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A POLICY RESPONSE TO INCREASE ACCESS TO FAMILY PLANNING SERVICES FOR THE POOR IN JHARKHAND, INDIA

SEPTEMBER 2010

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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ACKNOWLEDGMENTS

The USAID | Health Policy Initiative worked closely with the Government of Jharkhand's Department of Health and Family Welfare (DoHFW) to develop a strategy for operationalizing the state's Population and Reproductive & Child Health Policy 2004. Preparation of the Family Planning (FP) Strategy included a consultative process conducted from July 2009 through August 2010 to review the status of state's FP and other demographic indicators and assess the current programme situation, opportunities and gaps, and client feedback on availability and accessibility of services. Information gathered during this process informed development of the FP strategy, which will (1) help couples in Jharkhand achieve their desired family size, (2) ensure healthy families, and (3) support the state and national goals of replacement-level fertility.

A considerable amount of background work preceded development of the FP strategy, and the authors would like to acknowledge the main contributors. First, sincere appreciation goes to Shri. Sukhdeo Singh (former Secretary, Health, Medical Education & Family Welfare) and Dr. Nitin Madan Kulkarni (former Mission Director, National Rural Health Mission (NRHM)–Jharkhand) for initiating the process, facilitating the discussions, and encouraging critical thinking. We also thank Smt. Aradhana Patnaik, NRHM Mission Director, for her guidance and leadership in finalizing the strategy, and the DoHFW officials, FP Taskforce members, district officials, district program managers, auxiliary nurse-midwives, Anganwadi workers, Sahiyyas, and people of Jharkhand, for their input on local context and clarification of realities on the ground in terms of FP needs as well as service gaps and possible strategies for closing them.

We would also like to acknowledge the FP taskforce and our colleagues from the Innovations in Family Planning Services II Technical Assistance Project (ITAP) for assisting with data collection and analysis, facilitating discussions, and drafting the strategy and input of Dr. G. Narayana.

Finally, we are grateful for the support and technical inputs from the United States Agency for International Development, especially Mr. S Vijay Paulaj, Dr. Loveleen Johri, and Ms. Sheena Chhabra.

EXECUTIVE SUMMARY

To improve public health, policymakers must address the family planning and reproductive health (FP/RH) needs of the urban and rural poor, particularly in areas with a high rate of poverty. Despite the barriers to health services access that often occur among poor populations, successful strategies have emerged for delivering healthcare services, including family planning, in a wide range of settings. The northern state of Jharkhand has one of the highest poverty rates in India but lacks systematically designed and targeted interventions required to overcome obstacles to reaching its resource-poor populations with FP/RH and other basic healthcare services.

The USAID | Health Policy Initiative, Task Order 1, worked with the Government of Jharkhand from July 2009 through August 2010 to identify and characterize the state's rural, urban, and tribal poor; evaluate their family planning status and needs; and design and develop an FP strategy to ensure those needs are met, which will support the objectives of Jharkhand's Population and Reproductive & Child Health Policy. The collaboration included three main components: (1) quantitative and qualitative research and analysis to characterize resource-poor populations in Jharkhand and their family planning practices; (2) dialogue with policymakers and other stakeholders on the results of the analyses and their implications for policy and program development; and (3) design, development, and finalization of a Family Planning Strategy document. The methodology included the application of a conceptual framework known as the EQUITY Approach, designed by the Health Policy Initiative to provide stakeholders with a practical, step-by-step process for ensuring that members of poor populations are actively engaged in policymaking and that pro-poor strategies are incorporated into policy design and implementation.

Research and Analysis

The principal aim of the research and analysis was to identify and characterize poor populations in Jharkhand in both rural and urban areas and engage the poor in understanding barriers to service access and use. Qualitative assessment in six districts indicated poverty is a key factor in creating barriers to accessing FP/RH services. Quantitative results indicated a strong connection between poverty and both caste and class. Place of residence was also an important poverty indicator. Jharkhand districts with large concentrations of poor populations tend to have lower use of contraceptive methods than other districts. Use of modern contraceptive methods is lower among the poorest women. Poor women in rural areas are more likely to have unhealthy intervals between births than women from higher-income groups and have higher levels of unmet need for family planning.¹ Areas identified as needing improvement included the introduction of pregnancy spacing, benefits of FP, and development of FP-related counseling, clinical, and training skills at community and district levels.

