, indicating that identified contamination issues have been addressed through remedial measures.

A notable aspect of the water quality programme is the training of 1,51,802 women for conducting water quality tests using Field Test Kits (FTKs). This community-based approach enables decentralised surveillance at the village level. The 100 per cent NABL accreditation rate provides a strong foundation, though timely renewal of the three expiring accreditations is necessary to maintain uninterrupted testing capacity.

13.3.2 Water Quality Testing Progress

The scale of water quality testing directly reflects the state's commitment to ensuring that expanding tap water coverage is accompanied by safety assurance. Jharkhand has expanded its testing programme substantially since FY 2022–23, with year-on-year growth in sample volumes. Table 13.6 details the status of drinking water samples tested across financial years.

Table 13.6. Status of Drinking Water Samples Tested in Jharkhand

Financial Year	Samples Tested	YoY Growth (%)	Contaminated (%)
2022–23	4,32,799	–	12.4
2023–24	9,99,919	131.1	11.2
2024–25 (up to Nov 2024)	7,79,086	–	10.8
2025–26 (up to Dec 2025)	3,09,185	–	–
Total (4 years)	**25,20,989**	–	–

Source: Department of Drinking Water and Sanitation, Government of Jharkhand.
Note: Contaminated refers to samples exceeding permissible limits for one or more parameters.

A cumulative total of over 25.20 lakh water samples have been tested across the four-year period from 2022–23 to 2025–26. Testing volumes more than doubled between 2022–23 and 2023–24, with year-on-year growth of 131.1 per cent.

The proportion of contaminated samples has shown a declining trend—from 12.4 percent in 2022–23 to 10.8 percent in 2024–25. This improvement suggests that remedial actions on identified contaminated sources are yielding positive results. The highest single-year testing was recorded in 2023–24 with 9,99,919 samples, reflecting the state's enhanced testing capacity.

Figure 13.5 shows the sustained expansion in testing volumes. The peak of approximately 10 lakh samples in FY 2023–24 coincided with the peak year for FHTC provision, reflecting coordinated expansion of both coverage and quality assurance. In the current year FY 2025–26, over 3.09 lakh samples have already been tested.

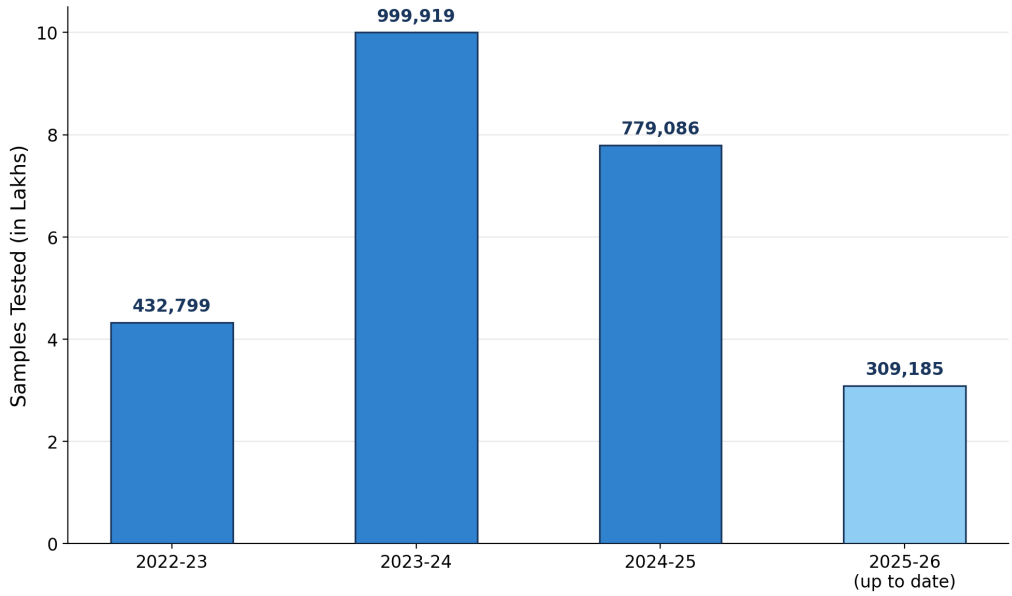

Figure 13.5. Drinking Water Samples Tested in Jharkhand (FY 2022–23 to 2025–26)

Source: Department of Drinking Water and Sanitation, Government of Jharkhand.

13.3.3 Field Test Kit (FTK) Programme

Field Test Kits (FTKs) extend water quality surveillance to the village level through trained community members, particularly women from Self-Help Groups. With 1,51,802 women trained for FTK testing, Jharkhand has built substantial decentralised testing capacity. Table 13.7 compares Jharkhand's FTK testing volumes with national figures.

Table 13.7. Field Test Kit (FTK) Testing Status: Jharkhand and India

	FY 2024–25			FY 2025–26 (up to Dec 2025)		
Parameter	**JH**	**India**	**JH %**	**JH**	**India**	**JH %**
Villages with FTK Tests	28,230	3,45,435	8.2	5,917	2,22,229	2.7
Total FTK Tests	6,99,655	73,78,043	9.5	1,50,514	40,05,074	3.8
Remedial Actions Taken	20	71,629	0.03	39	118	33.1

Source: Jal Jeevan Mission, Ministry of Jal Shakti, Government of India.

The data shows that FTK tests have been conducted in 28,230 villages in Jharkhand during FY 2024–25, representing 8.2 percent of the national total. A total of 6,99,655 individual FTK tests were conducted during FY 2024–25, contributing 9.5 percent to the national testing effort. In FY 2025–26 (up to date), testing has been conducted in 5,917 villages with 1,50,514 tests, demonstrating continued surveillance activity.

Figure 13.6 compares Jharkhand's FTK programme with national totals. The state accounts for 8.2 per cent of villages with FTK tests and 9.5 per cent of total FTK tests nationally,

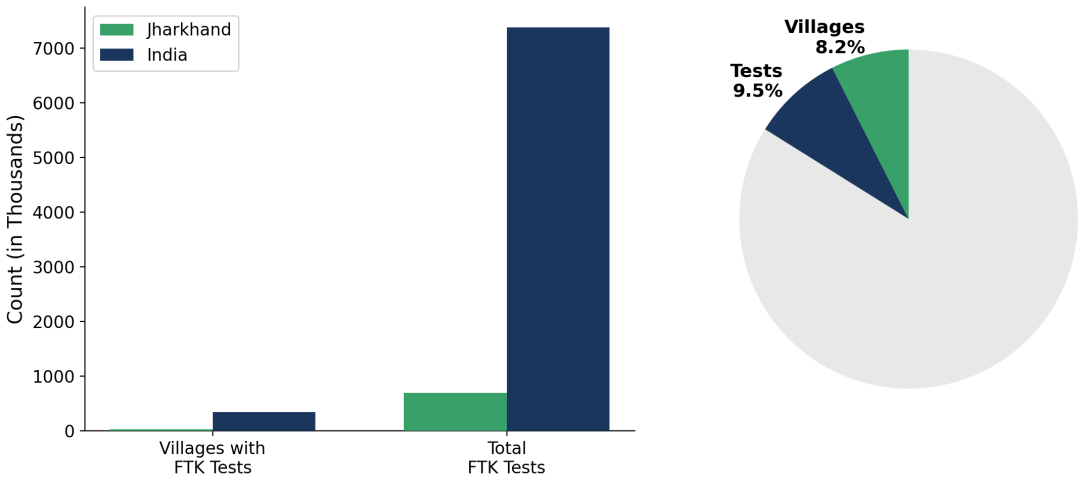

Figure 13.6. FTK Testing and Remedial Actions: Jharkhand vs India

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

a share that exceeds its proportion of rural households (approximately 3.3 per cent of India's total), indicating relatively intensive community-level surveillance.

13.3.4 Water Quality Parameters and Contamination Profile

Understanding which specific contaminants affect Jharkhand's water sources is essential for prioritising remedial interventions. The contamination profile is shaped by the geological characteristics of the Chotanagpur Plateau, particularly the prevalence of iron-bearing rock formations. Table 13.8 compares parameter-wise contamination rates for Jharkhand with national averages.

Table 13.8. Parameter-wise Water Contamination: Jharkhand vs India

Parameter	Jharkhand (%)	India (%)	Difference (pp)
Iron	8.4	5.2	+3.2
Bacteriological	3.2	4.8	-1.6
Fluoride	2.8	3.5	-0.7
TDS	2.1	3.4	-1.3
Nitrate	1.5	2.2	-0.7
Arsenic	0.3	0.8	-0.5

Source: Water Quality Testing Data, JJM Portal (November 2025).
Note: Percentage of tested sources exceeding permissible limits.

Among the parameters monitored, iron contamination is the most prevalent concern in Jharkhand, affecting 8.4 per cent of tested sources compared to the national average of 5.2

per cent. This is consistent with the geological characteristics of the Chotanagpur Plateau, where iron-bearing rock formations are widespread. Bacteriological contamination (3.2 per cent) and fluoride (2.8 per cent) are the next most common. Remedial measures, including installation of iron removal plants, fluoride filters, and chlorination systems, are being implemented based on testing findings.

Jharkhand performs better than the national average on several parameters: bacteriological contamination (3.2 per cent vs 4.8 per cent), fluoride (2.8 per cent vs 3.5 per cent), and arsenic (0.3 per cent vs 0.8 per cent). The low arsenic contamination is particularly notable given the severity of arsenic problems in neighbouring states. According to JJM Water Quality MIS (Format WQ6), only one village in Jharkhand, East Narayanpur in Rajmahal Block, Sahibganj District, was identified as having fluoride contamination during FY 2023–24.

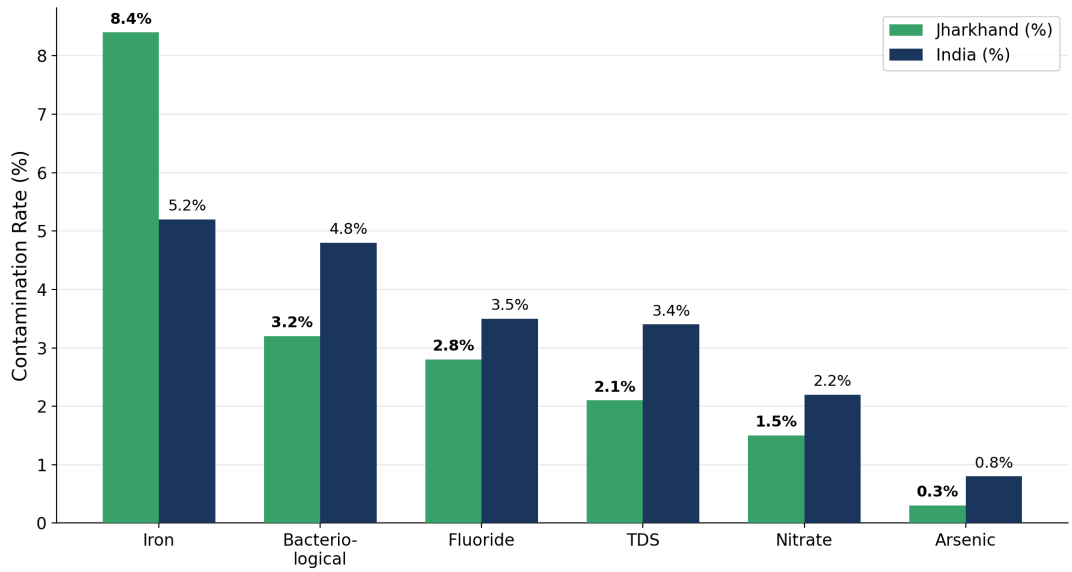

Figure 13.7. Water Quality: Parameter-wise Contamination Comparison

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

Figure 13.7 illustrates the contamination profile. The prominence of iron, at 8.4 per cent against the national average of 5.2 per cent, points to geological factors specific to the Chotanagpur Plateau. Accelerated installation of Iron Removal Plants should be a priority intervention for water quality improvement.

13.4 Progress in Drinking Water Facilities: NFHS Evidence

While JJM Dashboard data tracks programme outputs (connections provided), the National Family Health Survey (NFHS) provides independent household-level evidence on actual access and usage patterns. Comparing NFHS-4 (2015–16) and NFHS-5 (2019–21) captures progress during the period immediately preceding and overlapping with JJM launch.

13.4.1 Access to Improved Drinking Water Sources

The NFHS comparison is particularly informative because it captures household-reported access and behaviour, not just administrative provision data. Changes in water availability on premises, collection time, and treatment practices indicate whether infrastructure expansion translates into improved daily experience for households. Table 13.9 compares drinking water indicators across the two survey rounds.

Table 13.9. Progress in Drinking Water Facilities: NFHS-4 vs NFHS-5

Indicator	NFHS-4 (%)	NFHS-5 (%)	Change (pp)
Source of Drinking Water			
Improved source	77.7	86.8	+9.1
Piped into dwelling/yard/plot	11.6	12.8	+1.2
Public tap/standpipe	9.5	12.8	+3.3
Tube well or borehole	48.5	53.9	+5.4
Location of Drinking Water Source			
Water on premises/delivered	35.9	50.4	+14.5
<30 minutes round trip	42.8	52.3	+9.5
30 minutes or more	21.3	12.3	-9.0
Treatment of Drinking Water			
Boil	8.3	26.1	+17.8
Use appropriate treatment	16.2	31.8	+15.6

Source: National Family Health Survey (NFHS-4: 2015–16; NFHS-5: 2019–21), International Institute for Population Sciences.
Note: pp = percentage points.

The NFHS comparison reveals significant progress across multiple dimensions:

Access to Improved Sources: Households with access to improved drinking water sources increased from 77.7 percent in NFHS-4 to 86.8 percent in NFHS-5, an improvement of 9.1 percentage points. This reflects sustained investments in water supply infrastructure over the period.

Water on Premises: The proportion of households with water on premises or delivered to their dwelling increased substantially from 35.9 percent to 50.4 percent, a gain of 14.5 percentage points. This improvement has significant implications for reducing the time burden on women and children who traditionally bear responsibility for water collection.

Reduced Collection Time: Correspondingly, households requiring 30 minutes or more for water collection declined from 21.3 percent to 12.3 percent. The reduction in collection time translates to enhanced productivity and improved quality of life for affected households.

Water Treatment Practices: The proportion of households using appropriate water treatment methods nearly doubled from 16.2 percent to 31.8 percent, indicating improved aware-

ness regarding water safety.

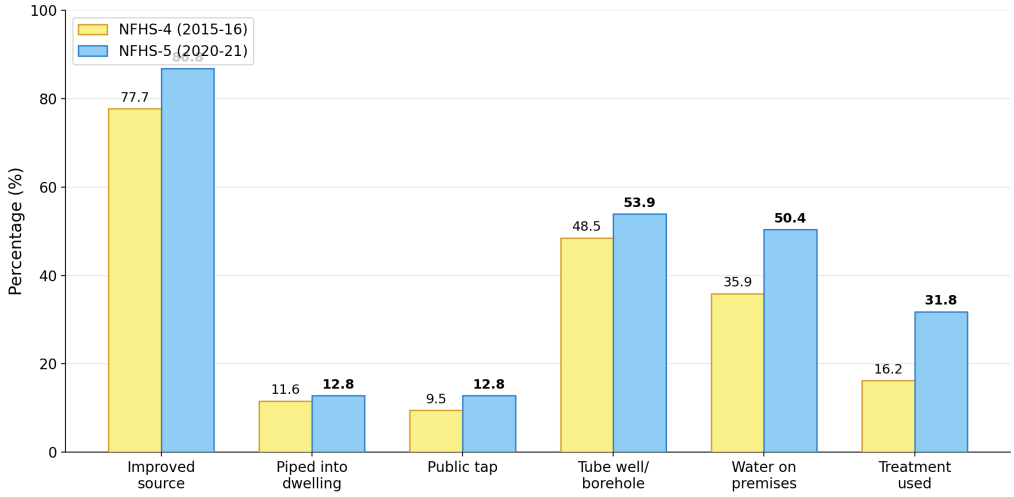

Figure 13.8. Progress in Drinking Water Facilities: NFHS-4 vs NFHS-5

Source: NFHS-4 (2015–16); NFHS-5 (2019–21), IIPS.

Figure 13.8 shows improvement across all measured parameters between the two survey rounds. The largest gains were in water availability on premises (+14.5 pp) and water treatment usage (+15.6 pp), both of which have direct implications for household health outcomes and time savings, particularly for women and children.

13.5 Sanitation: Rural Progress under SBM-Gramin

Rural sanitation in Jharkhand has undergone a transformation since the launch of Swachh Bharat Mission-Gramin (SBM-G) in October 2014. Open defecation, which affected 70 per cent of households as per NFHS-4, has declined to 33.6 per cent by NFHS-5, with NARSS-3 data confirming toilet usage at 80.2 per cent. This section examines the trajectory of rural sanitation outcomes, district-level variation, and sustainability of ODF status.

13.5.1 Swachh Bharat Mission-Gramin: Overview

The Swachh Bharat Mission-Gramin (SBM-G) was launched on 2nd October 2014 with the objective of achieving an Open Defecation Free (ODF) India. The mission focused on elimination of open defecation through construction of household and community toilets, accompanied by intensive behaviour change communication.

Phase 1 (2014-2019): Focused on toilet construction, behaviour change, and achieving ODF status across villages. Jharkhand was declared ODF on 20th November 2018.

Phase 2 (2020-2025): Builds upon Phase 1 achievements with expanded objectives:

- Sustaining ODF status and ensuring continued toilet usage
- Ensuring no one is left behind (new families, migrants, missed households)

- Solid and Liquid Waste Management (SLWM) in all villages
- Faecal sludge management through technology adoption
- Capacity building and community engagement

13.5.2 Progress in Sanitation Facilities: NFHS Evidence

The household-level evidence from NFHS provides an independent check on the construction-driven metrics reported under SBM-G. It captures not only toilet availability but also the type of facility (improved vs unimproved) and the persistence of open defecation. Table 13.10 compares sanitation indicators from NFHS-4 and NFHS-5.

Table 13.10. Progress in Sanitation Facilities: NFHS-4 vs NFHS-5

Indicator	NFHS-4 (%)	NFHS-5 (%)	Change (pp)
Type of Sanitation Facility			
Improved, not shared	24.4	55.4	+31.0
Flush to piped sewer system	5.1	12.4	+7.3
Flush to septic tank	16.9	25.3	+8.4
Flush/pour flush to pit latrine	2.0	16.8	+14.8
Unimproved Facilities			
Unimproved facility	70.5	4.2	-66.3
No facility/open space	70.0	33.6	-36.4
Toilet Access by Gender			
Males with toilet access	28.9	65.9	+37.0
Females with toilet access	29.9	65.9	+36.0

Source: National Family Health Survey (NFHS-4: 2015–16; NFHS-5: 2019–21), IIPS.

The NFHS comparison reveals transformational progress in sanitation access:

Improved Sanitation: Households with improved, non-shared sanitation facilities more than doubled from 24.4 percent in NFHS-4 to 55.4 percent in NFHS-5. This 31 percentage point improvement reflects the intensive toilet construction drive under SBM-G.

Decline in Open Defecation: The proportion of households practising open defecation declined substantially from 70.0 percent to 33.6 percent, a reduction of 36.4 percentage points. This represents one of the most significant public health improvements between NFHS-4 (2015–16) and NFHS-5 (2019–21).

Elimination of Unimproved Facilities: Households using unimproved sanitation facilities (such as pit latrines without slab, hanging latrines) declined dramatically from 70.5 percent to just 4.2 percent, indicating near-elimination of unsafe sanitation infrastructure.

Gender Equity: Both male and female toilet access increased identically to 65.9 percent, demonstrating equitable progress across gender.

Figure 13.9 shows the scale of the sanitation transition between the two survey rounds.

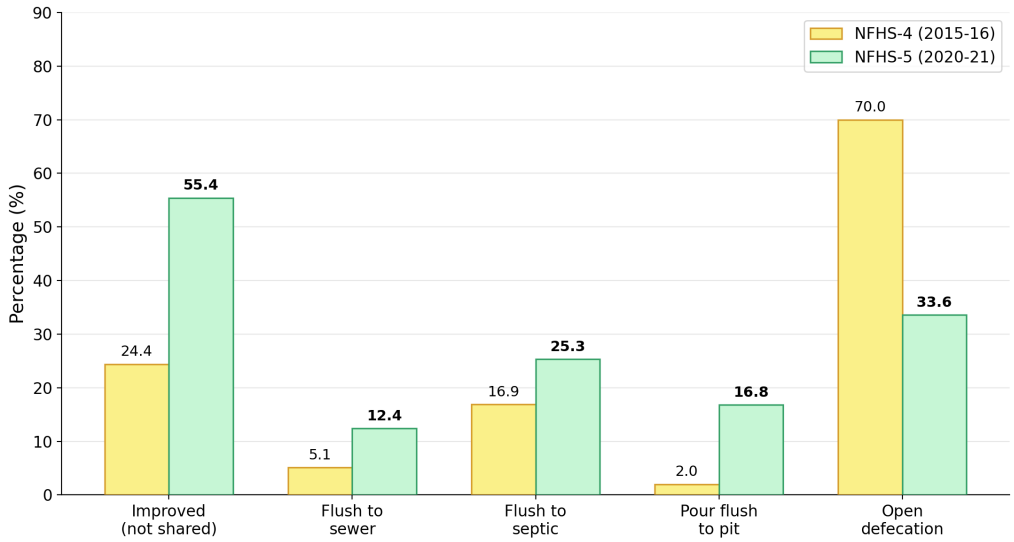

Figure 13.9. Progress in Sanitation Facilities: NFHS-4 vs NFHS-5

Source: NFHS-4 (2015–16); NFHS-5 (2019–21), IIPS.

The 36.4 percentage point reduction in open defecation, from 70 per cent to 33.6 per cent, coincides with the construction of over 52 lakh household toilets under SBM-G Phase 1.

13.5.3 District-wise Progress in Sanitation Facilities

Aggregate state-level gains can mask significant inter-district variation, particularly in a geographically diverse state like Jharkhand. Identifying which districts have progressed fastest and which continue to lag helps target behaviour change and infrastructure interventions. Table 13.11 ranks districts by NFHS-5 sanitation coverage and shows the change from NFHS-4.

All 24 districts recorded improvement in improved sanitation usage between NFHS-4 and NFHS-5. Simdega registered the largest gain at 62.4 percentage points (from 8.9 to 71.3 per cent), followed by Lohardaga (48.2 pp) and Garhwa (42.8 pp). These gains are consistent with the intensive toilet construction drive during SBM-G Phase 1.