Policy Dialogue on Results and Implications for the FP Strategy

The Health Policy Initiative supported a series of stakeholder dialogues on both the qualitative and quantitative research findings. Three major consultative meetings held in 2009 and 2010 provided a forum for (1) discussing the implications of the findings in terms of FP policy and programming, (2) identifying program priorities and challenges as well as potential strategies for FP interventions, and (3) designing, developing, and drafting the Family Planning Strategy. During this consultative process, it was agreed that Jharkhand's health program would incorporate its first-ever FP strategy to ensure a more rigorous approach to achieving the national goal of replacement-level fertility and subsequent population stabilization.

¹ A healthy birth interval is assumed to be 36 months or longer.

In the design and development of the strategy, four key goals were defined: (1) determining priorities for strengthening health systems; (2) defining key priorities for the FP program; (3) clarifying appropriate flow and use of funds; and (4) identifying priority districts with low contraceptive prevalence rates (CPRs) and limited access to FP services. In addition, stakeholders identified seven issues as program priorities: (1) adolescent health; (2) age at marriage; (3) service reach to poor and marginalized populations; (4) family planning and maternal and neonatal child health (MNCH); (5) promotion of the use of spacing methods; (6) promotion of long-acting or permanent methods (LAPMs); (7) greater involvement of the private sector.

The New FP Strategy

The final version of the Family Planning Strategy 2010–2020 was officially adopted on August 17, 2010. It advocates that two specific goals be met by the year 2020: reduce the total fertility rate (TFR) from the current estimated level of 3.2 to 2.1 and increase the use of modern contraceptive methods from the current level of about 31 percent to 54 percent.

Technical objectives include reducing the unmet need for spacing and permanent FP methods among various resource-poor groups—including urban, rural, scheduled caste and scheduled tribe (SC/ST) populations—to ensure universal coverage and access to FP/RH services statewide. The strategy focuses on three strategic directions: (1) cross-cutting interventions for strengthening state health systems; (2) strategic program interventions; (3) operational planning for priority districts (those performing poorly in terms of unmet need for FP services and use of modern contraceptive methods).

Under the second category, stakeholders defined nine strategic interventions; each strategy includes targeted interventions to help meet the FP needs of the poor, as identified during analysis. Strategy 6 focuses exclusively on targeted services for the poorest and marginalized populations:

Strategy 1: Increase age at marriage and delay first pregnancy and promote the use of spacing methods among young married couples (this strategy specifically targets adolescents, mainly through social and community mobilization)

Strategy 2: Promote the use of spacing methods to increase birth intervals, increase age at first birth, and space pregnancies, through frontline workers and providers as well as community-based programs

Strategy 3: Promote LAPMs to meet the demand for limiting births

Strategy 4: Integrate FP services with MNCH services

Strategy 5: Foster male engagement in the concept of “planned parenthood”

Strategy 6: Reach rural, urban, and tribal poor and other marginalized populations through various strategies, including (1) identifying and mapping urban slums and poor populations; (2) identifying public-private partnership (PPP) mechanisms to reach urban slum populations; (3) creating mobile medical units; (4) deploying female link volunteers and registered medical practitioners to provide intrauterine contraceptive devices (IUCDs); and (5) identifying and training tribal women as auxiliary nurse-midwives

Strategy 7: Increase the involvement of private sector, nongovernmental organization, and public sector undertakings through PPPs

Strategy 8: Integrate family planning in other departments (where possible)

Strategy 9: Improve communication by establishing an FP Cell to lead strategy operationalization

The Operational Plan for the districts targets priority (poor-performing) areas based on FP performance indicators and uses a phased approach for program implementation (see Annex B). The first phase will focus on the 10 worst-performing districts in the state to improve overall FP indicators by providing support in the following areas: training, infrastructure support, manpower development planning, large-scale community mobilization, and camps to address unmet need.

Conclusions and Recommendations

Jharkhand's Family Planning Strategy is a bold step forward that builds on and strengthens the state's Population and Reproductive & Child Health Policy by setting forth specific steps to help integrate FP/RH services into state healthcare programs and overcome obstacles to delivering these services to under-served populations. The Health Policy Initiative supported a process of analysis, advocacy, and dialogue during the preparation of the FP strategy that led to a systematic, evidence-based, country-driven process to bring attention to improving FP access among the poor as an integral part of the new FP strategy. The process was guided by the Health Policy Initiative's EQUITY Framework. The new FP strategy is innovative in both its prioritization of the needs of resource-poor populations and its recommendations for strategic interventions to meet the needs of the poor—and thus, the strategy provides the state of Jharkhand with a good opportunity to improve public health among its population, particularly the poorest groups.

ABBREVIATIONS

ANM	auxiliary nurse-midwife
AWW	Anganwadi worker
BCC	behavior change communication
BPL	below the poverty line
CPR	contraceptive prevalence rate
DLHS	District Level Household and Facility Survey
DoHFW	Department of Health and Family Welfare
FGD	focus group discussion
FP	family planning
GoJ	Government of Jharkhand
IEC	information, education, and communication
ITAP	Innovations in Family Planning Services Technical Assistance Project
IUCD	intrauterine contraceptive device
LAPM	long-acting or permanent method (LA/P)
MHW	male health worker
MNCH	maternal and neonatal child health
MPW	multi-purpose worker
NGO	nongovernmental organization
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
PHC	primary health centres
PPP	public-private partnership
RCH	reproductive and child health
RH	reproductive health
SC	scheduled caste
SRS	Sample Registration System
ST	scheduled tribe
TFR	total fertility rate

I. INTRODUCTION

Rationale

In many countries, there is evidence that government health expenditures tend to benefit the better-off more than the poor.² To improve the health of the general population, the reproductive health and family planning (FP/RH) needs of poor people in urban and rural areas and other vulnerable populations must be addressed. In India, the health of the urban poor is considerably worse than that of urban middle-income and wealthier groups. After several decades of rapid urbanization, the number of people living in India's towns and cities in 2010 is estimated at about 300 million (almost 30% of the total population) and is expected to reach about 534 million by the year 2026.³ The number of people residing in India's slum areas has grown even more rapidly and is now estimated at 100 million. These areas are characterized by unhealthy conditions such as overcrowding, poor hygiene and sanitation, and lack of access to healthcare and other essential services.⁴ In India's rural areas, the poor live in extreme poverty, with limited or no access to basic health services and high rates of infant and maternal mortality. The National Rural Health Mission (NRHM) aims to address the health and development challenges of this latter population.

The state of Jharkhand in North India has one of the highest levels of poverty in the country (40.3%, versus a national rate of 27.5%).⁵ As a relatively new state, created in the year 2000 with the combination of the Chotanagpur and Santhal Pargana regions of South Bihar, Jharkhand lacks the systematically designed and targeted efforts that are needed to improve poor populations' access to basic healthcare, including FP/RH services—even within the state's reproductive and child health (RCH) program (RCH-2). Compared with other states and overall national rates in India, the prevalence of unmet need for FP services to space or limit births in Jharkhand is extremely high (25.3% in urban areas and 33.1% for the state as a whole) (see Figure 1). According to Round Three of the District Level Household Survey (DLHS-3, 2007–2008), as cited in the Health Policy Initiative's publication, *Developing a Family Planning Strategy for the Poor (Urban, Rural, and Tribal) in Jharkhand*,⁶ the prevalence of unmet need is even higher in Jharkhand's rural areas (36.2%).