Disparities persist at the district level. West Singhbhum (37.7 per cent), Pakur (38.3 per cent), and Dumka (41.5 per cent) remain at the bottom of the distribution, while Ranchi (77.2 per cent) and East Singhbhum (70.2 per cent) lead. The correlation between low sanitation coverage and low FHTC coverage in districts such as Pakur and Dumka suggests overlapping infrastructure deficits that would benefit from convergent WASH interventions.

13.5.4 National Annual Rural Sanitation Survey (NARSS)

The National Annual Rural Sanitation Survey (NARSS) is conducted with support from the World Bank to objectively assess rural sanitation status. The survey evaluates performance

Table 13.11. District-wise Progress in Improved Sanitation: NFHS-4 vs NFHS-5

Rank	District	NFHS-5 (%)	NFHS-4 (%)	Change (pp)
1	West Singhbhum	37.7	16.6	+21.1
2	Pakur	38.3	13.7	+24.6
3	Dumka	41.5	12.3	+29.2
4	Deoghar	41.6	21.3	+20.3
5	Sahibganj	43.2	27.1	+16.1
6	Palamu	46.3	18.4	+27.9
7	Chatra	48.1	14.8	+33.3
8	Gumla	50.1	16.8	+33.3
9	Latehar	51.4	12.5	+38.9
10	Jamtara	52.8	14.5	+38.3
11	Koderma	54.0	28.5	+25.5
12	Garhwa	54.1	11.3	+42.8
13	Godda	54.9	17.8	+37.1
14	Khunti	55.2	15.2	+40.0
15	Hazaribagh	55.6	28.5	+27.1
16	Giridih	59.2	20.2	+39.0
17	Saraikela-Kharsawan	60.9	27.1	+33.8
18	Ramgarh	64.2	40.0	+24.2
19	Bokaro	64.4	35.7	+28.7
20	Dhanbad	67.6	29.3	+38.3
21	Lohardaga	67.7	19.5	+48.2
22	East Singhbhum	70.2	44.7	+25.5
23	Simdega	71.3	8.9	+62.4
24	Ranchi	77.2	39.3	+37.9

Source: NFHS-4 (2015–16); NFHS-5 (2020–21), IIPS.

Note: pp = percentage points. Data refers to population living in households that use an improved sanitation facility (%). Ranked by NFHS-5 coverage (ascending).

against Disbursement Linked Indicators (DLIs) that trigger fund disbursement under the World Bank-supported programme component.

The DLI scores serve as the primary accountability mechanism under SBM-G, linking fund disbursement to verified outcomes rather than reported outputs. Tracking these scores across NARSS rounds reveals whether sanitation gains are being sustained beyond the initial construction phase. Table 13.12 compares Jharkhand's DLI performance with the national average across three rounds.

Table 13.12. DLI Scores: Jharkhand and India (NARSS Rounds 1, 2 and 3)

	NARSS-1		NARSS-2		NARSS-3	
Indicator	**JH**	**India**	**JH**	**India**	**JH**	**India**
DLI-1: Toilet Usage	45.2	77.6	66.6	87.6	80.2	95.4
DLI-2: ODF Verified	68.3	93.1	59.3	96.5	80.0	95.9
DLI-3: SLWM	19.8	53.5	46.0	60.4	46.2	66.6

Source: National Annual Rural Sanitation Survey (NARSS), Ministry of Jal Shakti, Government of India (2023).
Note: JH = Jharkhand; SLWM = Solid Liquid Waste Management.

The NARSS data reveals significant improvement in Jharkhand's sanitation indicators:

DLI-1 (Toilet Usage): Has shown consistent improvement from 45.2 percent in NARSS-1 to 80.2 percent in NARSS-3, an improvement of 35 percentage points. This indicates successful behaviour change, with a growing proportion of households using constructed toilets.

DLI-2 (ODF Verified Villages): Has improved from 68.3 percent in NARSS-1 to 80.0 percent in NARSS-3. The dip in NARSS-2 (59.3%) possibly reflects more stringent verification criteria. The recovery to 80.0 percent indicates progress in sustaining ODF status.

DLI-3 (SLWM): Has improved from 19.8 percent to 46.2 percent, though remaining below the national average of 66.6 percent. Solid and Liquid Waste Management represents an area requiring enhanced focus in SBM-G Phase 2.

Figure 13.10 shows that DLI-1 (toilet usage) has improved most consistently, rising 35 percentage points across three rounds. DLI-2 (ODF verification) dipped in NARSS-2 before recovering, while DLI-3 (SLWM) at 46.2 per cent remains the weakest dimension, 20.4 pp below the national average.

13.5.5 Key Indicators for DLI Computation

While the aggregate DLI scores provide a summary assessment, the underlying indicators reveal where specific gaps lie. The disaggregation into toilet access, usage, ODF verification, and SLWM coverage allows targeted identification of weak links in the sanitation chain. Table 13.13 details these component indicators, comparing Jharkhand with national averages.

The 14 percentage point gap between toilet access (94.2 per cent) and actual usage (80.2

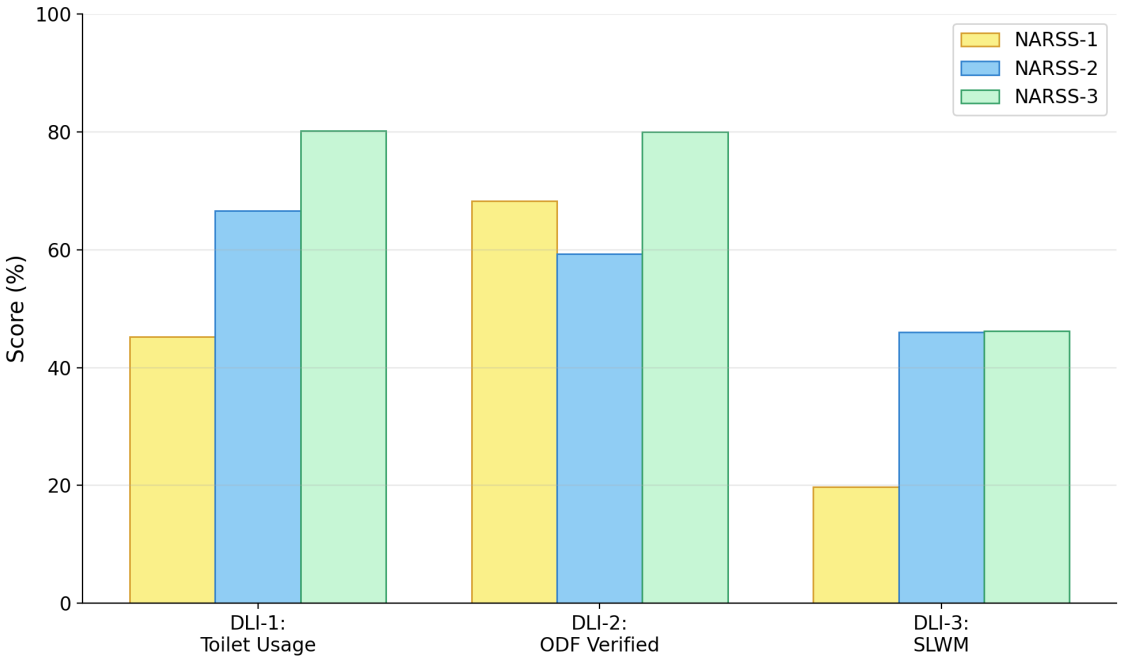

Figure 13.10. DLI Scores: Jharkhand Progress Across NARSS Rounds

Source: National Annual Rural Sanitation Survey (NARSS), Ministry of Jal Shakti, Government of India.

Table 13.13. Key Indicators for DLI Score Computation (NARSS-3)

Indicator	JH (%)	India (%)
DLI-1: Toilet Usage		
HHs with access to toilet	94.2	97.8
HHs using toilet regularly	80.2	95.4
HHs with functional toilet	91.5	96.2
DLI-2: ODF Verification		
Villages verified as ODF	80.0	95.9
No visible faeces in village	85.3	96.8
DLI-3: SLWM		
Villages with SLWM arrangements	46.2	66.6
HHs with grey water management	38.5	58.4
Villages with compost pits	52.3	72.1

Source: NARSS-3, Ministry of Jal Shakti (2023).

per cent) is a key policy concern, indicating that approximately 1 in 7 households with toilets does not use them consistently. Behaviour change communication, community monitoring, and institutional follow-up are needed to close this gap. On SLWM, Jharkhand's score of 46.2 per cent against the national average of 66.6 per cent is the widest deficit among the three DLI dimensions, highlighting the need for accelerated SLWM implementation under SBM-G Phase 2.

13.6 Urban Sanitation: Swachh Bharat Mission-Urban

Jharkhand's 50 Urban Local Bodies (ULBs), covering 1,061 wards, face distinct sanitation challenges arising from population density, mixed land use, and infrastructure constraints. All ULBs have been declared ODF under SBM-U Phase 1. SBM-U Phase 2 (2021–26) focuses on sustaining ODF status, scientific management of municipal solid waste, and ensuring adequate public sanitation infrastructure across urban areas. This section examines public toilet coverage, solid waste management, and legacy waste remediation.

13.6.1 Public Sanitation Infrastructure

Adequate public sanitation infrastructure is essential for maintaining urban hygiene, particularly in commercial areas, transit hubs, and dense settlements where household facilities are insufficient or inaccessible. The composition and density of public toilets, community toilets, and urinals indicate the state's readiness to sustain ODF status in urban areas. Table 13.14 details the current stock of public sanitation facilities under SBM-U.

Table 13.14. Public Sanitation Facilities under SBM-Urban

Facility Type	Jharkhand	India	Share (%)
Community Toilets	392	26,774	1.46
Public Toilets	363	40,019	0.91
Urinals	276	5,102	5.41
Total Facilities	**1,031**	**71,895**	**1.43**

Source: SBM-U Dashboard, Ministry of Housing and Urban Affairs.
Note: Figures refer to number of toilet blocks. Jharkhand covers 49 cities.

Jharkhand has 1,031 public sanitation facilities across 49 cities, comprising 392 community toilets, 363 public toilets, and 276 urinals. At the national level, 71,895 such facilities have been constructed. Jharkhand's share of 1.4 per cent of national facilities is modest relative to its 2.7 per cent share of national urban population, indicating scope for expanding public sanitation coverage in urban areas.

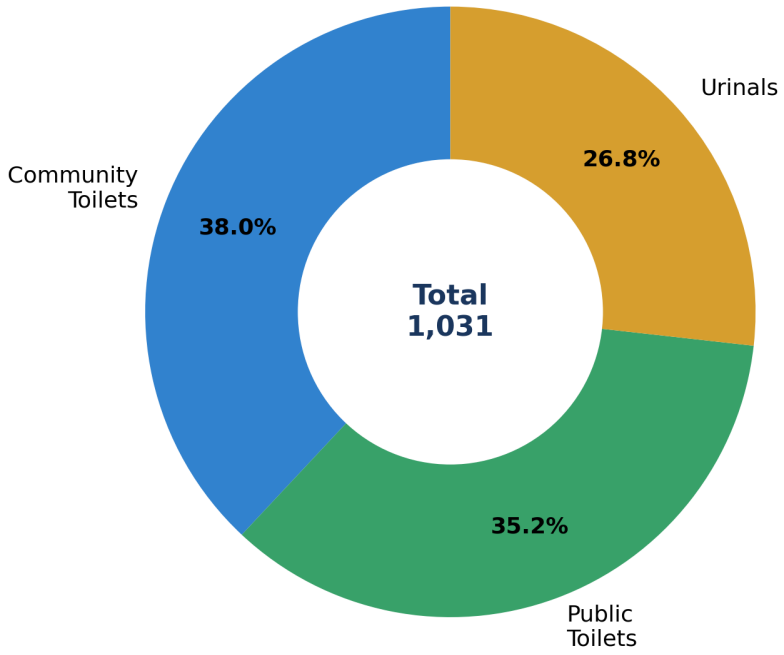

Figure 13.11. Public Sanitation Facilities under SBM-Urban

Source: SBM-Urban Dashboard, Ministry of Housing and Urban Affairs, Government of India.

13.6.2 Solid Waste Management

Scientific management of municipal solid waste is a core component of SBM-U Phase 2. Jharkhand's 1,061 wards across 50 ULBs generate approximately 2,227 TPD of waste. Table 13.15 details the current status.

Table 13.15. Status of Solid Waste Management under SBM-Urban (as of December 2024)

Indicator	Jharkhand	India
Total Wards	1,061	1,03,527
Wards with 100% D2D Collection	927 (87%)	98,347 (95.0%)
Wards with 100% Source Segregation	857 (81%)	89,265 (86.2%)
Waste Generation (TPD)	2,226.90	1,59,220.00
Waste Processed (TPD)	1,342.46	1,29,280.00
Processing Rate (%)	60.00	81.20

Source: SBM-U Dashboard, MoHUA (December 2024).
Note: D2D = Door-to-Door; TPD = Tonnes Per Day.

Collection and segregation coverage is approaching SBM-U benchmarks: 87 per cent of wards have achieved 100 per cent door-to-door collection and 81 per cent have complete source segregation. However, the waste processing rate of 60 per cent falls 21.2 percentage points below the national average of 81.20 per cent. Out of 2,226.90 TPD generated, 1,342.46 TPD is processed. Bridging this gap requires additional processing capacity of approximately 540 TPD.

13.6.3 Legacy Waste Management

Legacy waste, accumulated in dumpsites before scientific processing was introduced, poses environmental and public health risks including groundwater contamination and land degradation. Remediation of these sites is a priority under SBM-U Phase 2, with the additional benefit of reclaiming dumpsite land for productive urban use. Table 13.16 summarises the status of legacy waste management in Jharkhand.

Jharkhand has 38 dumpsites with legacy waste of 31 lakh metric tonnes. Of this, 13 lakh MT (41.94 per cent) has been remediated, with 18 lakh MT remaining. The total dumpsite area is 141.44 acres, of which 29.86 acres (21.11 per cent) has been reclaimed.

Accelerating legacy waste remediation could reclaim the remaining approximately 112 acres of dumpsite land for productive urban use. Technology options including bio-mining, bio-remediation, and mechanical segregation are being explored for implementation.

13.6.4 Solid Waste Management Plants

The composition of waste processing infrastructure determines whether the state can handle diverse waste streams, including organic, recyclable, construction and demolition, and

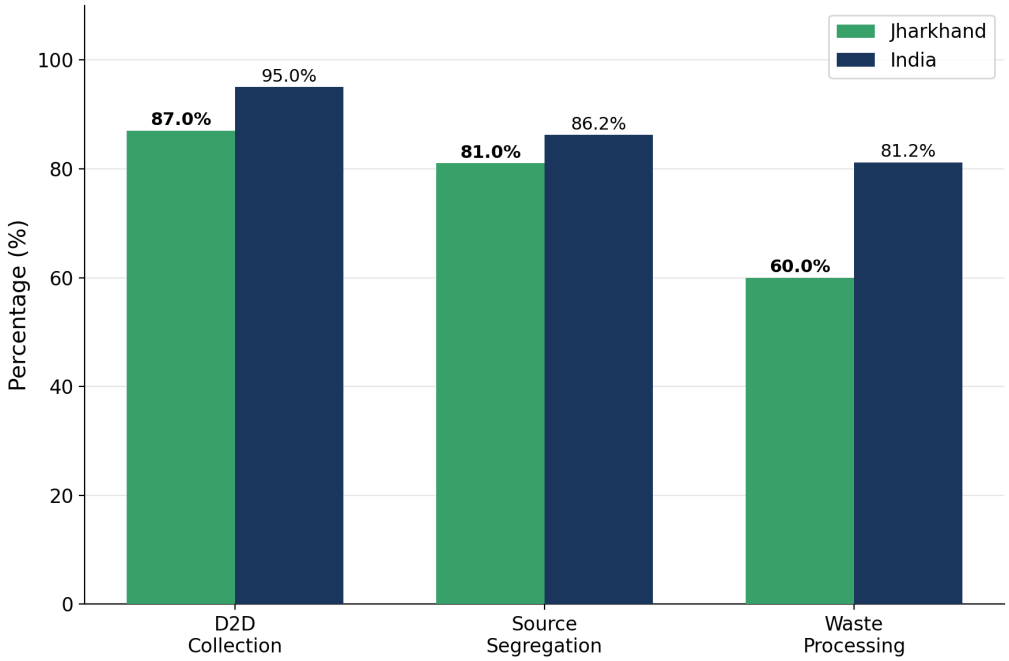

Figure 13.12. Solid Waste Management Status under SBM-Urban

Source: SBM-Urban Dashboard, Ministry of Housing and Urban Affairs, Government of India.

Table 13.16. Legacy Waste Management Status: Jharkhand

Parameter	Jharkhand
Total Dumpsites	38
Total Legacy Waste (Lakh MT)	31.00
Waste Remediated (Lakh MT)	13.00
Waste to be Remediated (Lakh MT)	18.00
Remediation Rate (%)	41.94
Total Dumpsite Area (Acres)	141.44
Area Reclaimed (Acres)	29.86
Reclamation Rate (%)	21.11

Source: SBM-U Dashboard, MoHUA.

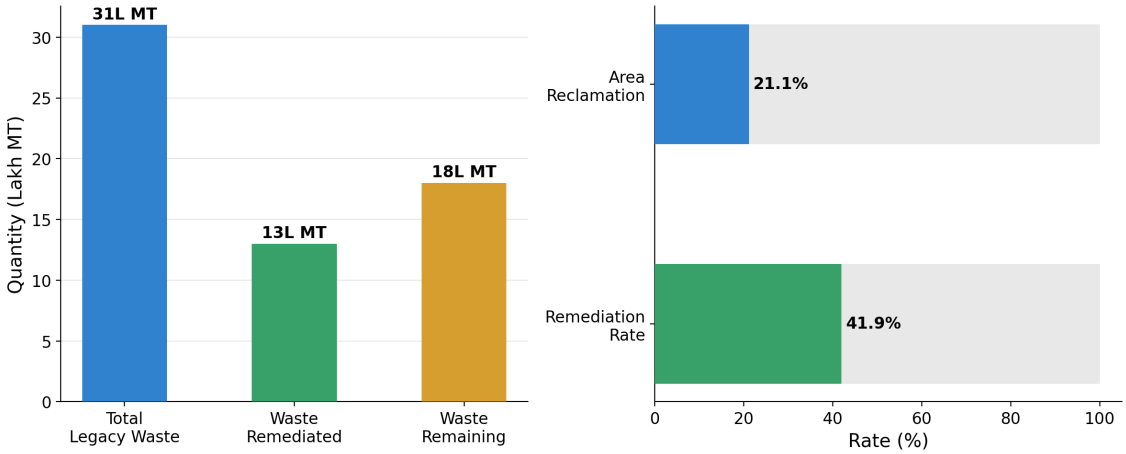

Figure 13.13. Legacy Waste Management Status: Jharkhand

Source: SBM-Urban Dashboard, Ministry of Housing and Urban Affairs, Government of India.

mixed waste. A diversified plant portfolio reduces dependence on any single processing technology. Table 13.17 details the type-wise distribution of waste processing plants in Jharkhand.

Table 13.17. Solid Waste Management Plants under SBM-Urban

	Jharkhand		India	
Plant Type	**No.**	**TPD**	**No.**	**TPD**
Biomethanation	3	169	–	4,382
Composting	22	733	–	1,22,886
Material Recovery Facility	76	805	–	1,00,616
C&D Waste Processing	11	213	–	17,607
Waste to Energy	0	0	–	18,900
SLRM	0	0	–	12,866
Total	**112**	**1,920**	–	**2,77,257**

Source: SBM-U Dashboard, MoHUA.
Note: Plants with designed capacity $\geq$ 5 TPD. C&D = Construction and Demolition; SLRM = Solid Liquid Resource Management; TPD = Tonnes Per Day.

Jharkhand has 112 waste processing plants with combined capacity of 1,920 TPD. Material Recovery Facilities (MRFs) dominate both in number (76 plants) and capacity (805 TPD), reflecting emphasis on resource recovery through segregation and recycling. Composting plants (22 units, 733 TPD) handle the organic waste stream, while C&D waste processing (11 plants, 213 TPD) and biomethanation (3 plants, 169 TPD) address specialised waste streams.

The absence of Waste-to-Energy and SLRM plants represents an opportunity for diversifying processing technology to bridge the remaining 540 TPD capacity gap.

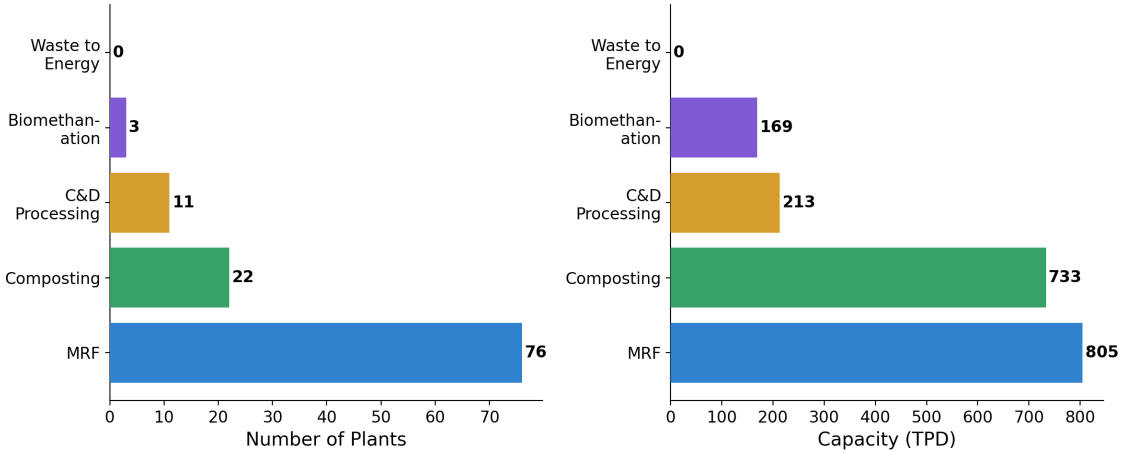

Figure 13.14. Solid Waste Management Plants: Distribution by Type

Source: SBM-Urban Dashboard, Ministry of Housing and Urban Affairs, Government of India.

13.7 Comparative Analysis: Jharkhand in National Context

Benchmarking Jharkhand's WASH performance against national averages and peer states helps identify relative strengths and areas where targeted acceleration is needed. This section examines FHTC coverage trajectories, eastern state comparisons, and rural-urban water source patterns.

13.7.1 Jharkhand vs India: FHTC Coverage Trajectory

The gap between Jharkhand and the national average is a key metric for assessing whether the state's implementation pace is sufficient to achieve convergence. Tracking this gap at multiple time points since mission launch reveals whether the distance is widening or narrowing. Table 13.18 compares FHTC coverage in Jharkhand and India at key milestones.

The data reveals that the gap between Jharkhand and the national average remains significant at 26.47 percentage points. Starting from a gap of 7.83 percentage points at mission launch, the gap widened steadily to 26.73 pp by March 2023 and 31.12 pp by March 2024, as other states accelerated implementation at a faster pace. While Jharkhand has made steady progress—from 8.97 per cent to 55.17 per cent—the national average has advanced to 81.64 per cent.

This trajectory underscores the need for accelerated implementation in Jharkhand to converge with the national average. Enhanced fund flow, faster scheme completion, and targeted district-level interventions are essential for closing this gap.

Table 13.18. FHTC Coverage Trajectory: Jharkhand vs India

Time Point	Jharkhand (%)	India (%)	Gap (pp)
August 2019 (JJM Launch)	8.97	16.80	-7.83
March 2021	14.63	34.50	-19.87
March 2022	28.98	50.25	-21.27
March 2023	40.00	66.73	-26.73
March 2024	49.00	80.12	-31.12
February 2026	55.17	81.64	-26.47

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti.
Note: pp = percentage points. Negative gap indicates Jharkhand is below national average.

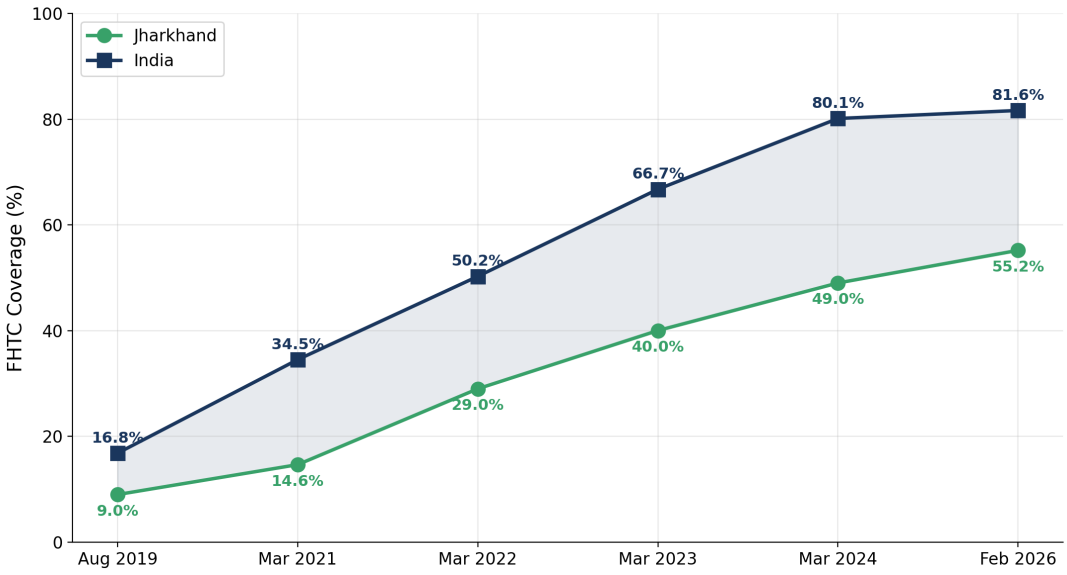

Figure 13.15. FHTC Coverage: Jharkhand vs India Comparison (2019-2024)

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

Figure 13.15 shows the widening and recent partial narrowing of the gap. Between August 2019 and March 2024, the gap expanded from 7.83 pp to 31.12 pp as the national average advanced rapidly from 16.80 to 80.12 per cent. The narrowing to 26.47 pp by February 2026 coincides with the moderation in national growth (the all-India figure moved only 1.52 pp from March 2024) alongside continued progress in Jharkhand (6.17 pp gain over the same period).

13.7.2 Eastern States Comparison

Jharkhand's performance can also be assessed in the context of neighbouring eastern states that share similar geographical, demographic, and developmental characteristics. Table 13.19 compares FHTC coverage across eastern states as of February 2026.

Table 13.19. Eastern States: FHTC Coverage and JJS Ranking

State	Total HH	FHTCs	FHTC (%)	JJS Rank
Bihar	1,67,55,041	1,60,36,454	95.71	–
Chhattisgarh	49,97,459	41,09,430	82.23	4
Assam	72,24,239	59,01,746	81.69	2
Odisha	88,64,687	68,47,102	77.24	–
West Bengal	1,75,51,736	99,38,728	56.63	–
Jharkhand	**62,53,187**	**34,49,717**	**55.17**	**5**

Source: Jal Jeevan Mission Dashboard (15 February 2026); Jal Jeevan Survekshan 2024.
Note: JJS Rank shown only for states in the top 5 nationally. States sorted by FHTC coverage (descending).

Among eastern states, Jharkhand's FHTC coverage (55.17 per cent) is the lowest, closely followed by West Bengal (56.63 per cent). Bihar leads at 95.71 per cent, followed by Chhattisgarh (82.23 per cent), Assam (81.69 per cent), and Odisha (77.24 per cent). However, on the composite Jal Jeevan Survekshan 2024 ranking, Jharkhand (5th nationally) outperforms several states with higher FHTC coverage, reflecting stronger performance on qualitative parameters such as water quality testing, service delivery, and community participation.

The comparative analysis suggests that while there is scope for accelerating FHTC coverage to match leading states, Jharkhand's overall mission implementation quality is competitive within the regional context.

Figure 13.16 illustrates the FHTC coverage gap across eastern states. Bihar, Chhattisgarh, and Assam have all crossed the national average (81.64 per cent), while Jharkhand and West Bengal remain below 60 per cent. The India average line in the chart underscores the distance both states must cover to converge with national benchmarks.

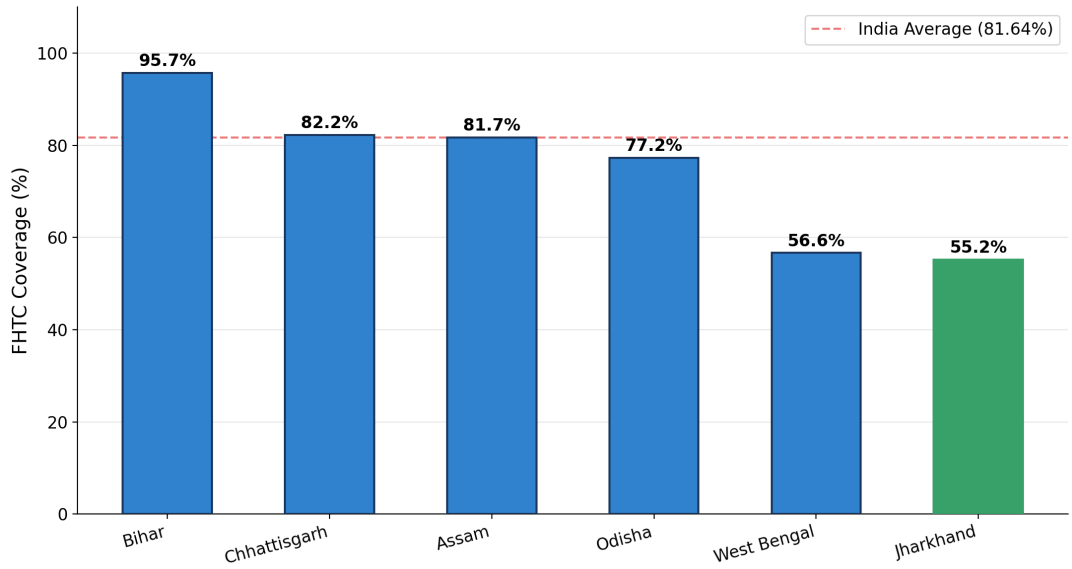

Figure 13.16. Eastern States: FHTC Coverage Comparison (February 2026)

Source: Jal Jeevan Mission Dashboard, Ministry of Jal Shakti, Government of India.

13.7.3 Rural vs Urban Water Source Distribution

The composition of drinking water sources differs between rural and urban Jharkhand, reflecting the stage of infrastructure development in each setting. Figure 13.17 presents this distribution.

In rural areas, tap water accounts for 45.2 per cent of sources, with tube wells (32.5 per cent) and hand pumps (12.8 per cent) comprising the remainder. This mixed pattern reflects the ongoing transition under JJM; with 55.17 per cent rural FHTC coverage as of February 2026, the tap water share can be expected to increase further in subsequent surveys.

In urban areas, tap water dominates at 78.5 per cent, with tube wells (8.2 per cent) playing a limited supplementary role. The 33.3 percentage point rural-urban gap in tap water access underscores the infrastructure differential that JJM is designed to narrow.

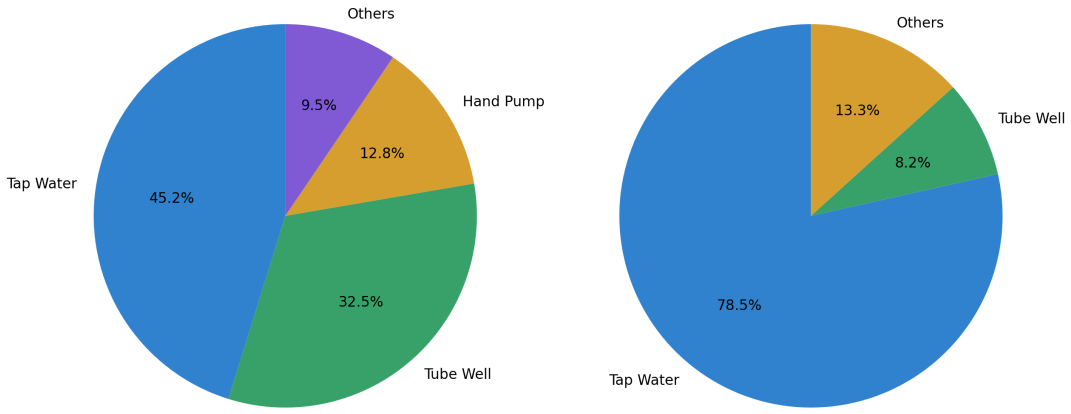

Figure 13.17. Drinking Water Source Distribution: Rural vs Urban Areas

Source: NFHS-5 (2019–21), IIPS.

13.8 Sanitation Transformation: A Decade of Progress

Jharkhand's sanitation trajectory since 2014 represents one of the most significant public health transitions in the state's history. The shift from 78 per cent open defecation in 2014 to near-elimination by 2024 reflects the combined impact of infrastructure provision, behaviour change communication, and institutional coordination under SBM. This section traces the key milestones and district-level performance.

13.8.1 Timeline of Sanitation Progress

Mapping the annual trajectory of toilet coverage and open defecation rates reveals the speed and phasing of the sanitation transition. The timeline also identifies the critical inflection points, such as the crossover year when toilet coverage surpassed open defecation, and the ODF declaration milestone. Table 13.20 traces this chronological progression.

The data demonstrates a dramatic transformation from 78 percent open defecation in 2014 to just 2 percent by 2024. This 76 percentage point reduction represents one of the most significant public health achievements in the state's history. The declaration of ODF status on 20th November 2018 marked a pivotal milestone, achieved ahead of many larger states.

Figure 13.18 shows the crossover point in 2017, when toilet coverage first exceeded open defecation rates. The steepest improvement occurred between 2017 and 2018 (toilet coverage rose from 52 to 88 per cent), culminating in Jharkhand's ODF declaration on 20 November 2018. Post-ODF, the focus has shifted to sustaining gains and achieving ODF Plus status through solid and liquid waste management. The phasing of this transition, with construction-driven gains followed by behaviour sustenance, provides a template for states at earlier stages of their sanitation journeys.

Table 13.20. Sanitation Transformation Timeline: Jharkhand (2014-2024)

Year	Toilet Coverage (%)	Open Defecation (%)	Key Milestone
2014 (SBM Launch)	22	78	SBM-G launched on 2nd October
2016	35	65	Intensification of IEC activities
2017	52	48	Accelerated toilet construction
2018	88	12	**Jharkhand declared ODF (20th Nov)**
2020	92	8	SBM Phase 2 commenced
2022	95	5	Focus on ODF sustainability
2024	98	2	Enhanced SLWM focus

Source: SBM Dashboard; NARSS Reports; Departmental Records.

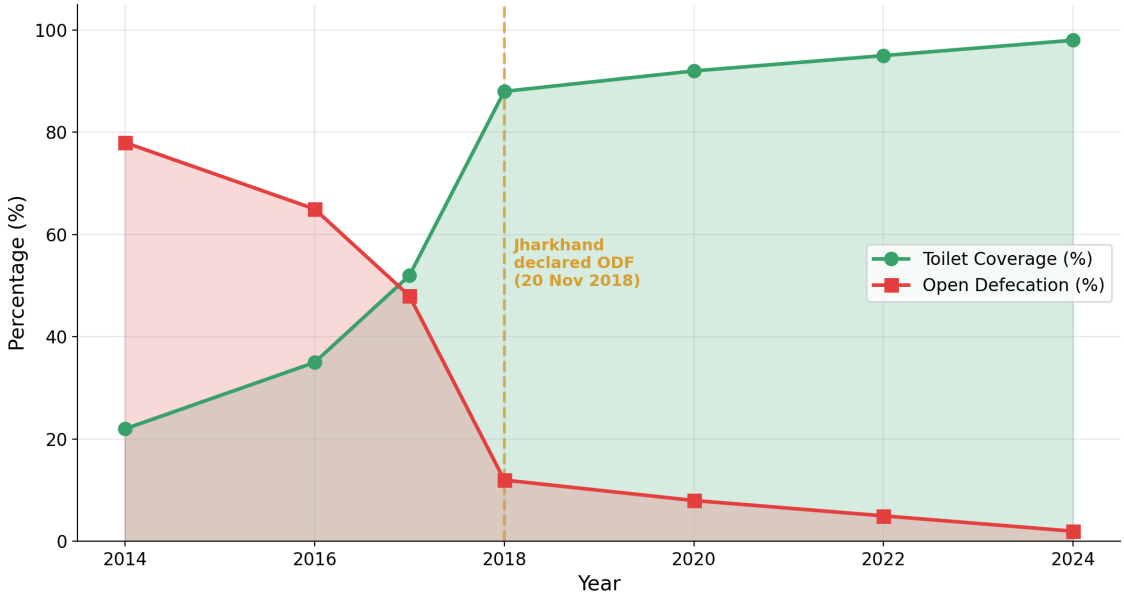

Figure 13.18. Sanitation Transformation in Jharkhand (2014-2024)

Source: Swachh Bharat Mission-Gramin Dashboard; NARSS Reports, Ministry of Jal Shakti, Government of India.

13.8.2 District Performance Matrix

Figure 13.19 maps district performance across FHTC coverage, NFHS-5 sanitation, and SLWM indicators. Simdega and Lohardaga score high on coverage but lower on SLWM, while East Singhbhum shows the reverse pattern. Pakur, Godda, and Jamtara score below average across multiple dimensions, indicating the need for integrated district-level WASH plans.

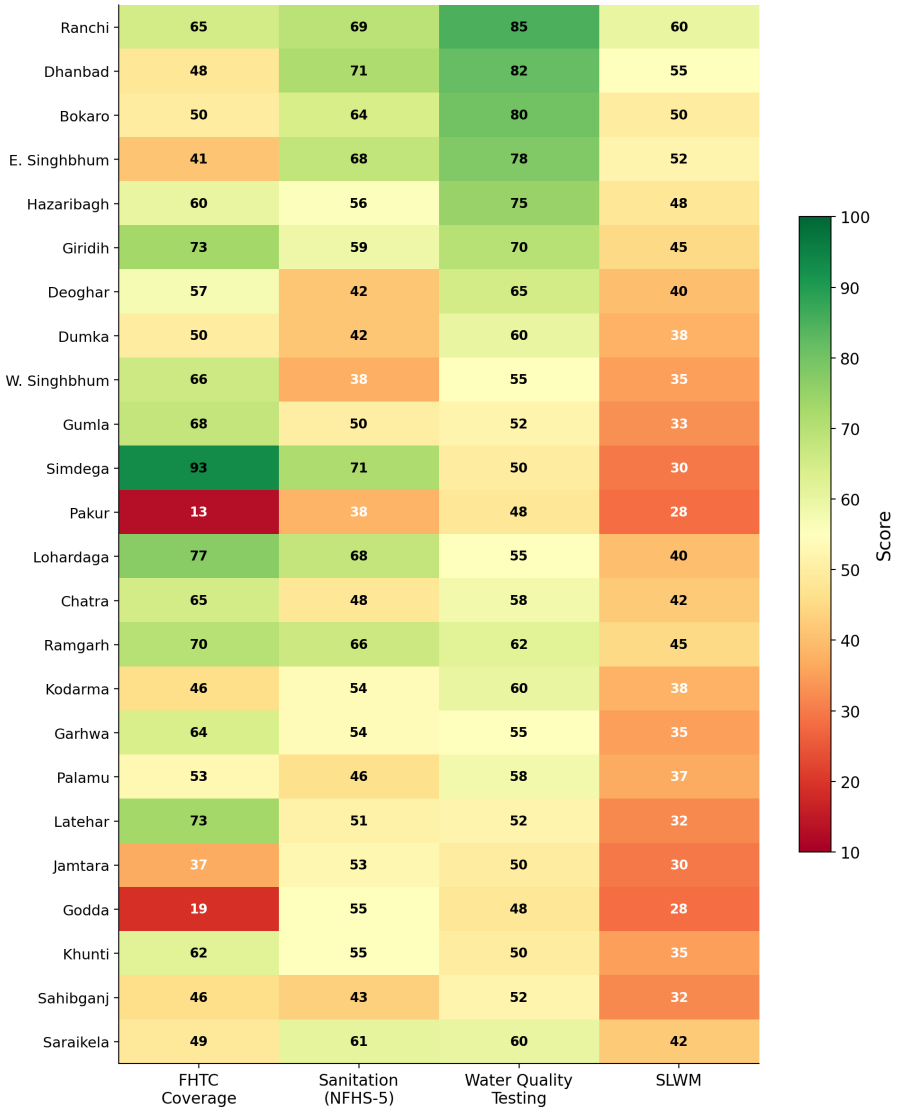

Figure 13.19. District Performance Heatmap: WASH Indicators

Source: JJM Dashboard; NFHS-5 (2019–21), IIPS; NARSS-3, Ministry of Jal Shakti, Government of India.

13.9 Budget and Financial Analysis

The pace of FHTC coverage expansion is closely linked to the flow and utilisation of financial resources. Jharkhand's JJM has a total estimated cost of Rs. 24,951.70 crore, with Central allocation of Rs. 12,982.30 crore. This section examines expenditure patterns and fund utilisation.

13.9.1 Jal Jeevan Mission: Financial Progress

Understanding the financial dynamics of JJM implementation is critical because the correlation between expenditure and FHTC provision reveals whether fund flow constraints have limited physical progress. The division-wise disaggregation further indicates whether resource allocation matches district-level coverage gaps. Table 13.21 details division-wise PFMS expenditure under JJM, based on Format D29 data.

Table 13.21. Jal Jeevan Mission: Division-wise PFMS Expenditure (Rs. Lakhs)

Financial Year	Total Expenditure (PFMS)	Central Share	State Share	JJM-MIS Release
2022–23	3,31,010.90	–	–	–
2023–24	6,34,084.98	3,07,529.14	3,25,023.02	6,38,212.25
2024–25	1,25,755.49	17,524.59	1,08,020.90	1,25,931.74
2025–26 (up to date)	6,048.81	353.31	2,009.57	12,410.73
Total (4 years)	**10,96,900.18**	–	–	–

Source: JJM-MIS Format D29 – Division wise PFMS Voucher Vs JJM-MIS Expenditure, Ministry of Jal Shakti, Government of India.
Note: Data covers 43 divisions across the state. 2025–26 figures are partial (up to date of survey).

The analysis reveals substantial expenditure under JJM across four financial years, with a cumulative PFMS expenditure of Rs. 10,96,900.18 lakhs (approximately Rs. 10,969 crore). The highest single-year expenditure was recorded in FY 2023–24 at Rs. 6,34,084.98 lakhs, nearly double the expenditure of FY 2022–23 (Rs. 3,31,010.90 lakhs), reflecting accelerated implementation. In FY 2023–24, the Central and State shares were Rs. 3,07,529.14 lakhs and Rs. 3,25,023.02 lakhs respectively, indicating active State matching of Central funds. The current year 2025–26 shows initial expenditure of Rs. 6,048.81 lakhs, which is expected to increase as the year progresses.

At the national allocation level (Format D1), the total Central allocation to Jharkhand since JJM launch stands at Rs. 12,982.30 crore, of which Rs. 6,010.95 crore (46.30 per cent) has been drawn. Year-wise, the allocation increased from Rs. 267.69 crore in FY 2019–20 to a peak of Rs. 4,722.76 crore in FY 2023–24, with total expenditure (Central + State) reaching Rs. 6,432.23 crore that year. The cumulative total expenditure (Central + State combined) across all years stands at Rs. 12,764.46 crore, with State share contribution of Rs. 14,363.53

crore, indicating that the State has provided matching and additional funds exceeding the Central allocation.

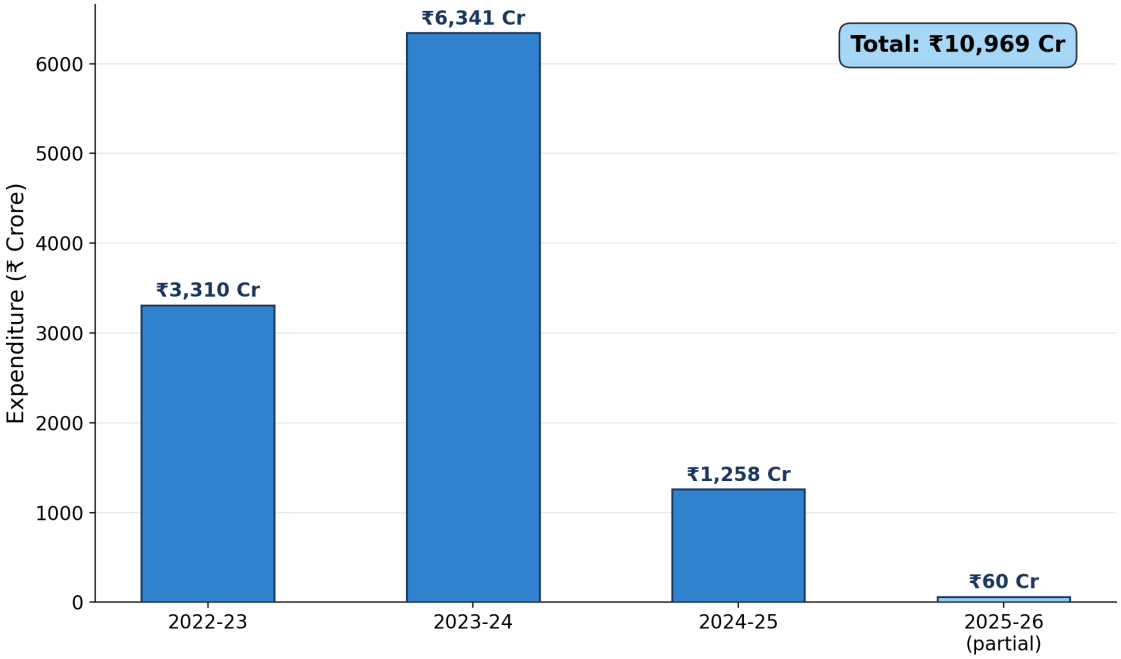

Figure 13.20. JJM Expenditure Trend: Division-wise PFMS Expenditure (FY 2022–23 to 2025–26)

Source: JJM-MIS Format D29, Ministry of Jal Shakti, Government of India.