² Health Policy Initiative. 2007. *Inequalities in the Use of Family Planning and Reproductive Health Services: Implications for Policies and Programs*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

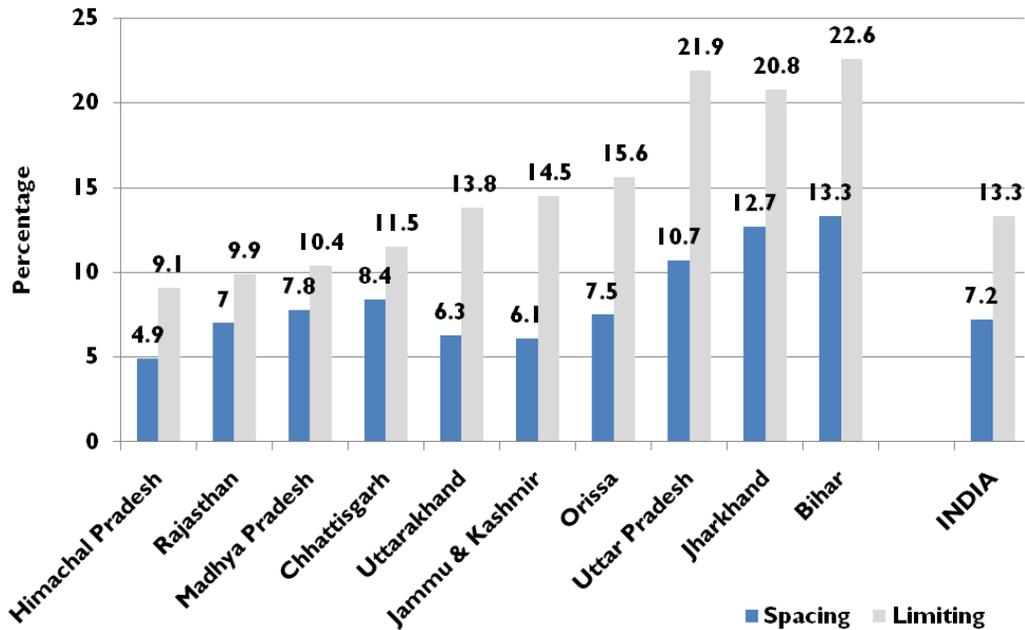
³ Urban Health Resource Centre. n.d. "Urban Health Facts and Figures." Available at: <http://uhrc.in/module-ContentExpress-display-ceid-92.html>.

⁴ Ibid.

⁵ According to the 61st round of the National Sample Survey Organisation, 2004–2005.

⁶ Health Policy Initiative. *Developing a Family Planning Strategy for the Poor (Urban, Rural, and Tribal) in Jharkhand*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Figure 1. Prevalence of unmet need for FP in Jharkhand compared with other states and overall national rates in India



Source: DLHS-3, 2007-2008.

Urban, rural, and tribal poor groups in Jharkhand continue to face obstacles accessing healthcare despite evidence from other countries that it is possible to reach poor populations with health services, in a wide range of settings, using various approaches. In a study of healthcare delivery across 27 developing countries, several programs favored the poor versus the better-off—either by achieving higher coverage among the impoverished populations or reducing previous disparities.⁷ Each program used different approaches, depending on the setting, type of health program, and service delivery mechanism. The results of the study point to the need for policymakers to recognize that it is possible to improve healthcare programming for the poor and that many different approaches—evidence-based, using locally relevant solutions—are available.