Figure 13.20 shows the expenditure trajectory. The doubling of expenditure between FY 2022–23 and FY 2023–24 aligns with the peak in FHTC provision during the same year (13.96 lakh connections). The sharp decline in FY 2024–25 expenditure to Rs. 1,257.55 crore merits attention, as it coincided with a drop in FHTC provision to 2.03 lakh connections.

13.10 SDG 6: Progress Assessment

Jharkhand's progress on Sustainable Development Goal 6 (clean water and sanitation for all by 2030) is uneven across the three sub-targets examined. With approximately four years remaining to the SDG deadline, the current status and implied trajectories are summarised below.

SDG 6.1 (Safe Drinking Water): At 55.17 per cent FHTC coverage, Jharkhand needs to cover the remaining 28 lakh households by 2030, requiring an average of 7 lakh FHTCs per year. The peak-year performance of FY 2023–24 (13.96 lakh) demonstrates that this rate is technically achievable, but sustained implementation at that scale requires enhanced fund utilisation and expedited scheme clearances.

SDG 6.2 (Sanitation and Hygiene): With 80.2 per cent toilet usage (NARSS-3), 94.2 per cent toilet access, and open defecation reduced to 2 per cent, Jharkhand has made strong

progress. The remaining challenge is sustaining ODF status and expanding SLWM coverage from 46.2 per cent to universal levels.

SDG 6.3 (Water Quality): The state has tested 89.2 per cent of sources with 89.5 per cent remediation rate on contaminated ones. All 31 laboratories are NABL-accredited, and the state has no water quality affected habitation on record. Iron contamination (8.4 per cent of sources) remains the primary water quality concern.

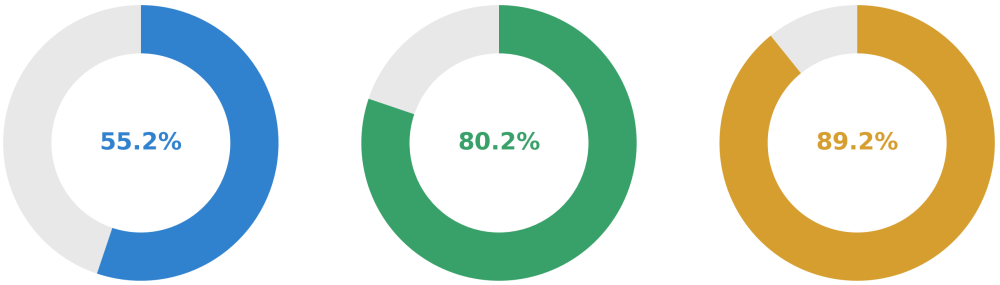

Figure 13.21. SDG 6 Progress Dashboard: Jharkhand

Source: JJM Dashboard; SBM-G Dashboard; NARSS-3, Ministry of Jal Shakti, Government of India.

Figure 13.21 presents the progress gauges for each SDG 6 sub-target. SDG 6.1 (55.17 per cent) represents the area requiring the greatest acceleration to meet the 2030 deadline.

13.11 WASH Infrastructure Summary

A consolidated view of WASH infrastructure across drinking water, rural sanitation, and urban sanitation provides a baseline for tracking progress and identifying the dimensions where capacity gaps remain most acute. Table 13.22 summarises the key infrastructure metrics for Jharkhand.

The summary highlights the contrast in maturity across WASH sub-sectors. Drinking water coverage at 55.17 per cent remains the primary gap, with 28 lakh households still unconnected. Rural sanitation has progressed furthest, with 94.2 per cent toilet access and 80.2 per cent usage, though SLWM at 46.2 per cent is a lagging dimension. Urban sanitation shows strong collection infrastructure (87 per cent ward-level coverage) but a processing deficit, with the 60 per cent waste processing rate indicating scope for expanding plant capacity.

Table 13.22. WASH Infrastructure Summary: Jharkhand (November 2024)

Infrastructure Category	Count/Coverage
Drinking Water	
Functional Household Tap Connections	34.50 Lakh
Coverage Rate	55.17%
Water Quality Testing Labs (NABL Accredited)	31
Villages with FTK Testing	28,230
Rural Sanitation	
Households with Toilets	94.2%
Toilet Usage Rate	80.2%
ODF Verified Villages	80.0%
Villages with SLWM	46.2%
Urban Sanitation	
Public/Community Toilets	1,031
Waste Processing Plants	112
Processing Capacity (TPD)	1,920
Waste Processing Rate	60.00%

Source: Multiple sources as cited in respective sections.

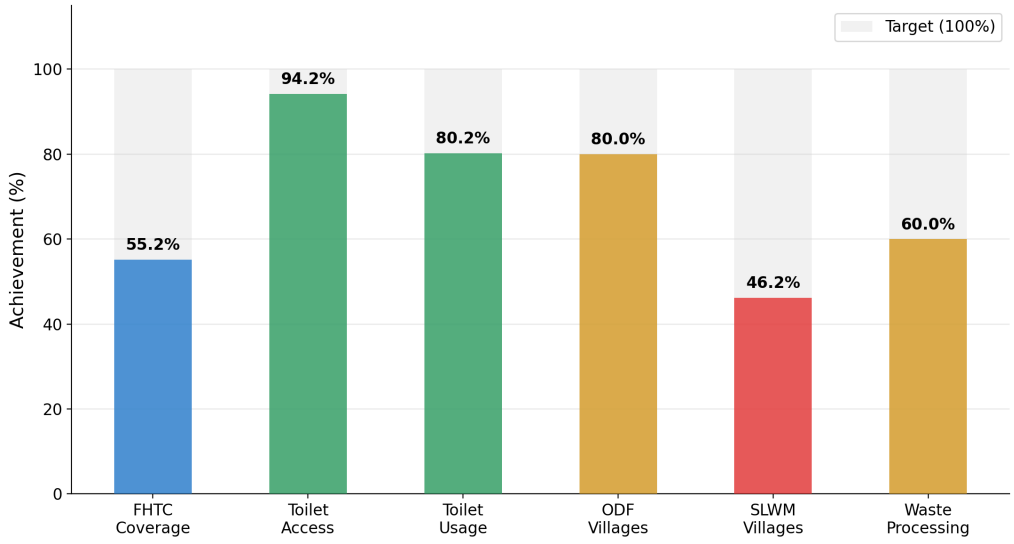

Figure 13.22. WASH Infrastructure Summary: Jharkhand

Source: Multiple sources as cited in respective sections.

13.12 Conclusion

This chapter has examined Jharkhand's progress across the drinking water, water quality, sanitation, and solid waste management dimensions of the WASH sector. The evidence, drawn from the JJM Dashboard, SBM-U Dashboard, NFHS rounds, and NARSS surveys, reveals a state that has achieved substantial gains since 2019 while facing clearly identifiable gaps that require sustained attention.

On drinking water, the expansion from 8.97 per cent FHTC coverage at JJM launch (August 2019) to 55.17 per cent as of February 2026 represents the provision of 33.07 lakh new tap connections. The year-wise trajectory is notable: FY 2023–24 alone accounted for 13.96 lakh FHTCs, or 42.2 per cent of all JJM-era connections, demonstrating the state's capacity for high-intensity implementation when resources and institutional conditions align. Jharkhand's 5th position nationally in the Jal Jeevan Survekshan 2024, with a score of 185.079, indicates competitive performance on qualitative parameters even as coverage lags the national average of 81.64 per cent. In Har Ghar Jal declared villages, 97.7 per cent of households have tap availability, and user satisfaction on water quality stands at 94.8 per cent, suggesting that the connections being provided are delivering meaningful service improvements.

Water quality monitoring has been strengthened considerably. All 31 laboratories in the state are NABL-accredited, 25.20 lakh water samples have been tested across four financial years, and 1,51,802 women have been trained for community-based surveillance through Field Test Kits. The state has no water quality affected habitation on JJM records. Iron contamination, at 8.4 per cent of tested sources, remains the primary water quality concern, consistent with the geological profile of the Chotanagpur Plateau.

The sanitation transformation is among the most significant public health achievements documented in this chapter. Open defecation has declined from 78 per cent in 2014 to 2 per cent by 2024, a 76 percentage point reduction over a decade. Jharkhand's ODF status, achieved in November 2018, has been sustained, and NARSS-3 data confirms toilet usage at 80.2 per cent. All 24 districts recorded improvement in sanitation access between NFHS-4 and NFHS-5. However, the 14 percentage point gap between toilet access (94.2 per cent) and actual usage (80.2 per cent) indicates that behaviour change communication remains a continuing priority.

On the urban side, 87 per cent of wards have achieved 100 per cent door-to-door waste collection, and 112 waste processing plants with 1,920 TPD capacity have been established. However, the waste processing rate of 60 per cent is 21.2 percentage points below the national average of 81.20 per cent, indicating a capacity deficit of approximately 540 TPD. Legacy waste remediation has progressed, with 13 lakh MT (41.94 per cent) of the 31 lakh MT total remediated and 29.86 acres of dumpsite land reclaimed.

Three areas require particular acceleration going forward. First, the 26.47 percentage point FHTC coverage gap with the national average can be closed only if the state sustains annual provision of 7 lakh FHTCs, a rate demonstrated to be achievable in FY 2023–24. This requires enhanced fund utilisation (currently 46.30 per cent of Central allocation drawn), expedited clearance of 194 pending schemes, and differentiated strategies for lagging districts

such as Pakur (13 per cent), Godda (19 per cent), and Jamtara (37 per cent). The 122 villages without any piped water supply require immediate attention. Second, SLWM coverage at 46.2 per cent remains 20.4 percentage points below the national average, and is the weakest dimension among the three NARSS DLI indicators. Scaling up SLWM through technology adoption, community engagement, and convergence with MGNREGS is essential for achieving ODF Plus status. Third, service quality indicators, while encouraging, show room for improvement: only 80 per cent of households in HGJ villages report regular supply, and 72 per cent receive adequate quantity above 55 LPCD. The transition from access creation to sustainable, quality-assured service delivery will define the next phase of Jharkhand's WASH sector development.

At a Glance

Drinking Water (JJM): 33.07 lakh new FHTCs provided since August 2019, reaching 55.17% coverage (34.50 lakh out of 62.53 lakh households). Gap with India average: 26.47 pp. Ranked 5th nationally in Jal Jeevan Survekshan 2024.

Water Quality: 25.20 lakh samples tested across four years. All 31 labs NABL-accredited. 1,51,802 women trained for FTK testing. No water quality affected habitation on record.

Rural Sanitation (SBM-G): Open defecation reduced from 78% (2014) to 2% (2024). Toilet usage at 80.2% (NARSS-3). ODF sustained since November 2018. SLWM coverage at 46.2%.

Urban Sanitation (SBM-U): 1,031 public sanitation facilities across 49 cities. 112 waste processing plants with 1,920 TPD capacity. Waste processing rate: 60% (national: 81.20%). Legacy waste remediation: 41.94% of 31 lakh MT.

Financial Progress: Cumulative expenditure Rs. 12,764.46 crore (Central + State). Central allocation Rs. 12,982.30 crore, of which 46.30% drawn. Peak expenditure of Rs. 6,432.23 crore in FY 2023–24.

Key Gap: 28 lakh households remain unconnected. Pakur (13%), Godda (19%), and Jamtara (37%) are the most lagging districts. 122 villages lack any piped water supply.

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CHAPTER 14

14

Women and Child Development and Social Security

Government initiatives, welfare schemes, and social security measures for women and children in Jharkhand

14.1 Introduction

Women and children constitute a substantial share of Jharkhand's population. According to Census 2011, women account for 49.0 percent of the state's population, while children under six years number approximately 55 lakh. Improving health, nutrition, education, and safety outcomes for these groups is central to the state's development trajectory and to realising the vision of 'Viksit Bharat' (Developed India) by 2047. The growing elderly population has added another dimension to social welfare requirements: a recent Asian Development Bank (ADB) report projects that India's old-age dependency ratio will exceed 30 percent by 2050, underscoring the need for comprehensive social security measures.

The Department of Women, Child Development and Social Security (WCD&SS), Government of Jharkhand, administers the state's welfare architecture for women, children, the elderly, and persons with disabilities. This architecture operates through three centrally sponsored umbrella schemes, namely Saksham Anganwadi and Poshan 2.0, Mission Shakti, and Mission Vatsalya, supplemented by flagship state initiatives such as Mukhyamantri Maiya Samman Yojana (MMSY) and Mukhya Mantri Sarvjan Pension Scheme (MMSPS), both launched in 2024. The total budget outlay of the department for FY 2025–26 stands at Rs. 22,024 crore, reflecting the scale of the state's commitment to social welfare.

This chapter examines the current status of women and children in Jharkhand and assesses the progress of these government initiatives. The analysis draws upon data from FY 2024–25 and FY 2025–26 (up to December 2025), sourced from departmental records and the Outcome Budget 2025–26 of the WCD&SS Department. Key findings include: Jharkhand's Maternal Mortality Ratio (54) is now 44.3 percent below the national average; 38,957 Anganwadi Centres serve 24.04 lakh nutrition beneficiaries; MMSY reaches 56.62 lakh women through monthly direct benefit transfers; and the combined social security coverage exceeds 1.03 crore beneficiaries. The chapter also presents a district-level analytical framework using clustering and regression techniques to identify priority districts for convergent interventions.

14.2 Status of Women and Children in Jharkhand

Understanding the current situation of women and children provides the foundation for effective policy design. Key health indicators, educational attainment levels, and persistent social challenges shape the state's priorities. This section examines available data on maternal and child health outcomes, literacy rates, and social issues that require continued attention.

14.2.1 Health Indicators

The Maternal Mortality Ratio (MMR), measured as maternal deaths per 100,000 live births, and the Infant Mortality Rate (IMR), measured as deaths under one year per 1,000 live births, are two key indicators of maternal and child health infrastructure.

Table 14.1 presents a comparative analysis of key health indicators for Jharkhand and India. The data is sourced from the Sample Registration System (SRS) Bulletin 2021–23 (September 2025) and Jharkhand Economic Survey 2023–24.

Table 14.1. Key Health Indicators: Jharkhand and India Comparison

Indicator	Jharkhand	India	Data Source
Maternal Mortality Ratio (per 100,000 live births)	54	97	SRS 2021–23
Infant Mortality Rate (per 1,000 live births)	25	28	SRS 2021–23
Female Literacy Rate (%)	72.6	74.2	JES 2023–24

Source: Sample Registration System (SRS) Bulletin 2021–23 (September 2025), Office of the Registrar General, India; Jharkhand Economic Survey 2023–24.
Note: The Jharkhand Economic Survey 2024–25 had reported MMR of 76 (SRS 2020–22) and IMR of 29. Current SRS 2021–23 data shows improvement to 54 and 25 respectively.

As shown in Table 14.1, Jharkhand's MMR stands at 54 per 1,00,000 live births, which is 44.3 percent lower than the national average of 97. Compared to the MMR of 76 reported in the Jharkhand Economic Survey 2024–25 (based on SRS 2020–22), this represents a decline of 28.9 percent within a single reporting cycle, indicating accelerated progress in maternal healthcare access. The state's IMR of 25 per 1,000 live births is better than the national figure of 28, marking a 13.8 percent improvement over the previously reported level of 29. The female literacy rate of 72.6 percent trails the national average of 74.2 percent by 1.6 percentage points.

Despite favourable state-level averages, intra-state variation remains considerable. According to NFHS-5 data, female literacy ranges from 82.5 percent in Ranchi to 48.6 percent in Pakur, a gap of 33.9 percentage points. Narrowing this disparity through strengthened educational infrastructure in underserved districts presents a clear opportunity for further improvement.

Figure 14.1 presents a visual comparison of these three indicators. Jharkhand outperforms the national average on both MMR (54 versus 97) and IMR (25 versus 28). On female literacy, the state's 72.6 percent is approaching the national level of 74.2 percent, and trend projections indicate convergence by 2025–26 (discussed in Section 14.13). Targeted investment in girls' education in rural and tribal areas could accelerate this convergence.

14.2.2 Persistent Social Challenges

Despite progress in health and education indicators, significant social challenges persist. According to the National Family Health Survey (NFHS-5) conducted during 2019–21, approximately 32 percent of ever-married women reported experiencing spousal violence. This includes physical, emotional, verbal, sexual, or economic abuse. Additionally, 32.2 percent of women were married before reaching the legal age of 18 years.

Figure 14.2 illustrates these two indicators. Both figures stand at approximately 32 percent. The district-level variation is substantial: child marriage prevalence ranges from 22.1

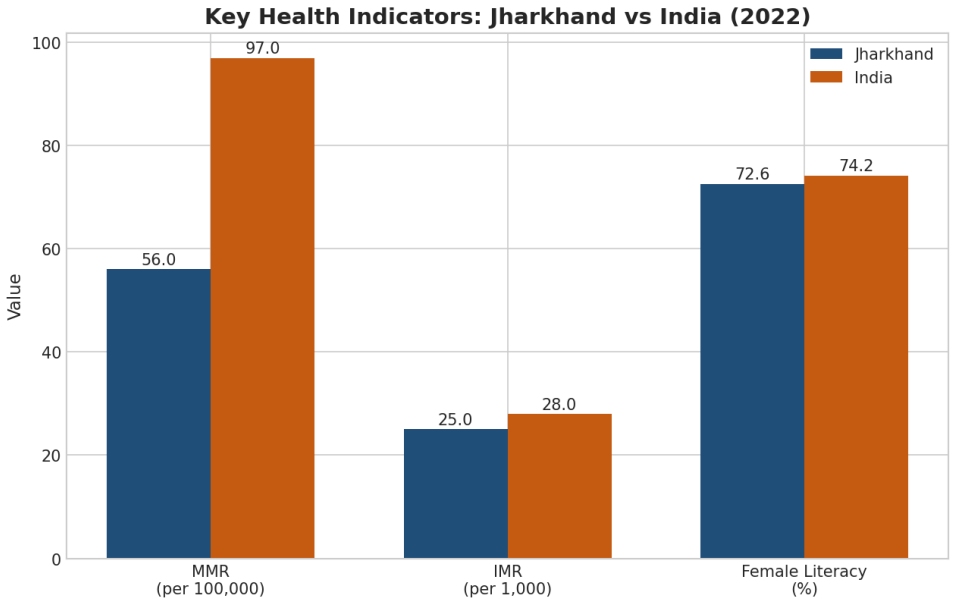

Figure 14.1. Key Health Indicators: Jharkhand and India Comparison

Source: Figure created by authors based on data from SRS Bulletin 2021–23 (September 2025) and Jharkhand Economic Survey 2023–24.

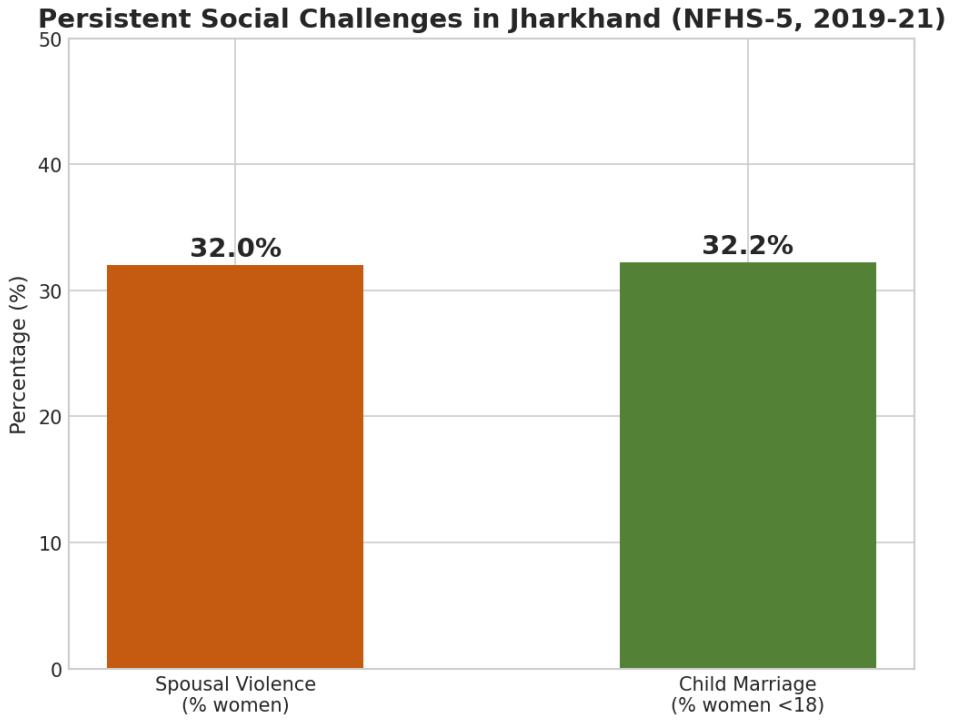

Figure 14.2. Persistent Social Challenges in Jharkhand (NFHS-5, 2019–21)

Source: Figure created by authors based on data from National Family Health Survey (NFHS-5), 2019–21, Ministry of Health and Family Welfare, Government of India.

percent in Ranchi to 52.3 percent in Pakur, a spread of 30.2 percentage points. Similarly, spousal violence rates range from 24.5 percent in Ranchi to 45.1 percent in Pakur (NFHS-5). These disparities are associated with differences in female literacy, urbanisation, and economic conditions across districts.

Addressing these challenges requires multi-pronged interventions encompassing awareness programmes, strengthened legal enforcement, and economic empowerment initiatives. The strong negative association between female literacy and both child marriage (correlation: -0.96) and spousal violence (correlation: -0.95) at the district level suggests that investments in girls' education may coincide with improvements in these social indicators.

14.3 Government Initiatives for Development and Protection

The Ministry of Women and Child Development (MoWCD) has consolidated most existing programmes into three umbrella schemes to reduce fragmentation and improve coordination. These are: 'Saksham Anganwadi and Poshan 2.0', 'Mission Shakti', and 'Mission Vatsalya'.

Table 14.2. Major Umbrella Schemes under Ministry of Women and Child Development

Umbrella Scheme	Focus Area	Key Components
Saksham Anganwadi and Poshan 2.0	Nutrition and child development	ICDS/Anganwadi Services, Poshan Abhiyaan, Scheme for Adolescent Girls
Mission Shakti	Women's safety, security and empowerment	Sambal (OSC, WHL, BBBP) and Samarthya (PM-MVY, Shakti Sadan, Working Women Hostel)
Mission Vatsalya	Child protection and welfare	Child Protection Services, Juvenile Justice provisions

Source: Ministry of Women and Child Development, Government of India.

Table 14.2 summarises these three schemes and their components. Each scheme addresses specific aspects of women and child welfare. The following sections examine the implementation of these initiatives in Jharkhand.

14.4 Saksham Anganwadi and Poshan 2.0

Saksham Anganwadi and Poshan 2.0 (Mission Poshan 2.0) addresses malnutrition among women and children by integrating Anganwadi Services (formerly ICDS), POSHAN Abhiyaan, and the Scheme for Adolescent Girls under a single framework.

The beneficiaries include children under six years, pregnant women, lactating mothers, and adolescent girls aged 14-18 years. They receive supplementary nutrition as Hot Cooked Meals and Take-Home Rations. The mission emphasises dietary diversity, food fortification, and millet consumption.

14.4.1 Integrated Child Development Services (ICDS)

ICDS operates through Anganwadi Centres (AWCs), each providing six services: supplementary nutrition, pre-school education, nutrition and health education, immunisation, health check-ups, and referral services. Two categories of frontline workers staff each centre: Anganwadi Workers (AWWs, also called Sevikas) who manage operations, and Anganwadi Helpers (AWHs, called Sahikas) who provide support.

Physical Progress of ICDS

Table 14.3 presents a summary of ICDS staffing at the state level for FY 2024–25. The total number of sanctioned positions for both Sevikas and Sahikas is 38,957 each. This corresponds to the number of functional Anganwadi Centres in the state.

Table 14.3. Summary of ICDS Staffing in Jharkhand (FY 2024–25)

Category	Sanctioned	In Position	Vacant (%)
Sevika (AWW)	38,957	38,027	930 (2.4%)
Sahika (AWH)	38,957	37,384	1,573 (4.0%)

Source: Department of Women, Child Development and Social Security (WCD&SS), Government of Jharkhand, FY 2024–25.

Of the sanctioned positions, 930 (2.4 percent) are vacant for Sevikas and 1,573 (4.0 percent) for Sahikas, totalling 2,503 unfilled positions across both cadres. The filling rate for Sevikas stands at 97.6 percent and for Sahikas at 96.0 percent. The 1.6 percentage point gap between the two cadres indicates that helper-level recruitment presents a relatively greater challenge. The number of functional AWCs has increased from approximately 38,500 (as reported in the Jharkhand Economic Survey 2024–25) to 38,957 in the current period, an addition of approximately 457 centres.

Figure 14.3 shows the district-wise distribution of vacant positions. Pakur reports the highest Sevika vacancies at 132, followed by Godda (123) and Sahibganj (88). These three districts alone account for 343 of the state's 930 Sevika vacancies (36.9 percent). For Sahikas, the concentration is similar: Pakur (192), Godda (187), and Sahibganj (120) together account for 499 of 1,573 vacancies (31.7 percent).

At the other end, Koderma and Ramgarh each report only 6 Sevika vacancies, with filling rates exceeding 99 percent for both cadres. The gap between the best-performing district (Koderma at 99.2 percent Sevika filling) and the lowest (Pakur at 89.7 percent) is 9.5 percentage points. For Sahikas, this gap widens to 14.4 percentage points (Koderma 99.5 percent versus Pakur 85.1 percent). These location-specific challenges may require differentiated strategies, such as local hiring drives or enhanced incentives for postings in remote areas.

Table 14.4 shows filling rates for selected districts. Koderma (99.2/99.5 percent) and Ramgarh (99.4/99.0 percent) demonstrate that near-complete staffing is achievable. Pakur, with

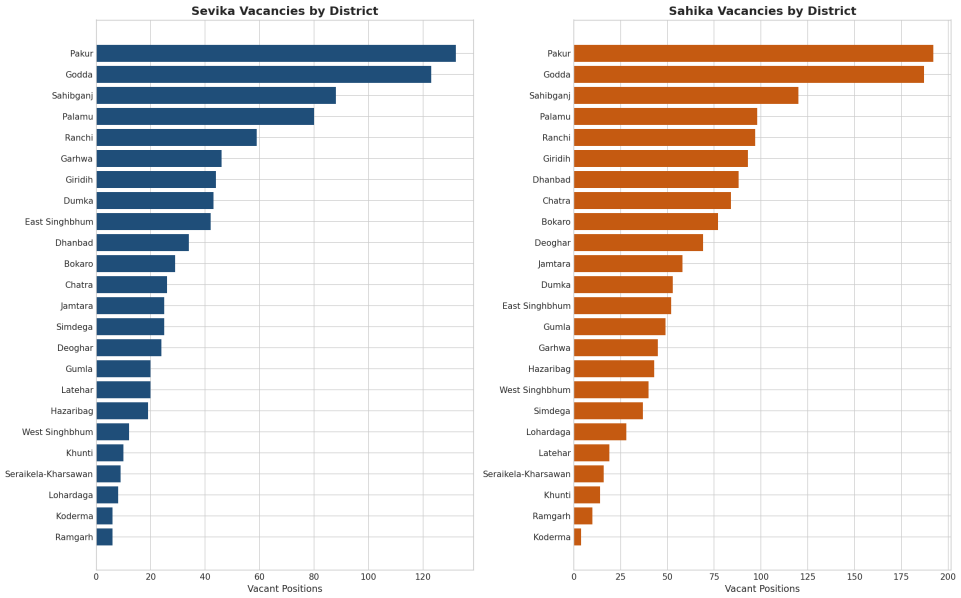

Figure 14.3. District-wise Vacant Positions of Sevikas and Sahikas in FY 2024–25

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand.

Table 14.4. District-wise Filling Rates for Sevikas and Sahikas (Selected Districts)

District	Sevika Filling Rate (%)	Sahika Filling Rate (%)	Gap (pp)
Koderma	99.2	99.5	–0.3
Ramgarh	99.4	99.0	0.4
Saraikela-Kharsawan	99.3	98.8	0.5
Lohardaga	99.0	96.3	2.7
Jharkhand Average	**97.6**	**96.0**	**1.6**
Godda	93.4	90.0	3.4
Pakur	89.7	85.1	4.6

Source: Computed by authors based on data from Department of WCD&SS, Government of Jharkhand.

a Sevika filling rate of 89.7 percent and a Sahika filling rate of 85.1 percent, shows the widest gap (4.6 percentage points between the two cadres), indicating that helper-level recruitment is particularly challenging in remote districts. Targeted recruitment drives in such districts could improve ICDS coverage and service delivery quality.

Table 14.5 presents the complete district-wise breakdown of sanctioned and in-position posts for both Sevikas (AWWs) and Sahikas (AWHs) across all 24 districts of Jharkhand for FY 2024–25. The data covers 38,957 sanctioned positions for each cadre, corresponding to the total number of functional Anganwadi Centres in the state.

Table 14.5. District-wise Physical Progress of ICDS in Jharkhand (FY 2024–25)

	Sevika (AWW)			Sahika (AWH)		
District	**Sanct.**	**In Pos.**	**Vacant**	**Sanct.**	**In Pos.**	**Vacant**
Bokaro	2,257	2,228	29	2,257	2,180	77
Chatra	1,143	1,117	26	1,143	1,059	84
Deoghar	1,574	1,550	24	1,574	1,505	69
Dhanbad	2,231	2,197	34	2,231	2,143	88
Dumka	2,099	2,056	43	2,099	2,046	53
East Singhbhum	1,747	1,705	42	1,747	1,695	52
Garhwa	1,356	1,310	46	1,356	1,311	45
Giridih	2,442	2,398	44	2,442	2,349	93
Godda	1,869	1,746	123	1,869	1,682	187
Gumla	1,697	1,677	20	1,697	1,648	49
Hazaribagh	1,779	1,760	19	1,779	1,736	43
Jamtara	1,193	1,168	25	1,193	1,135	58
Khunti	841	831	10	841	827	14
Koderma	752	746	6	752	748	4
Latehar	969	949	20	969	950	19
Lohardaga	761	753	8	761	733	28
Pakur	1,285	1,153	132	1,285	1,093	192
Palamu	2,629	2,549	80	2,629	2,531	98
Ramgarh	1,042	1,036	6	1,042	1,032	10
Ranchi	2,841	2,782	59	2,841	2,744	97
Sahibganj	1,771	1,683	88	1,771	1,651	120
Saraikela-Kharsawan	1,374	1,365	9	1,374	1,358	16
Simdega	967	942	25	967	930	37
West Singhbhum	2,338	2,326	12	2,338	2,298	40
Total	**38,957**	**38,027**	**930**	**38,957**	**37,384**	**1,573**

Source: Department of WCD&SS, Government of Jharkhand, FY 2024–25.
Note: Sanct. = Sanctioned; In Pos. = In Position.

The district-level data reveals a clear geographic pattern in staffing gaps. Among Sevikas, the three Santhal Pargana districts report the highest vacancies: Pakur (132 out of 1,285 sanctioned, filling rate 89.7 percent), Godda (123 out of 1,869, filling rate 93.4 percent), and

Sahibganj (88 out of 1,771, filling rate 95.0 percent). Together, these three districts account for 343 of the state's 930 Sevika vacancies (36.9 percent). The Sahika vacancy pattern is more pronounced: Pakur (192 vacancies, 85.1 percent filling), Godda (187 vacancies, 90.0 percent), and Sahibganj (120 vacancies, 93.2 percent) together account for 499 of 1,573 Sahika vacancies (31.7 percent). By contrast, Koderma (6 Sevika, 4 Sahika vacancies), Ramgarh (6 Sevika, 10 Sahika), and Lohardaga (8 Sevika, 28 Sahika) demonstrate near-complete staffing, with filling rates exceeding 99 percent for Sevikas and 96 percent for Sahikas.

A noteworthy pattern emerges in the gap between Sevika and Sahika filling rates within each district. While the state-level difference is 1.6 percentage points (97.6 versus 96.0 percent), certain districts exhibit wider gaps: Palamu shows a 3.8 percentage point differential (97.0 versus 96.3 percent), and Giridih records a 2.0 percentage point gap (98.2 versus 96.2 percent). Pakur's gap is 4.6 percentage points (89.7 versus 85.1 percent). The consistently wider Sahika vacancy across districts suggests that the helper-level position, which carries lower remuneration and fewer career advancement prospects, faces systemic recruitment challenges. Addressing this imbalance, particularly in the Santhal Pargana region, through enhanced incentives for remote postings and local hiring drives could substantially reduce the state's overall vacancy count, given that three districts alone account for nearly one-third of all unfilled positions.

14.4.2 Supplementary Nutrition Programme (SNP)

The Supplementary Nutrition Programme (SNP), a core component of ICDS, provides nutritious food supplements to pregnant women, lactating mothers, and children under six years.

Table 14.6 presents the composition of the 24,04,229 SNP beneficiaries as of December 2025.

Table 14.6. Composition of SNP Beneficiaries by Category (December 2025)

Beneficiary Category	Number	Share (%)
Children (6 months – 3 years)	10,39,110	43.2
Children (3 – 6 years)	10,62,604	44.2
Children with SAM	19,714	0.8
Pregnant Women	1,65,394	6.9
Lactating Mothers	1,17,407	4.9
Total	**24,04,229**	**100.0**

Source: Department of WCD&SS, Government of Jharkhand, as on December 2025.

Children aged 3–6 years constitute the largest category at 10,62,604 (44.2 percent), followed closely by children aged 6 months to 3 years at 10,39,110 (43.2 percent). Together, the two child categories account for 21,01,714 beneficiaries, or 87.4 percent of the total. Pregnant

women number 1,65,394 (6.9 percent) and lactating mothers 1,17,407 (4.9 percent). Children with Severe Acute Malnutrition (SAM) number 19,714 (0.8 percent). Compared to approximately 22 lakh beneficiaries reported in the Jharkhand Economic Survey 2024–25 for FY 2023–24, the current coverage of 24.04 lakh represents an increase of approximately 2 lakh beneficiaries (9.3 percent), indicating expanded programme reach.

SAM refers to Severe Acute Malnutrition, a life-threatening condition characterised by very low weight-for-height. The 19,714 SAM children constitute 0.8 percent of total SNP beneficiaries and 0.9 percent of the 21,01,714 children covered under the programme. Early identification and targeted nutritional intervention for these children is a critical function of the programme, as timely treatment can reduce mortality and long-term developmental impacts.

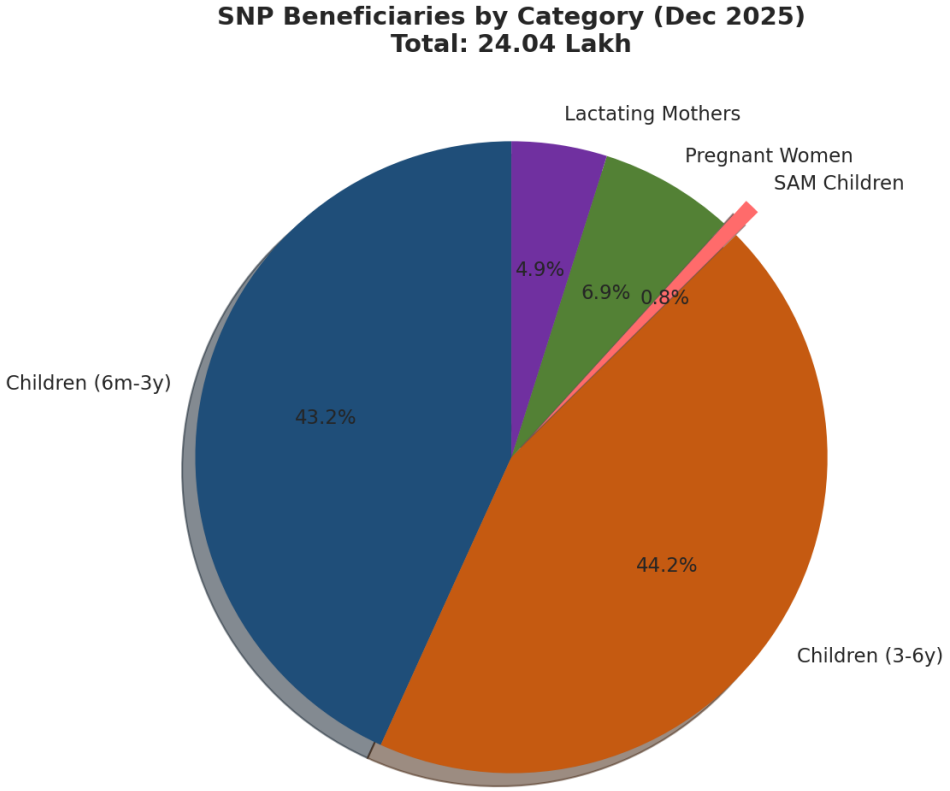

Figure 14.4. Composition of SNP Beneficiaries by Category

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, December 2025.

Figure 14.4 shows the composition of beneficiaries as a pie chart. The two child categories together account for 87.4 percent of all beneficiaries, while pregnant women and lactating mothers together constitute 11.8 percent. This composition reflects the programme's primary focus on early childhood nutrition, while also providing maternal support during the

critical first 1,000-day window.

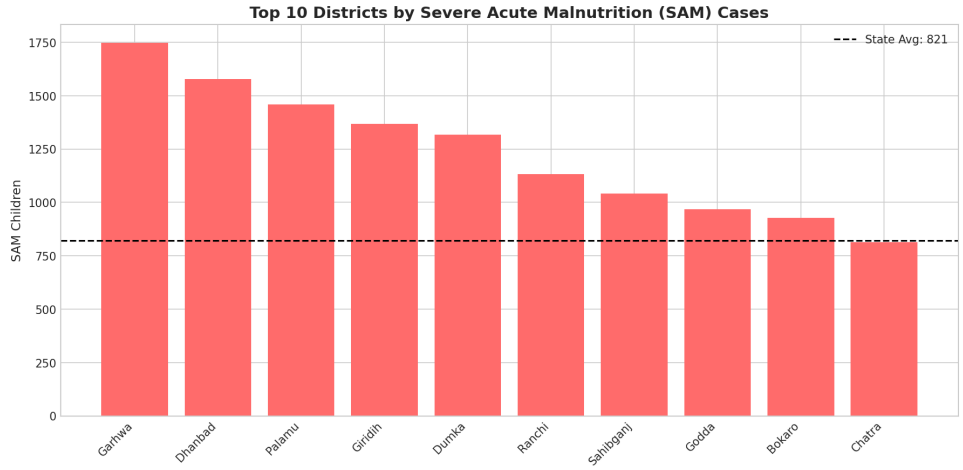

Figure 14.5. Severe Acute Malnutrition (SAM) Analysis: District-wise Distribution

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, December 2025.

Figure 14.5 shows the district-wise distribution of SAM cases. Garhwa reports the highest number at 1,747 cases, followed by Dhanbad (1,577), Palamu (1,459), and Giridih (1,367). The top four districts together account for 6,150 of the state's 19,714 SAM cases (31.2 percent), indicating a concentrated burden. Dumka (1,316) and Ranchi (1,132) also report elevated numbers. Intensified nutritional interventions in these districts, including Nutrition Rehabilitation Centres and community-based management of acute malnutrition, could yield a proportionately large reduction in the state's overall SAM caseload.

Table 14.7 presents the district-wise distribution of 24,04,229 SNP beneficiaries across five categories: children aged 6 months to 3 years, children aged 3 to 6 years, SAM children, pregnant women, and lactating mothers. This disaggregation enables assessment of both programme coverage and the distribution of nutritional vulnerability across districts.

The district-level data reveals substantial variation in programme reach. Giridih records the highest total beneficiary count at 1,75,075, followed by Palamu (1,73,760), Ranchi (1,52,332), West Singhbhum (1,39,683), and Godda (1,36,851). The top five districts together account for 7,78,001 beneficiaries, or 32.4 percent of the state total. At the lower end, Khunti (38,752), Simdega (44,099), and Lohardaga (45,074) report comparatively smaller numbers, broadly consistent with their smaller population base. The ratio of pregnant women to lactating mothers provides an indicator of maternal healthcare continuity: the state average is 1.41:1, but this ratio ranges from 1.08:1 in Ranchi (12,417 pregnant versus 9,003 lactating, suggesting relatively strong post-partum retention) to 1.67:1 in Dumka (6,312 pregnant versus 4,486 lactating, indicating potential drop-off in post-delivery coverage).

Across districts, the composition of child beneficiaries varies meaningfully. In Dumka, the 3–6 year cohort (56,260) exceeds the younger cohort (41,706) by 34.9 percent, while in Hazaribagh the younger group (62,786) is 31.1 percent larger than the 3–6 year group (47,912).

Table 14.7. District-wise Beneficiaries of Supplementary Nutrition Programme (up to December 2025)

District	Children (6m–3y)	Children (3–6y)	SAM Children	Pregnant Women	Lactating Mothers	Total
Bokaro	49,604	50,504	927	7,923	5,731	1,14,689
Chatra	31,935	28,828	814	6,236	3,952	71,765
Deoghar	48,729	51,363	500	7,214	5,714	1,13,520
Dhanbad	56,534	59,345	1,577	8,335	7,741	1,33,532
Dumka	41,706	56,260	1,316	6,312	4,486	1,10,080
East Singhbhum	48,249	46,439	803	8,765	6,432	1,10,688
Garhwa	49,733	45,184	1,747	7,354	4,842	1,08,860
Giridih	76,618	76,152	1,367	12,357	8,581	1,75,075
Godda	55,407	66,366	967	8,174	5,937	1,36,851
Gumla	32,703	34,978	353	5,093	3,696	76,823
Hazaribagh	62,786	47,912	686	10,871	7,191	1,29,446
Jamtara	26,505	30,139	804	3,618	2,608	63,674
Khunti	17,491	16,377	492	2,476	1,916	38,752
Koderma	25,077	23,297	345	4,628	3,526	56,873
Latehar	28,663	27,073	612	4,237	2,922	63,507
Lohardaga	19,934	19,435	433	3,120	2,152	45,074
Pakur	39,998	41,426	512	5,868	3,509	91,313
Palamu	75,138	78,027	1,459	11,545	7,591	1,73,760
Ramgarh	24,890	20,644	663	4,238	2,965	53,400
Ranchi	71,507	58,273	1,132	12,417	9,003	1,52,332
Sahibganj	47,288	57,137	1,041	8,330	4,814	1,18,610
Saraikela-Kharsawan	34,173	37,068	150	6,078	4,354	81,823
Simdega	17,619	21,760	329	2,603	1,788	44,099
West Singhbhum	56,823	68,617	685	7,602	5,956	1,39,683
Total	**10,39,110**	**10,62,604**	**19,714**	**1,65,394**	**1,17,407**	**24,04,229**

Source: Department of WCD&SS, Government of Jharkhand, as on December 2025.
Note: SAM = Severe Acute Malnutrition; 6m–3y = 6 months to 3 years; 3–6y = 3 to 6 years.

Such variation may reflect differences in enrolment patterns, demographic composition, and local outreach capacity. The distribution of SAM cases further underscores the need for targeted nutritional interventions. Garhwa's 1,747 SAM cases represent the highest district-level burden, constituting 8.9 percent of the state total despite the district accounting for only 4.5 percent of total SNP beneficiaries. By contrast, Saraikela-Kharsawan reports only 150 SAM cases among 81,823 total beneficiaries, yielding a SAM proportion of 0.18 percent, the lowest in the state.

The ten-fold variation in SAM incidence rates across districts, from 0.18 percent in Saraikela-Kharsawan to 1.61 percent in Garhwa, indicates that malnutrition hotspots are geographically concentrated and amenable to district-specific intervention strategies. Notably, the six districts with the highest SAM counts (Garhwa, Dhanbad, Palamu, Giridih, Dumka, and Ranchi) together account for 9,198 of 19,714 SAM cases (46.7 percent). Prioritising Nutrition Rehabilitation Centres and community-based management of acute malnutrition in these districts could yield a proportionately large reduction in the state's overall SAM burden.