The successful strategies for delivering healthcare to the urban, rural, and tribal poor that have emerged in other parts of India can be used as models for reaching similar under-served populations in Jharkhand. These include the use of various types of public-private partnership (PPP) mechanisms, such as those developed by the USAID-funded Innovations in Family Planning Services Technical Assistance Project (ITAP/Delhi) implemented 2005-2010. Under ITAP, more than 14 PPP models for reaching the poor were piloted, tested, and monitored for impact. In Agra District, Uttar Pradesh, the project targeted women below the poverty line (BPL) and created various mechanisms to provide them with access to FP/RH services, including voucher schemes, mobile clinics, franchising, and service outsourcing, among others. In other countries such as Cambodia, analysis of healthcare delivery through partnerships between government and nongovernmental organizations (NGOs) showed that districts that contracted services through NGOs were better at reaching the poor with primary healthcare services than those whose services were provided directly by the government.⁸ In Nepal, a franchise scheme that held providers to a

⁷ Gwatkin, Davidson R., Adam Wagstaff, and Abdo S. Yazbeck. 2005. "What Did the Reaching the Poor Studies Find?" Pp. 47-61 in *Reaching the Poor with Health, Population, and Nutrition Services: What Works, What Doesn't and Why*, edited by Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck. Washington, DC: World Bank.

⁸ Schwartz, J.B. and I. Bhushan. 2005. "Cambodia: Using Contracting to Reduce Inequity in Primary Health

uniform standard of care appeared to be successful in increasing their commitment to delivering higher-quality services in a poverty-stricken and under-served district.⁹ Jharkhand can draw on these experiences in defining its FP strategy, particularly for areas with urban, rural, or tribal poor or other marginalized populations.

Purpose

From July 2009 through August 2010, the USAID | Health Policy Initiative, Task Order 1, worked with the state's Department of Health and Family Welfare (DoHFW) to increase emphasis on meeting the FP needs of Jharkhand's resource-poor populations to support the achievement of the state's population policy. The activity consisted of three main components: (1) quantitative and qualitative research and analysis to determine the status of family planning among the poor statewide; (2) dialogue with state policymakers and other key stakeholders on the research findings and their implications for future policy and program development; and (3) development and finalization of the Family Planning Strategy (Family Planning Strategy for Jharkhand, 2010–2020).

The Health Policy Initiative's main task was to help the DoHFW develop the Family Planning Strategy to fully incorporate program intervention strategies to address the FP needs of the poor. These efforts built on those carried out during implementation of the state's Population and Reproductive & Child Health Policy of 2004, which recognizes the role of FP in achieving health and development goals. The state's Population and Reproductive & Child Health Policy was adopted in 2004 with the objectives of achieving a total fertility rate (TFR) of 2.1 children by 2020 and a contraceptive prevalence rate (CPR) of 60 percent by 2015. Those objectives, in turn, provide overall support for the state's long-term goals of achieving a replacement-level fertility rate of 2.1 by 2020; improving knowledge of modern spacing methods from current levels to above 90 percent by 2015; and increasing the use of modern contraceptives (reported as 25% for 1999) to 60 percent by 2015. Over the 1998–2006 period, the annual increase in CPR was 0.9 percent (with an overall increase of 25% to 31%). If the increase in CPR were to continue at this pace, it would take 27 years for the state to reach a CPR of 55 percent, and target replacement-level fertility would not be achieved until 2033. To ensure that programs are more effective in reaching the poor and to achieve the state's FP goals, an FP strategy for the state was required.

The Health Policy Initiative's support aimed to closely align the strategy development process around inclusion of pro-poor interventions. This involved the following processes: identification of the poorest population groups in the state, clarification of the level of inequality in both health status and access to health services, and elucidation of the barriers to access by the poor. To ensure that the poor were involved in all aspects of the design, implementation, and monitoring of policies and programs addressing their FP/RH needs, research was conducted on vulnerable population sub-groups, such as indigenous tribes, to engage them in identifying the socio-cultural and delivery barriers they encounter in accessing FP/RH services. Based on this information, potential strategic interventions were explored with policymakers and providers to address access barriers. Through policy dialogue with leaders and stakeholders, a draft strategy was created, discussed, and revised to ensure that benefits reach the poor.