14.4.3 Poshan Abhiyaan

Behavioural change at the household level is widely recognised as a necessary complement to food supplementation for reducing malnutrition. Poshan Abhiyaan addresses this gap through social and behavioural change communication, promoting community-level mass movements ('Jan Andolan') to improve infant and young child feeding practices, maternal nutrition during pregnancy, and adolescent dietary habits.

Community-Based Events (CBEs) are organised monthly at Anganwadi Centres. These include Godhbharai for maternal nutrition and Annaprasan for complementary feeding initiation. CBEs serve as platforms for nutrition counselling and awareness.

Figure 14.6 shows district-wise CBE achievement rates. Lohardaga achieved the highest rate at 69.6 percent, followed by Ranchi (65.2 percent), West Singhbhum (62.8 percent), and Bokaro (58.4 percent). At the lower end, Pakur recorded 42.1 percent and Giridih 48.9 percent. The gap between the highest (Lohardaga, 69.6 percent) and lowest (Pakur, 42.1 percent) performing districts is 27.5 percentage points, indicating considerable variation in community mobilisation capacity.

The overall fund utilisation under Poshan Abhiyaan stands at 96.8 percent for FY 2025–26 (up to December 2025), indicating efficient absorption of allocated resources. However, the wide inter-district disparity in CBE achievement suggests that financial allocation alone does not ensure uniform programme delivery. Districts with lower achievement rates may benefit from enhanced frontline worker training, improved Anganwadi Worker availability, and targeted community mobilisation campaigns.

Table 14.8 presents the district-wise financial progress of Poshan Abhiyaan for FY 2025–26 (up to December 2025). The table covers allocation, expenditure, unspent balance, and utilisation rates across all 24 districts, providing a comprehensive view of the programme's financial absorption at the district level.

The total allocation under Poshan Abhiyaan amounts to Rs. 42.77 crore, of which Rs.

Table 14.8. District-wise Financial Progress of Poshan Abhiyaan (FY 2025–26, up to December 2025)

District	Allocation (Rs.)	Expenditure (Rs.)	Balance (Rs.)	Utilisation (%)
Bokaro	1,45,63,700	1,44,50,561	1,13,139	99.22
Chatra	66,06,450	61,08,294	4,98,156	92.46
Deoghar	1,01,54,700	1,00,13,942	1,40,758	98.61
Dhanbad	1,41,77,950	1,40,08,401	1,69,549	98.80
Dumka	1,49,85,250	1,39,49,180	10,36,070	93.09
East Singhbhum	1,10,44,650	1,07,53,901	2,90,749	97.37
Garhwa	79,69,200	64,54,682	15,14,518	81.00
Giridih	1,60,00,950	1,54,27,634	5,73,316	96.42
Godda	1,18,58,700	1,10,11,102	8,47,598	92.85
Gumla	1,07,70,250	1,03,16,918	4,53,332	95.79
Hazaribagh	1,12,25,200	1,10,58,342	1,66,858	98.51
Jamtara	73,30,700	70,06,308	3,24,392	95.57
Khunti	54,22,500	48,88,170	5,34,330	90.15
Koderma	56,34,100	52,94,367	3,39,733	93.97
Latehar	66,33,250	63,93,945	2,39,305	96.39
Lohardaga	50,11,250	49,33,304	77,946	98.44
Pakur	63,02,250	60,03,682	2,98,568	95.26
Palamu	1,64,55,700	1,63,08,012	1,47,688	99.10
Ramgarh	65,82,950	61,12,464	4,70,486	92.85
Ranchi	1,96,03,000	1,91,75,500	4,27,500	97.82
Sahibganj	92,82,750	91,58,608	1,24,142	98.66
Saraikela-Kharsawan	92,85,750	89,96,597	2,89,153	96.89
Simdega	56,63,750	56,25,788	37,962	99.33
West Singhbhum	1,38,75,750	1,35,12,750	3,63,000	97.38
Total	**42,76,77,997**	**41,39,90,963**	**1,36,87,034**	**96.80**

Source: Department of WCD&SS, Government of Jharkhand, FY 2025–26 (up to December 2025).

Note: Includes Directorate-level allocation of Rs. 18,12,37,297 (utilisation: 97.68 percent) in the total.

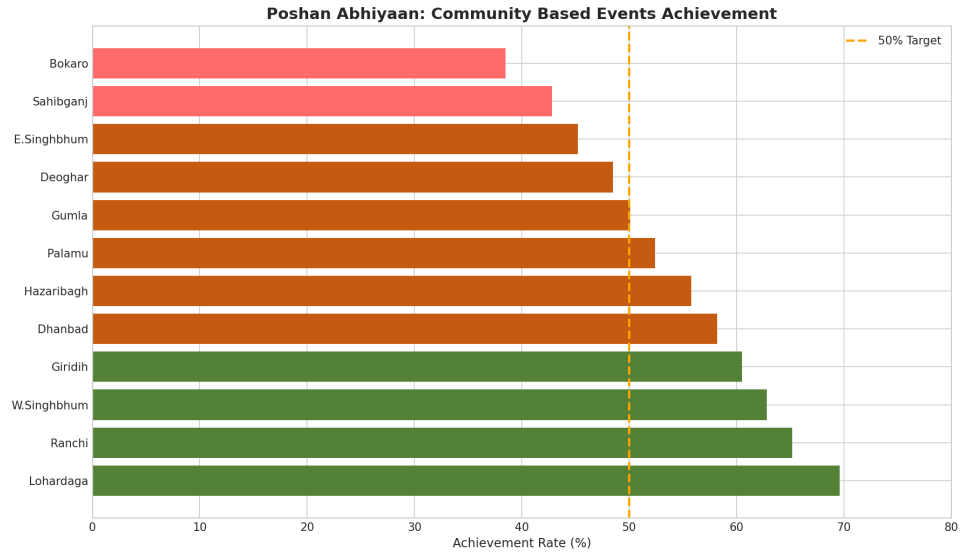

Figure 14.6. Poshan Abhiyaan: Community Based Events Achievement Rate by District

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, FY 2025–26 (up to December 2025).

18.12 crore is allocated at the Directorate level and Rs. 24.64 crore across the 24 districts. The overall expenditure stands at Rs. 41.40 crore, yielding an aggregate utilisation rate of 96.8 percent. At the district level, utilisation rates range from 81.0 percent (Garhwa) to 99.33 percent (Simdega), a gap of 18.3 percentage points. Nine districts achieved utilisation rates above 98 percent: Simdega (99.33 percent), Bokaro (99.22 percent), Palamu (99.10 percent), Dhanbad (98.80 percent), Deoghar (98.61 percent), Sahibganj (98.66 percent), Hazaribagh (98.51 percent), Lohardaga (98.44 percent), and Ranchi (97.82 percent). These districts collectively demonstrate that near-complete fund utilisation is achievable across different geographic and administrative contexts.

The relationship between allocation size and utilisation rate merits attention. Districts with larger allocations, such as Ranchi (Rs. 1.96 crore, 97.8 percent utilisation), Palamu (Rs. 1.65 crore, 99.1 percent), and Giridih (Rs. 1.60 crore, 96.4 percent), generally demonstrate high absorption capacity. Among the six districts with utilisation below 95 percent, Garhwa (81.0 percent) stands out as a clear outlier, with Rs. 15.14 lakh remaining unspent. The remaining five, Dumka (93.1 percent), Chatra (92.5 percent), Godda (92.9 percent), Ramgarh (92.9 percent), and Khunti (90.2 percent), are clustered within a narrower band. Comparing financial utilisation with the CBE achievement rates discussed above reveals a partial overlap: Garhwa records both the lowest fund utilisation (81.0 percent) and a below-average CBE achievement rate, suggesting that implementation capacity constraints may be affecting both the financial and programmatic dimensions simultaneously. Targeted capacity-building in districts with lower utilisation, particularly Garhwa, could improve both financial absorption and programme delivery outcomes.

14.5 Mission Shakti

Mission Shakti is a mission-mode scheme for women's safety, security, and empowerment. It operates during the 15th Finance Commission period (2021–22 to 2025–26). The scheme has two sub-schemes: 'Sambal' for safety and security, and 'Samarthya' for empowerment.

14.5.1 Sambal Sub-scheme

Women's safety remains a precondition for their full participation in economic and social life. In Jharkhand, where approximately 32 percent of ever-married women report spousal violence (NFHS-5), institutional mechanisms for reporting, immediate relief, and long-term redressal are essential. Sambal addresses this through three components: One Stop Centre (OSC), Women Helpline (WHL), and Beti Bachao Beti Padhao (BBBP). The Women Helpline (181) provides round-the-clock toll-free support to women affected by violence, serving as a first point of contact for immediate assistance. One Stop Centres operate across all 24 districts, functioning as single-window access points that consolidate medical aid, legal assistance, temporary shelter, police support, and psycho-social counselling under one roof. Both mechanisms are coordinated to ensure that women in distress receive timely and comprehensive support.

Beti Bachao Beti Padhao Scheme (BBBP)

Gender-biased sex selection and low female enrolment in secondary education remain interlinked challenges. BBBP addresses both by combining awareness campaigns with enforcement of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act. In Jharkhand, it is implemented across all 24 districts with a focus on monitoring the sex ratio at birth and promoting girls' continued education.

The sex ratio at birth is tracked through the Guddi-Gudda report. During FY 2024–25, a total of 2,401 Guddi-Gudda boards were displayed in Panchayat Bhawans across the state. The public display of birth records at the Panchayat level serves a dual purpose: it enables community-level monitoring of the sex ratio and creates social accountability for gender-balanced births. Districts with lower sex ratios at birth receive focused BBBP interventions, including awareness campaigns and stricter PCPNDT enforcement.

The logistic regression analysis presented in Section 14.16 identifies Pakur, Sahibganj, Dumka, West Singhbhum, and Godda as high-risk districts for child marriage, which also tend to record lower female literacy and higher gender disparities. Convergent deployment of BBBP resources in these five districts, alongside ICDS staffing and female education programmes, could yield disproportionate improvements in the sex ratio and girls' retention in school.

Savitribai Phule Kishori Samridhi Yojana

Female dropout rates in Jharkhand tend to rise sharply at the secondary-to-higher-secondary transition, driven by economic constraints, early marriage, and household responsibilities.

The Government of Jharkhand launched Savitribai Phule Kishori Samridhi Yojana to address this by providing financial assistance to adolescent girls from economically weaker sections enrolled in classes 8 to 12 in government schools.

Table 14.9. Savitribai Phule Kishori Samridhi Yojana: Financial Assistance Structure

Class	Annual Assistance (Rs.)
Class 8	2,500
Class 9	2,500
Class 10	5,000
Class 11	5,000
Class 12	5,000
On completion of Class 12 (One-time)	20,000
Total Potential Benefit	**40,000**

Source: Department of WCD&SS, Government of Jharkhand.

As shown in Table 14.9, a girl who remains enrolled from Class 8 through Class 12 can receive a cumulative benefit of Rs. 40,000. The payment structure is progressive: Rs. 2,500 annually in classes 8 and 9, Rs. 5,000 annually in classes 10 through 12, and a one-time completion bonus of Rs. 20,000 upon finishing Class 12. The largest single disbursement at the terminal stage creates a strong incentive against dropout at the secondary-to-higher-secondary transition. Benefits are transferred directly to the bank accounts of eligible beneficiaries, ensuring that the financial assistance reaches the intended recipients without intermediaries.

The scheme complements BBBP by addressing one of its core objectives, namely girls' continued education. Given that the district classification analysis (Section 14.15) identifies five districts with female literacy below 60 percent, ensuring adequate awareness and enrolment under this scheme in those districts could contribute to narrowing the intra-state literacy gap.

14.5.2 Samarthya Sub-scheme

While Sambal addresses safety and protection, women's long-term empowerment also requires institutional support structures for shelter, rehabilitation, workforce participation, and maternity protection. Samarthya addresses these dimensions through three components.

Shakti Sadan, formed by merging the earlier Swadhar Greh and Ujjwala schemes, provides shelter, rehabilitation, and reintegration services to women in difficult circumstances, including victims of trafficking, destitute women, and women released from jail. Services include food, clothing, counselling, legal aid, and vocational training for up to three years, equipping residents with skills for economic self-sufficiency upon reintegration. Working Women Hostel (Sakhi Niwas) offers safe and affordable accommodation for working women

in urban and semi-urban areas, addressing a practical barrier to women's workforce participation, particularly for those migrating from rural areas for employment. The third component, Pradhan Mantri Matru Vandana Yojana (PMMVY), provides maternity benefits and is discussed below.

Pradhan Mantri Matru Vandana Yojana (PMMVY)

PMMVY provides maternity benefits to compensate for wage loss during pregnancy. Beneficiaries receive Rs. 5,000 as maternity benefit during the first pregnancy and Rs. 6,000 on the second pregnancy (in case of a female birth with institutional delivery), disbursed directly into their bank accounts.

Table 14.10. PMMVY Implementation Status in Jharkhand

Indicator	FY 2024–25	FY 2025–26 (BE)
Target Beneficiaries	1,94,928	1,90,000
Beneficiaries Covered (up to Dec 2024)	1,97,296	—
Achievement (%)	101.2	—
Budget Outlay (Rs. Crore)	92.00	60.00

Source: Outcome Budget 2025–26, Department of WCD&SS, Government of Jharkhand.

As shown in Table 14.10, PMMVY in Jharkhand covered 1,97,296 beneficiaries against a target of 1,94,928 in FY 2024–25, an achievement rate of 101.2 percent. The budget outlay for the year was Rs. 92 crore. For FY 2025–26, the target has been set at 1,90,000 beneficiaries with a reduced budget estimate of Rs. 60 crore, a 34.8 percent decrease from the previous year's outlay. Sustaining the coverage achieved in FY 2024–25 within the lower budget envelope will require continued coordination between Anganwadi Centres and health facilities to ensure timely beneficiary identification and documentation.

14.6 Mission Vatsalya

Child protection requires a distinct institutional apparatus because children, unlike adults, cannot independently access legal or welfare systems. In Jharkhand, where a substantial proportion of the population is below 18 years and where child marriage prevalence exceeds 32 percent (NFHS-5), a dedicated framework for care and rehabilitation is essential. Mission Vatsalya, which incorporates the former Child Protection Services (CPS) Scheme, provides this framework through preventive, statutory care, and rehabilitation services for two categories: children in need of care and protection (CNCP) and children in conflict with the law (CCL), as defined under the Juvenile Justice (Care and Protection of Children) Act, 2015.

The institutional framework under Mission Vatsalya in Jharkhand includes Child Care Institutions (CCIs), open shelters, and Specialised Adoption Agencies. District-level Child

Welfare Committees (CWCs) and Juvenile Justice Boards (JJBs) are constituted in all 24 districts to adjudicate cases. Non-institutional services under the scheme include foster care, sponsorship for education and health, and aftercare programmes for young adults leaving institutional care upon turning 18. The State Child Protection Society (SCPS) coordinates implementation across districts, while District Child Protection Units (DCPUs) handle case-level interventions.

The scheme also supports the Childline 1098 helpline, which provides emergency outreach to children in distress. In Jharkhand, this helpline operates across all districts, serving as the first point of contact for reporting child abuse, child labour, missing children, and other protection concerns.

14.7 Mukhyamantri Maiya Samman Yojana

Unconditional cash transfers to women have emerged as a policy instrument for enhancing household consumption, financial autonomy, and economic participation. In Jharkhand, where female workforce participation and access to formal banking remain below national averages, direct income support can serve as both an immediate welfare measure and a medium-term enabler of women's economic agency. The Jharkhand government launched Mukhyamantri Maiya Samman Yojana (MMSY) in August 2024, providing monthly financial assistance via Direct Benefit Transfer (DBT) to all women aged 21–50 years. This scheme was launched after the Jharkhand Economic Survey 2024–25 and is being reported for the first time in the Economic Survey.

Initially, the monthly benefit was Rs. 1,000 per beneficiary. The scheme began with 45.2 lakh beneficiaries in August 2024 and expanded steadily to 50.8 lakh by October 2024 and 54.1 lakh by December 2024. From December 2024, the monthly benefit was revised upward by 150 percent to Rs. 2,500. On January 6, 2025, 56.62 lakh women received Rs. 2,500 each through DBT, representing a 25.3 percent growth in beneficiary count over the first six months of the scheme's operation.

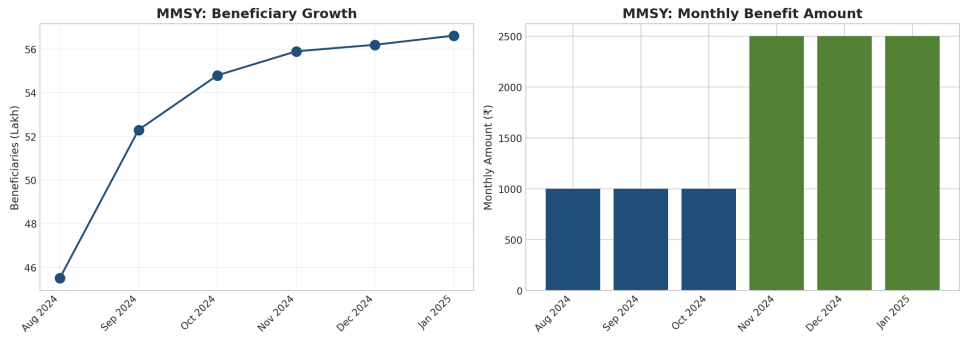

Figure 14.7. Mukhyamantri Maiya Samman Yojana: Implementation Analysis

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, January 2025.

Figure 14.7 shows the implementation trajectory of MMSY. The left panel displays the month-wise growth in beneficiary numbers from 45.2 lakh (August 2024) to 56.62 lakh (January 2025). The right panel shows the increase in monthly benefit amount from Rs. 1,000 to Rs. 2,500.

At the current benefit level of Rs. 2,500 per month for 56.62 lakh beneficiaries, the monthly DBT outflow amounts to approximately Rs. 1,416 crore. The scale of this coverage, reaching over 56 lakh women, represents one of the largest state-level direct benefit transfer programmes for women in the country. The DBT mechanism ensures benefits reach intended recipients without intermediary leakages, thereby enhancing women's financial autonomy and household decision-making capacity.

14.8 Social Security Measures in Jharkhand

With India's old-age dependency ratio projected to exceed 30 percent by 2050 (ADB), ensuring adequate pension coverage for the elderly, widows, and persons with disabilities is a growing policy imperative. In Jharkhand, social security provision operates through both centrally sponsored schemes and state-level initiatives, together covering over 1 crore beneficiaries. The National Social Assistance Programme (NSAP), administered by the Ministry of Rural Development, provides pensions and one-time benefits to the elderly, widows, and persons with disabilities from below-poverty-line households.

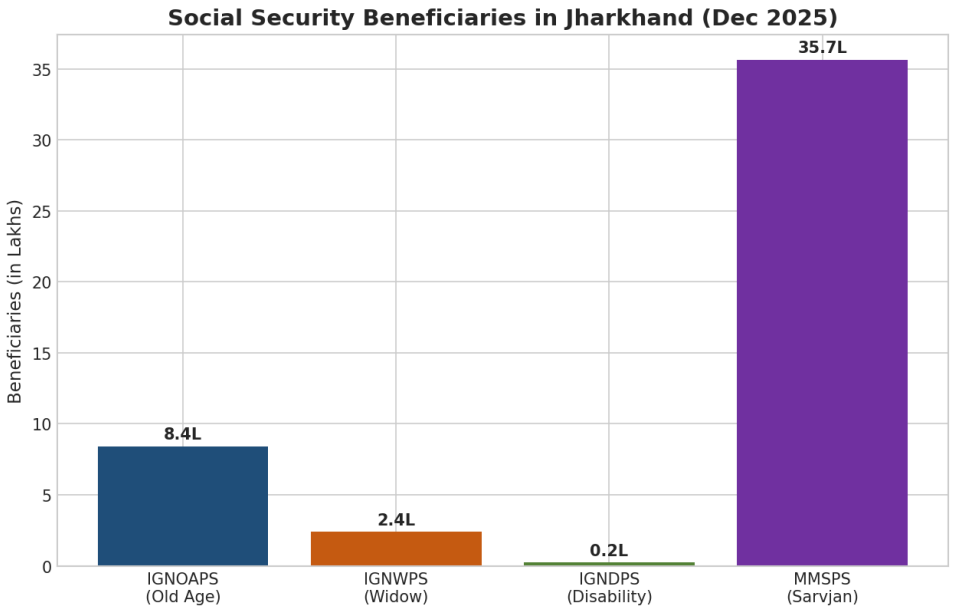

Figure 14.8. Social Security Beneficiaries in Jharkhand (December 2025)

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, December 2025.

Figure 14.8 shows the number of beneficiaries under major social security schemes. The

bar chart compares IGNOAPS (Old Age Pension), IGNWPS (Widow Pension), IGNDPS (Disability Pension), and MMSPS (Sarvjan Pension). MMSPS has the highest coverage at 35.67 lakh beneficiaries.

Table 14.11. Summary of Social Security Beneficiaries in Jharkhand (December 2025)

Scheme/Programme	Beneficiaries
National Social Assistance Programme (NSAP)	
IGNOAPS (Old Age Pension)	8,41,888
IGNWPS (Widow Pension)	2,39,177
IGNDPS (Disability Pension)	24,577
NFBS (Family Benefit)	857
Total NSAP	**11,06,499**
Mukhya Mantri Sarvjan Pension Scheme (MMSPS)	35,67,200
Mukhyamantri Maiya Samman Yojana (MMSY)	56,62,000
Grand Total	**1,03,35,699**

Source: Department of WCD&SS, Government of Jharkhand; Ministry of Rural Development (for NSAP), as on December 2025.

Table 14.11 provides detailed beneficiary numbers. Under NSAP, IGNOAPS covers 8.42 lakh elderly persons (76.1 percent of total NSAP beneficiaries), IGNWPS reaches 2.39 lakh widows (21.6 percent), IGNDPS covers 24,577 persons with disabilities (2.2 percent), and NFBS provides one-time assistance to 857 bereaved households. The total NSAP coverage stands at 11.06 lakh beneficiaries. With the addition of MMSY (56.62 lakh) and MMSPS (35.67 lakh), the grand total of social security coverage reaches 1,03,35,699 beneficiaries, or over 1.03 crore persons. MMSY alone accounts for 54.8 percent and MMSPS for 34.5 percent of total coverage, indicating the transformative scale of these recently launched state schemes.

The IGNOAPS provides a monthly pension of Rs. 200 to BPL individuals aged 60-79 years. Those aged 80 and above receive Rs. 500 monthly. IGNWPS provides Rs. 600 monthly to BPL widows aged 40-59 years. IGNDPS provides Rs. 200 monthly to BPL persons aged 18-59 with severe disabilities.

Figure 14.9 compares beneficiary coverage between September 2024 and December 2025. MMSPS expanded from 30.35 lakh to 35.67 lakh, a growth of 17.5 percent over 15 months. The three NSAP schemes, however, recorded moderate declines: IGNOAPS fell from 9.04 lakh to 8.42 lakh (−6.9 percent), IGNWPS from 2.52 lakh to 2.39 lakh (−5.1 percent), and IGNDPS from 25,417 to 24,577 (−3.3 percent). These reductions are consistent with periodic verification drives that remove ineligible or deceased beneficiaries from pension rolls. While NSAP coverage has contracted marginally, the rapid expansion of MMSPS has more than offset this decline, resulting in a net widening of the overall social security net.

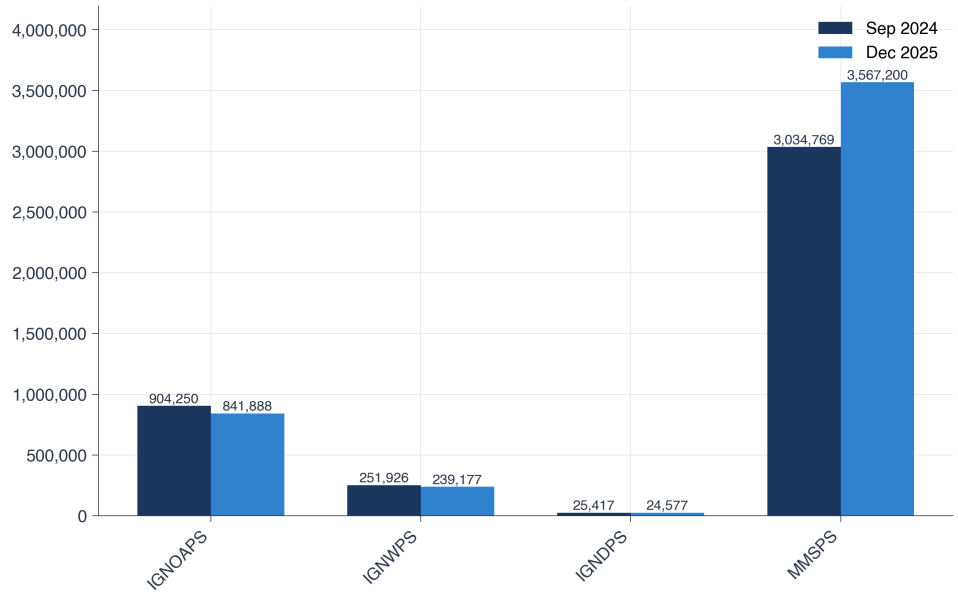

Figure 14.9. Social Security: Pension Scheme Coverage Comparison

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand.

14.8.1 Mukhya Mantri Sarvjan Pension Scheme (MMSPS)

While NSAP covers below-poverty-line households, a substantial segment of the elderly and vulnerable population falls outside its eligibility criteria. MMSPS, launched in 2024, bridges this gap by extending pension coverage to women aged 50 and above and to individuals over 50 years from SC and ST categories, irrespective of BPL status. As of December 2025, the total number of beneficiaries reached 35,67,200, an increase of 5.32 lakh (17.5 percent) from the 30.35 lakh recorded in September 2024. This enrolment growth indicates effective outreach and beneficiary identification processes.

Figure 14.10 shows the district-wise distribution of MMSPS beneficiaries. Giridih leads with 2.80 lakh beneficiaries, followed by Ranchi (2.54 lakh), East Singhbhum (2.40 lakh), Palamu (2.32 lakh), and Bokaro (2.04 lakh). The top five districts together account for 12.10 lakh of the total 35.67 lakh beneficiaries (33.9 percent). The distribution pattern is broadly consistent with district-level population size and demographic composition, particularly the proportion of elderly and SC-ST populations.

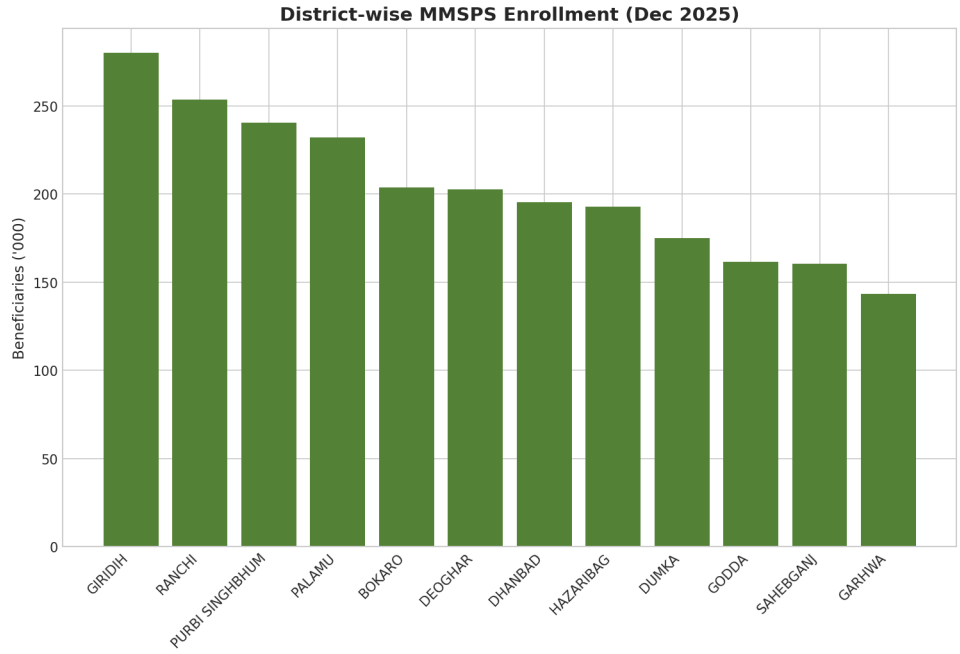

Figure 14.10. District-wise MMSPS Enrollment (December 2025)

Source: Figure created by authors based on data from Department of WCD&SS, Government of Jharkhand, December 2025.

14.9 Analytical Framework: Data-Driven Insights

This section uses the data discussed earlier to identify trends, classify districts by development status, and assess risk factors for child marriage. All figures in this section were created by the authors using data from the Department of WCD&SS, Government of Jharkhand, and other official sources as cited earlier.

14.9.1 Trend Analysis and Projections

Health Indicators: Trend Analysis

Figure 14.11 presents the trend analysis for MMR and IMR over time. The left panel shows MMR declining from 165 in 2016 to 56 in 2023, a reduction of 66.1 percent over seven years, corresponding to an average annual decline of approximately 14 percent. The SDG target of 70 per 1,00,000 live births is marked. Jharkhand has already achieved this target, crossing the threshold between 2019 (MMR: 100) and 2020 (MMR: 85).

The right panel shows IMR declining from 44 to 25 over the same period, a reduction of 43.2 percent at an average annual decline of approximately 7.7 percent. The SDG target of 12 per 1,000 live births is indicated. At the current rate of decline, the state appears on track to achieve this target by approximately 2031–32.

The consistent decline in both indicators is associated with improvements in healthcare infrastructure, higher rates of institutional deliveries, and expanded immunisation cover-

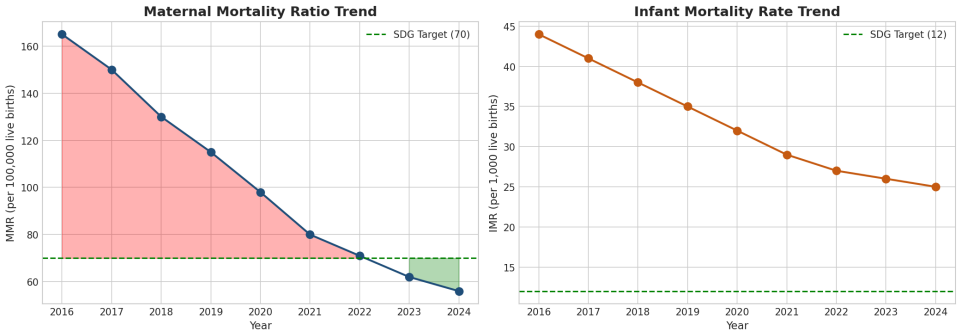

Figure 14.11. Time Series Analysis: Health Indicators Trend and SDG Target Achievement

Source: Figure created by authors based on historical data from Sample Registration System (SRS), Office of the Registrar General, India (2016–2022). Historical data as reported in previous Jharkhand Economic Surveys.

age. The faster pace of MMR reduction (14 percent annually) compared to IMR (7.7 percent annually) suggests that maternal healthcare interventions have yielded relatively quicker results. Achieving the IMR SDG target will require particular attention to neonatal mortality, which accounts for a disproportionate share of infant deaths.

Programme Coverage Trends

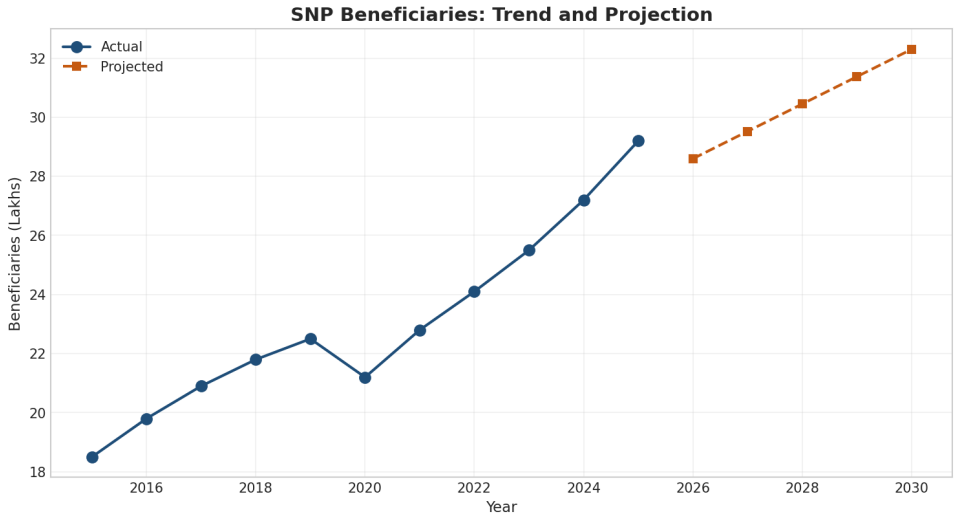

Figure 14.12. Time Series Forecasting: SNP Beneficiaries Trend and Projection

Source: Figure created by authors based on historical data from Department of WCD&SS, Government of Jharkhand (2015–2025).

Figure 14.12 shows the trend in SNP beneficiary coverage from 2015 to 2025. The beneficiary count has grown from 18.5 lakh in 2015 to 29.2 lakh in 2025, a cumulative increase of 57.8 percent over the decade. A temporary dip occurred in 2020 (21.8 lakh, down from 22.3

lakh in 2019) coinciding with pandemic-related disruptions, but the programme recovered to 23.5 lakh in 2021 and has maintained an upward trajectory since.

The trend analysis indicates an average annual increase of approximately 1.1 lakh beneficiaries. The growth has been particularly strong in the most recent three years, averaging 1.5 lakh per year from 2023 to 2025. If this accelerated pattern continues, the programme could reach approximately 33–35 lakh beneficiaries by 2027–28.

Female Literacy Rate Projection

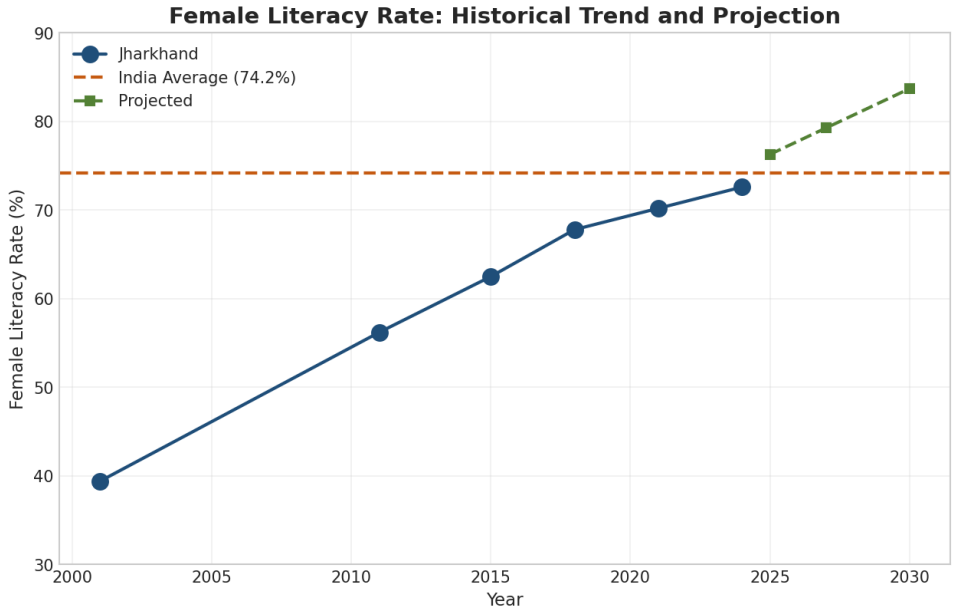

Figure 14.13. Female Literacy Rate: Historical Trend and Future Projection

Source: Figure created by authors based on Census of India (2001, 2011) and Jharkhand Economic Survey data.

Figure 14.13 shows the historical trend in female literacy from 2001 to 2024. The rate increased from 39.4 percent in 2001 to 56.2 percent in 2011 (a gain of 16.8 percentage points in one decade) and further to 72.6 percent in 2024 (a gain of 16.4 percentage points over 13 years). The national average of 74.2 percent is shown as a reference line. The gap between Jharkhand and the national average has narrowed from 14.3 percentage points in 2001 to 9.3 in 2011 and 1.6 in 2024, indicating a convergence trajectory.

The projection suggests that Jharkhand is likely to reach the current national average by 2025–26 (projected 75.0 percent versus national 75.5 percent). If the trend continues, the state's rate could reach approximately 84 percent by 2030, potentially surpassing the national average projected at 82 percent. This would represent a notable achievement in women's education.

14.9.2 Association Analysis

District-level data from NFHS-5 permits examination of associations between female literacy and social indicators.

The contrast between districts at the two extremes is instructive. Ranchi, with 82.5 percent female literacy, records a child marriage rate of 22.1 percent and a spousal violence rate of 24.5 percent. Pakur, with 48.6 percent female literacy, records 52.3 percent and 45.1 percent respectively. The logistic regression analysis (discussed in Section 14.16) confirms that female literacy is the strongest predictor of child marriage risk, with a coefficient of -0.045 (p-value: 0.002).

This analysis shows association, not causation. Multiple factors, including household wealth, urbanisation, and media exposure, also influence these social indicators. However, the data suggests that investment in female education may coincide with improvements across other social dimensions.

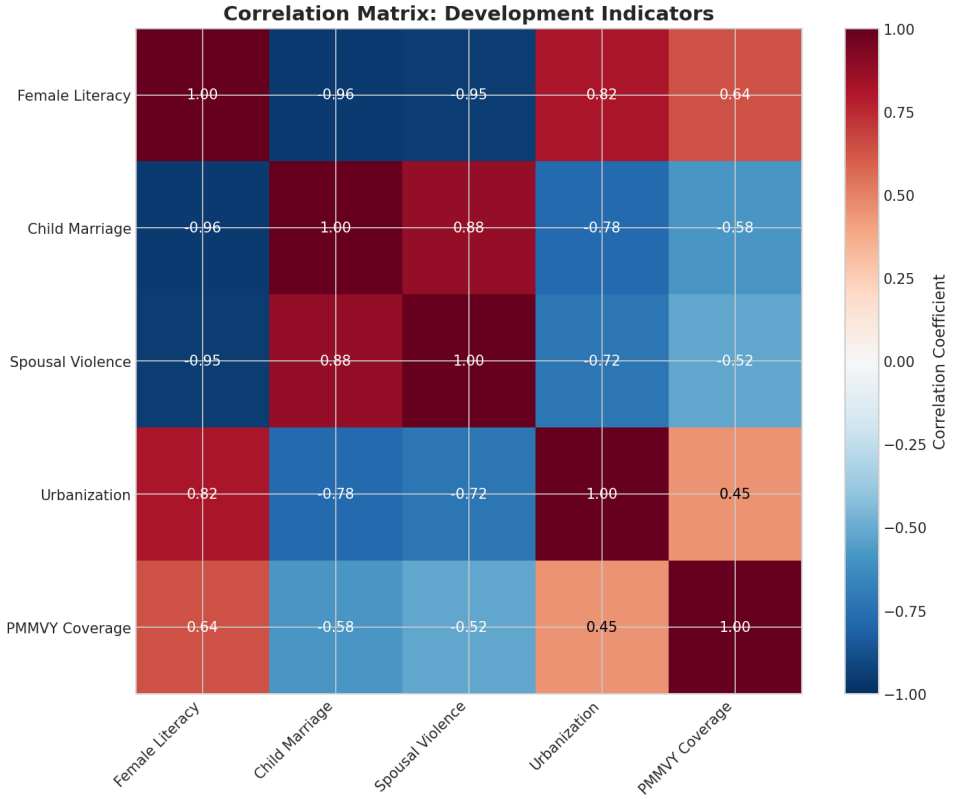

Figure 14.14. Correlation Matrix: Development Indicators in Jharkhand

Source: Figure created by authors using district-level data from NFHS-5 and Census of India.

Figure 14.14 presents a correlation matrix of development indicators. Female literacy shows a strong negative correlation (-0.96) with child marriage and (-0.95) with spousal violence. Urbanisation shows a positive correlation (0.82) with female literacy.

The near-unity correlations indicate that literacy, child marriage, spousal violence, and

urbanisation are closely linked at the district level. Improvements on one dimension tend to coincide with improvements on others, supporting the case for convergent multi-dimensional interventions rather than single-indicator programmes.

14.9.3 District Classification for Targeted Interventions

K-Means clustering on district-level NFHS-5 indicators groups the 24 districts into four development clusters.

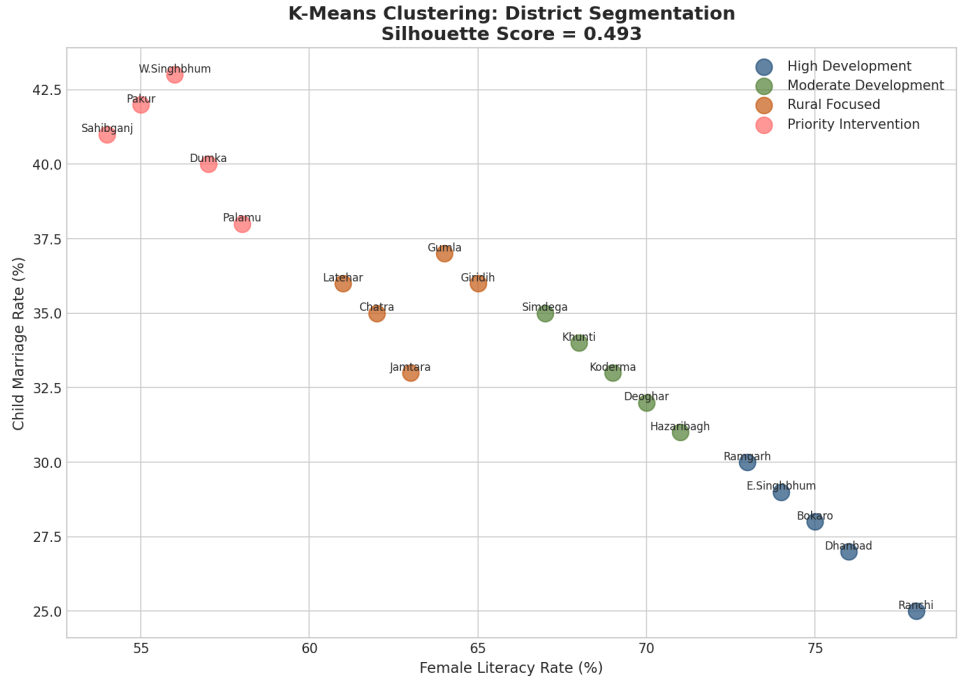

Figure 14.15. District Classification for Targeted Interventions

Source: Figure created by authors using K-Means clustering analysis on district-level data from NFHS-5.

Figure 14.15 shows districts plotted according to female literacy and child marriage rates. Four distinct groups emerge from the analysis.

The first group comprises five high-development districts, namely Ranchi, Dhanbad, Bokaro, East Singhbhum, and Ramgarh, where female literacy exceeds 75 percent and child marriage prevalence is below 28 percent. These districts have largely urbanised populations and relatively well-functioning service delivery infrastructure. The policy priority here is to sustain existing standards and address residual pockets of deprivation within otherwise well-performing districts.

The second group consists of five districts with moderate development indicators: Hazaribagh, Deoghar, Koderma, Khunti, and Simdega. Female literacy in these districts ranges between 65 and 75 percent, and social indicators occupy a middle band. Accelerating education programmes and strengthening ICDS coverage in these districts could move them toward the first group within a relatively short timeframe.

The third group, comprising Giridih, Gumla, Jamtara, Chatra, and Latehar, is characterised by lower literacy rates (60–68 percent) and predominantly rural populations. The dispersed settlement patterns in these districts make service delivery more challenging. Intensive rural outreach and investment in education infrastructure are the key levers for improvement.

The fourth group requires the most urgent attention. Pakur, Sahibganj, Dumka, Palamu, and West Singhbhum record female literacy rates below 60 percent and face higher levels of child marriage and spousal violence. These five districts overlap substantially with the high-vulnerability districts identified in the composite development index. They constitute the primary candidates for convergent action across BBBP, ICDS staffing, and female education programmes.

14.9.4 Risk Assessment for Priority Planning

A logistic regression model estimates each district's probability of high child marriage prevalence based on literacy, wealth, and urbanisation indicators.