Methodology

Conceptual framework: the EQUITY Approach

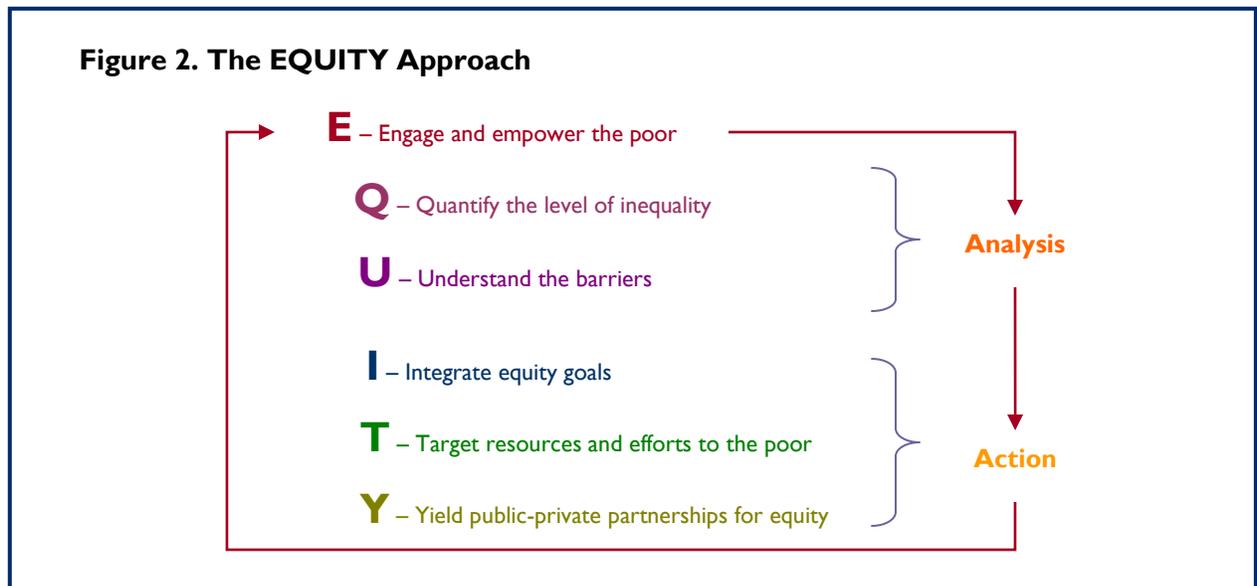
The Health Policy Initiative designed the EQUITY Approach in 2010 to provide stakeholders with a practical, step-by-step process for ensuring that the voices of the poor are actively engaged in

Care Delivery.” Pp. 137–162 in *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why*, edited by Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck. Washington, DC: World Bank.

⁹ Agha S., A.M. Karim, A. Balal, and S. Sosler. 2007. “The Impact of a Reproductive Health Franchise on Client Satisfaction in Rural Nepal.” *Health Policy and Planning* 22(5): 320–328.

policymaking and that pro-poor strategies are incorporated in policy design and implementation (see Figure 2). Drawing on the project's prior experiences and international best practices, the EQUITY Approach advocates the following:

- Engaging and empowering the poor
- Quantifying the level of disparity in healthcare use and health status
- Understanding the barriers to access
- Integrating equity goals and approaches in policies, plans, and agendas
- Targeting resources and efforts to the poor
- Yielding PPPs for equity



In the research, the EQUITY Approach was applied as a framework for understanding how to incorporate equity considerations into policy dialogue and discussion as well as strategic planning. The components of the framework are dynamic, can overlap, and do not necessarily follow a linear process—they often are undertaken as an iterative, parallel process.

Engaging and empowering the poor. The poor should be empowered to become involved in the program decisions that affect their healthcare needs. Best suited to describe the challenges they face and provide insight on how to design appropriate solutions, the poor have an important role to play in problem identification, advocacy, planning, and monitoring.

Quantifying the levels of inequality in healthcare access and health status. One prerequisite to getting the FP/RH needs of the poor on the national policy agenda is a clear understanding of the magnitude and urgency of the issue. Market segmentation analyses based on National Family Health Survey–3 (NFHS-3, 2005–2006) data and poverty mapping helped to reveal the level of inequality in FP/RH services and pinpoint the areas of greatest need.