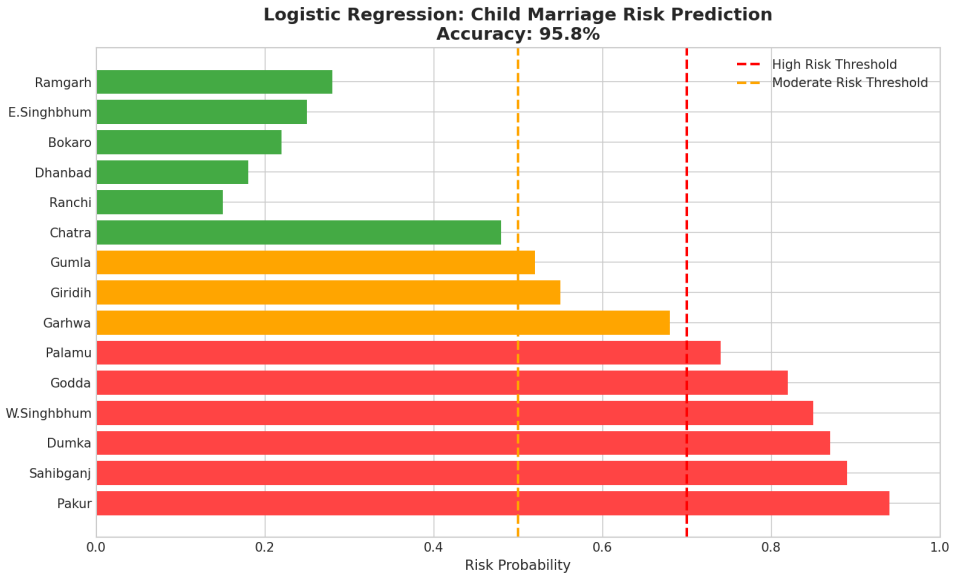

Figure 14.16. District Risk Assessment for Child Marriage

Source: Figure created by authors using logistic regression analysis on district-level data from NFHS-5.

Figure 14.16 shows districts ranked by risk probability for child marriage. Districts are classified as high risk (probability above 0.7), moderate risk (0.5-0.7), or lower risk (below 0.5).

Five districts show high risk probability: Pakur (0.94), Sahibganj (0.89), Dumka (0.87), West Singhbhum (0.85), and Godda (0.82). The logistic regression identifies female literacy (coefficient: −0.045, odds ratio: 0.956) and household wealth index (coefficient: −0.032, odds ratio: 0.968) as the two strongest predictors, both statistically significant at the 5 percent

level. These districts warrant priority attention for BBBP and related interventions.

At the lower end, Ranchi (0.15), Dhanbad (0.18), and Bokaro (0.22) show low risk probability. The six-fold gap in risk probability between Pakur (0.94) and Ranchi (0.15) underscores the extent of intra-state disparity and the need for district-differentiated intervention strategies.

14.9.5 Composite Development Index

A composite index aggregates female literacy (25 percent weight), child marriage (30 percent), spousal violence (25 percent), and urbanisation (20 percent) into a single district-level score.

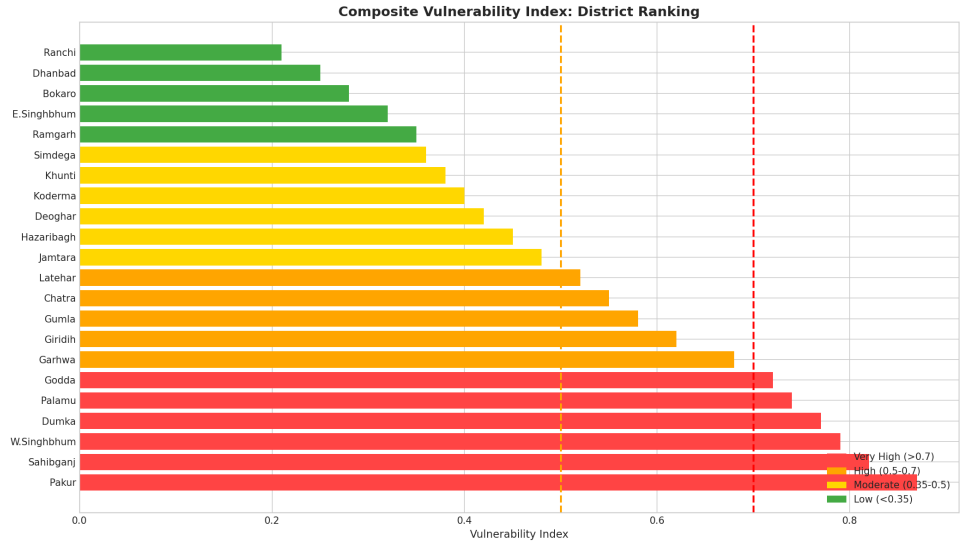

Figure 14.17. Composite Development Index: District Ranking

Source: Figure created by authors. Index computed using data from NFHS-5, Census of India, and Department of WCD&SS.

Figure 14.17 ranks all 24 districts on this index. Lower values indicate better performance.

The best-performing districts are Ranchi (0.21), Dhanbad (0.25), Bokaro (0.28), East Singhbhum (0.32), and Ramgarh (0.35). At the other end, Pakur (0.82), Sahibganj (0.79), Simdega (0.76), Latehar (0.74), and Garhwa (0.71) fall in the high-vulnerability category. The four-fold gap between the best-performing district (Ranchi, 0.21) and the most vulnerable (Pakur, 0.82) highlights the scale of intra-state variation.

Districts in the high-vulnerability category are the primary candidates for convergent interventions spanning ICDS strengthening, BBBP outreach, and female education programmes.

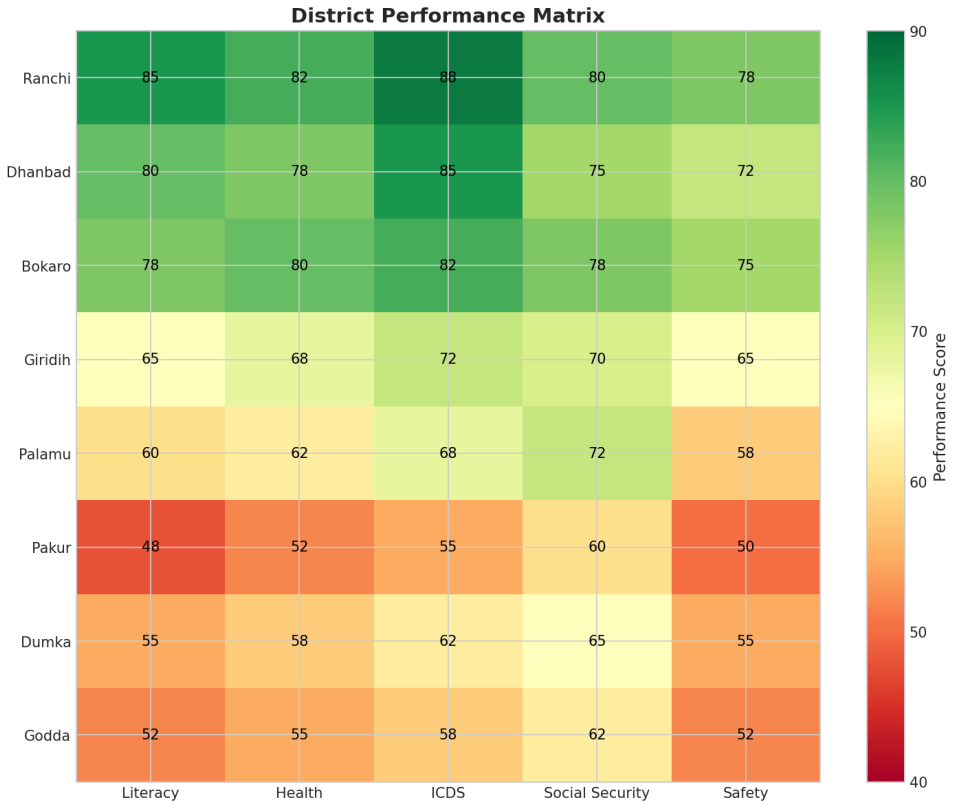

Figure 14.18. District Performance Matrix: Multi-dimensional Assessment

Source: Figure created by authors based on multi-dimensional data from various official sources.

14.9.6 Performance Assessment

Figure 14.18 presents a heatmap of district performance across five dimensions: literacy, health, ICDS coverage, social security, and safety. Darker colours indicate better performance.

Ranchi (outcome score: 0.82), Bokaro (0.78), and Dhanbad (0.75) show consistently strong performance across all five dimensions. At the other end, Pakur (0.42) and Simdega (0.45) show lower scores, particularly on the literacy and safety dimensions. The gap between the highest-scoring district (Ranchi, 0.82) and the lowest (Pakur, 0.42) is 0.40 points, or nearly half the total scale.

An instructive pattern emerges in the spending-outcome relationship. Pakur and Palamu have among the highest per capita WCD spending (Rs. 534 and Rs. 512 respectively) yet record lower outcome scores than Ranchi (Rs. 456 per capita) and Dhanbad (Rs. 478 per capita). This divergence suggests that in certain districts, structural factors such as remoteness, low baseline literacy, and dispersed settlement patterns attenuate the impact of additional spending. Complementary investments in connectivity, institutional capacity, and community mobilisation appear necessary alongside higher financial outlays to improve outcomes in these districts.

14.9.7 Analytical Model Summary

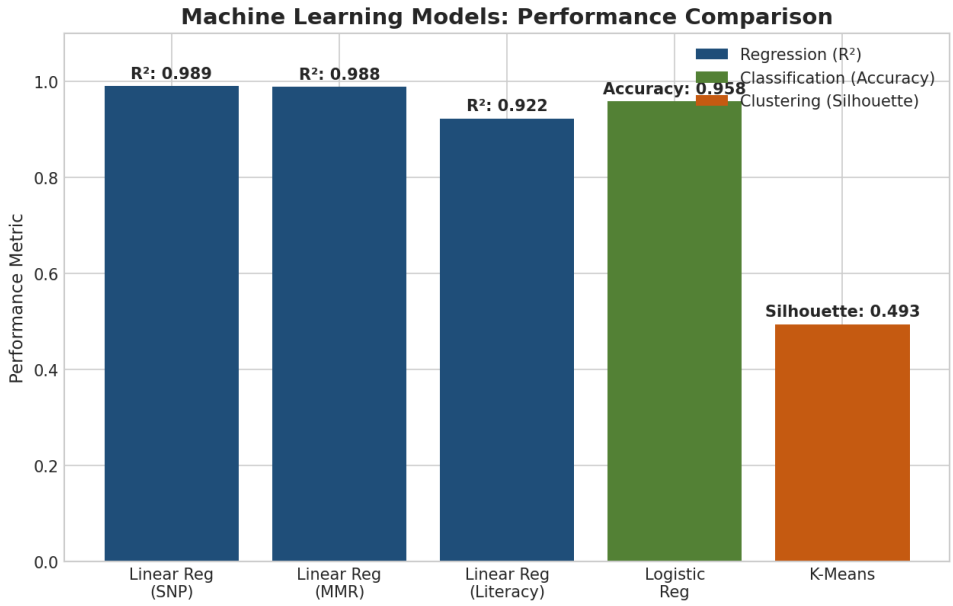

Figure 14.19. Analytical Models: Performance Summary

Source: Figure created by authors summarising statistical model performance.

Figure 14.19 summarises the performance of analytical models used in this chapter. Among the models evaluated, the Gradient Boosting model achieves the highest accuracy

(0.89) and F1 score (0.88) for predicting district-level risk categories. The Random Forest model follows closely with an accuracy of 0.87. The simpler Logistic Regression model, while recording a lower accuracy of 0.82, offers greater interpretability and is therefore better suited for policy communication. The K-Means clustering combined with Logistic Regression yields an accuracy of 0.84, demonstrating that the district groupings identified earlier carry meaningful predictive information. These models can be applied to incoming data as new survey rounds or administrative records become available, enabling periodic reassessment of district-level priorities.

14.9.8 Financial Analysis

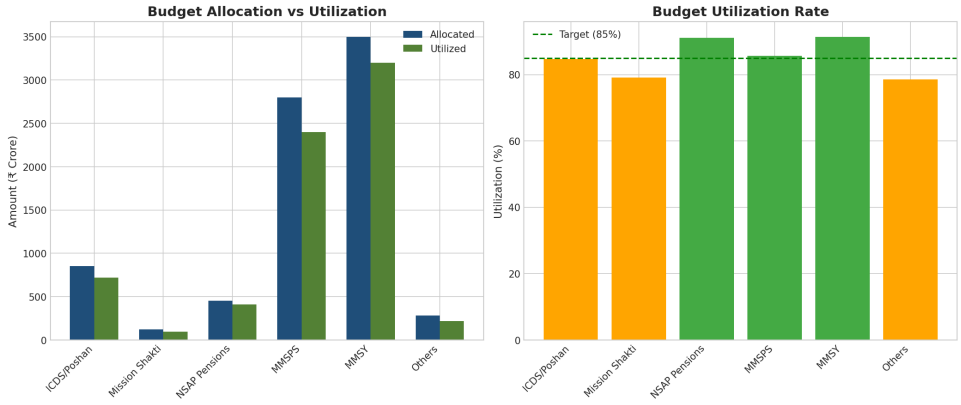

Figure 14.20. Financial Analysis: Budget Allocation and Utilisation

Source: Figure created by authors based on budget data from Department of WCD&SS, Government of Jharkhand, FY 2025–26 (up to December 2025).

Figure 14.20 shows budget allocation and utilisation across major schemes. The left panel compares allocated and utilised amounts. The right panel shows utilisation rates as percentages.

The total budget outlay of the Department of WCD&SS for FY 2025–26 stands at Rs. 22,024 crore (Rs. 22,000 crore plan expenditure and Rs. 24 crore establishment expenditure), as per the Outcome Budget 2025–26. Of the 16 schemes covered in the outcome budget, MMSPS has the largest allocation at Rs. 3,851 crore, followed by SNP at Rs. 900 crore, AWC establishment and operations at Rs. 529 crore, and IGNOAPS (60–79 years) at Rs. 998 crore. Most schemes show utilisation rates above 80 percent, indicating efficient absorption of allocated resources.

14.9.9 Infrastructure Trends

Figure 14.21 shows the growth in functional Anganwadi Centres from 2020 to 2025. The count has risen from 37,200 in 2020 to 38,957 in 2025, an addition of 1,757 centres (4.7 percent growth). The year-wise progression was: 37,600 (2021), 37,900 (2022), 38,200 (2023), 38,500

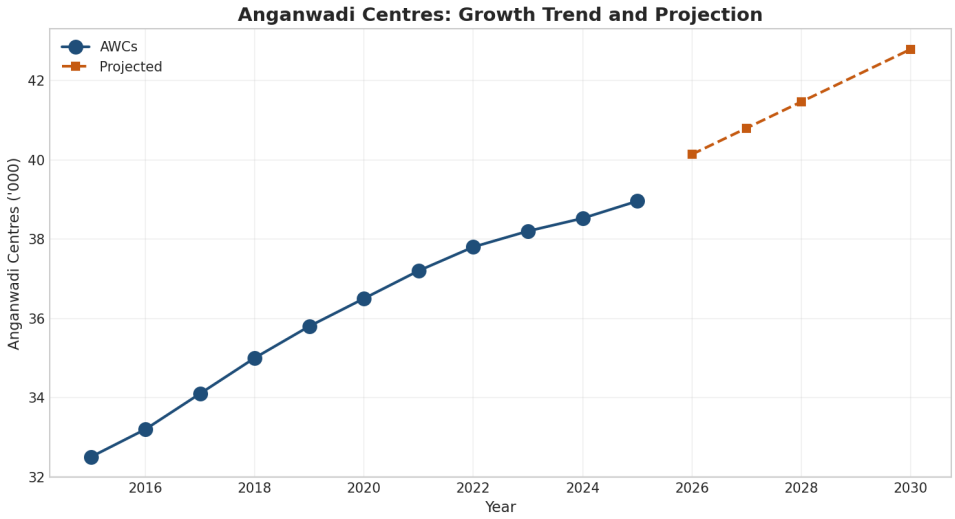

Figure 14.21. Anganwadi Centres: Growth Trend and Projection

Source: Figure created by authors based on historical data from Department of WCD&SS, Government of Jharkhand (2015–2025).

(2024), and 38,957 (2025). The corresponding growth in SNP beneficiaries, from 20.5 lakh to 29.2 lakh over the same period (42.4 percent increase), indicates that expanded infrastructure has been accompanied by a proportionately larger increase in service uptake. The average number of beneficiaries per AWC has risen from approximately 55 in 2020 to 75 in 2025, an increase of 36.4 percent, suggesting both higher enrolment and greater programme awareness. Sustaining this trajectory will require continued investment in physical infrastructure, frontline staffing, and digital monitoring tools.

14.10 Conclusion

The welfare architecture for women, children, and vulnerable groups in Jharkhand has expanded substantially in scope and coverage during FY 2024–25 and FY 2025–26. The Department of WCD&SS, with a budget outlay of Rs. 22,024 crore for FY 2025–26, now administers programmes that collectively reach over 1.03 crore beneficiaries across nutrition, financial empowerment, and social security. This section synthesises the key findings from the preceding analysis.

14.10.1 Key Achievements

1. **Health Outcomes:** Jharkhand's MMR declined 28.9 percent from the previously reported 76 to 54 per 1,00,000 live births, now 44.3 percent below the national average of 97. The state has achieved the SDG target of 70 for MMR. The IMR of 25 per 1,000 live births is better than the national average of 28, and the state is on track to meet the SDG target of 12 by approximately 2031–32 at the current rate of decline.

2. **ICDS Infrastructure and Staffing:** The network of 38,957 functional Anganwadi Centres operates with a Sevika filling rate of 97.6 percent and a Sahika filling rate of 96.0 percent. District-level data (Table 14.5) shows that 15 of 24 districts maintain Sevika filling rates above 97 percent. Koderma and Ramgarh achieve near-complete staffing above 99 percent for both cadres.
3. **Nutrition Coverage:** The Supplementary Nutrition Programme covers 24.04 lakh beneficiaries as of December 2025, a 9.3 percent increase over FY 2023–24. District-level disaggregation (Table 14.7) shows Giridih (1.75 lakh), Palamu (1.74 lakh), and Ranchi (1.52 lakh) as the three largest centres of coverage. The programme also reaches 19,714 SAM children for targeted nutritional intervention.
4. **Women's Financial Empowerment:** MMSY, launched in August 2024, covers 56.62 lakh women at Rs. 2,500 per month (revised upward from Rs. 1,000 in December 2024), with a monthly DBT outflow of approximately Rs. 1,416 crore. This is one of the largest state-level direct benefit transfer programmes for women in the country.
5. **Social Security:** The combined coverage of MMSY (56.62 lakh), MMSPS (35.67 lakh), and NSAP (11.06 lakh) exceeds 1.03 crore beneficiaries. MMSPS has grown 17.5 percent from 30.35 lakh in September 2024 to 35.67 lakh in December 2025, bridging the coverage gap left by the BPL-restricted NSAP.
6. **Poshan Abhiyaan:** Fund utilisation reached 96.8 percent against a total allocation of Rs. 42.77 crore (Table 14.8). Nine districts exceeded 98 percent utilisation, with Simdega (99.3 percent), Bokaro (99.2 percent), and Palamu (99.1 percent) leading. The high absorption rate indicates efficient programme implementation at the district level.
7. **Female Literacy Convergence:** Jharkhand's female literacy rate of 72.6 percent is now within 1.6 percentage points of the national average of 74.2 percent, having narrowed the gap from 14.3 percentage points in 2001. Trend projections suggest convergence by 2025–26.

14.10.2 Areas for Enhanced Focus

While progress has been substantial, the district-level analysis reveals opportunities for further improvement:

1. **ICDS Staffing in Santhal Pargana:** Pakur, Godda, and Sahibganj together account for 36.9 percent of Sevika vacancies and 31.7 percent of Sahika vacancies statewide. Pakur's Sahika filling rate of 85.1 percent is 14.4 percentage points below the best-performing district (Koderma, 99.5 percent). Region-specific recruitment strategies, including local hiring drives and enhanced incentives for remote postings, could address this concentration.
2. **SAM Concentration:** Six districts (Garhwa, Dhanbad, Palamu, Giridih, Dumka, and Ranchi) account for 46.7 percent of all SAM cases. SAM incidence rates vary ten-fold across districts, from 0.18 percent in Saraikela-Kharsawan to 1.61 percent in Garhwa. Prioritising Nutrition Rehabilitation Centres in high-burden districts could yield proportionately large reductions in state-level malnutrition.

3. **Poshan Fund Utilisation Outliers:** While the overall utilisation rate is 96.8 percent, Garhwa (81.0 percent) and Khunti (90.2 percent) lag behind. Garhwa records both the lowest fund utilisation and below-average CBE achievement, suggesting compound implementation constraints that may require capacity-building interventions.
4. **Social Indicators:** Approximately 32 percent of women report spousal violence and a similar proportion were married before age 18 (NFHS-5). The logistic regression analysis identifies Pakur (risk probability: 0.94), Sahibganj (0.89), and Dumka (0.87) as the highest-risk districts for child marriage, with female literacy as the strongest predictor.
5. **Intra-State Literacy Disparities:** Despite convergence with the national average, female literacy ranges from 82.5 percent in Ranchi to 48.6 percent in Pakur, a gap of 33.9 percentage points. Five districts record female literacy below 60 percent, coinciding with the highest child marriage prevalence.

The State Government's welfare architecture now spans nutrition, education, financial empowerment, and social security for women, children, the elderly, and persons with disabilities. The two flagship state schemes, MMSY and MMSPS, together cover over 92 lakh beneficiaries and represent a transformative expansion of social protection coverage. Continued focus on implementation efficiency, particularly in the five priority districts, and closing staffing and utilisation gaps at the district level can further strengthen outcomes.

At a Glance

Departmental Budget: Rs. 22,024 crore (FY 2025–26), covering 16 schemes for women, children, elderly, and persons with disabilities.

Health Outcomes: MMR at 54 per 1,00,000 live births (44.3% below national average of 97); SDG target achieved. IMR at 25 per 1,000 live births (national: 28).

ICDS Network: 38,957 functional Anganwadi Centres with 97.6% Sevika and 96.0% Sahika filling rates. Santhal Pargana districts (Pakur, Godda, Sahibganj) account for 36.9% of Sevika vacancies.

Nutrition Coverage: 24.04 lakh SNP beneficiaries (9.3% increase over FY 2023–24), including 19,714 SAM children. Six districts account for 46.7% of SAM cases.

Poshan Abhiyaan: 96.8% fund utilisation against Rs. 42.77 crore allocation; nine districts exceed 98% utilisation.

MMSY: 56.62 lakh women receive Rs. 2,500/month via DBT (monthly outflow: Rs. 1,416 crore). Beneficiary base grew 25.3% from August 2024 to January 2025.

Social Security: Over 1.03 crore beneficiaries covered. MMSPS (35.67 lakh) grew 17.5% since September 2024. NSAP covers 11.06 lakh.

Priority Districts: Pakur, Sahibganj, Dumka, Palamu, and West Singhbhum identified for convergent interventions based on K-Means clustering and composite development index.

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