Understanding the barriers to service access and use. Once the level of inequality is determined, policymakers must decipher the reasons behind it in order to devise appropriate responses.

Integrating equity goals into policies, plans, and strategies. To eliminate or reduce poverty, access to family planning for the poorest groups must be integrated into national poverty alleviation efforts. Specific policies, goals, strategies, resources, and monitoring mechanisms are needed to accomplish this goal.

Targeting resources and efforts to reach the poor. Implementation efforts, resource allocation mechanisms, and monitoring mechanisms must be carefully targeted to ensure that they serve the interests of poor populations and deliver resources to their intended beneficiaries.

Yielding PPPs for equity. Meeting the FP/RH needs of the poor requires that countries make the best use of all available resources—public, private, donor, and NGO. This in turn requires a plan to strengthen PPPs with the commercial sector and explore the use of innovative models with NGOs to reach under-served populations.

Data analysis

The purpose of the data analysis was to gain a better understanding of the demographic and socioeconomic characteristics related to FP needs of the urban and rural poor in Jharkhand. There is limited information available on the health conditions of the urban poor in India, including those living in Jharkhand. Most of the available information, including that from the NFHS, is limited to rural-urban comparisons that are biased toward urban populations and use national wealth quintiles that can create false impressions about the relative status of the urban and rural poor.

Quantitative analysis

Quantitative analysis for the current research focused on disaggregating health indicators for different groups within urban and rural areas of Jharkhand through analysis of datasets from NFHS-3 (2005–2006) and DLHS-3, 2007–2008. Reviews were conducted of existing programs and strategies currently being implemented by national and state government and their development partners that address access to FP services in urban and rural areas. A review of various types of FP services financing was conducted to determine whether the user fees, informal and indirect payment systems, and access costs (e.g., travel costs, lost wages, and child care) incurred by poor populations seeking FP/RH services create barriers to healthcare among the poor.

Qualitative research

A qualitative study of the primary data collected for this research was designed to identify FP/RH service needs among the urban and rural poor, the key barriers to accessing them, and potential strategies to surmount them. The work was carried out at two levels:

1. Research on poor populations in rural and urban areas, specifically women less than 30 years old and those older than 30 years old. Qualitative research methodologies included focus group discussions (FGDs) and exit interviews (following service delivery).
2. Interviews with policymakers and service providers to identify specific service delivery, financing, structural, operational, and policy barriers to reaching the urban and rural poor.

District selection. A two-stage sampling plan was used to select districts. In the first stage, 22 out of 24 districts were categorized into three categories by proportion of scheduled tribe (ST) residents. The two districts that were not categorized were newly created and thus excluded from the sampling process. Nine districts had a low proportion of ST residents (less than 20% of the district population) and were therefore classified as Category I; six districts were classified as Category II, which had a medium proportion of ST residents (20–40% the district population); and seven districts were classified as Category III, which had a high proportion of ST residents (> 40% of the district population). ST population proportions were obtained from the 2001 national census.

Six districts with the highest and lowest contraceptive use were selected for the study and classified into one of each of the three groups (“low,” “medium,” and “high” proportion of ST residents). Data on district contraceptive use were taken from the DLHS-3 (2007–2008). In the final study sample, the six districts and three categories were as follows:

- Category I: Bokaro and Giridih
- Category II: East Singhbhum and Dumka
- Category III: West Singhbhum and Simdega

The state capital of Ranchi was also included in the study sample.

Sub-district selection. In the second stage, one primary health centre (PHC) from each of the six districts was selected based on feasibility and accessibility of service delivery.

Dialogue with state policymakers and key stakeholders

In February 2010, in collaboration with DoHFW officials, development partners, NGOs, and medical colleges, the DoHFW created an FP taskforce to provide oversight, implementation, and mentoring support to the state FP program. The Health Policy Initiative worked closely with the FP taskforce in organizing consultations to finalize the assessment methodology and identify the key activities, goals, and indicators for the strategy. Two large consultations plus a series of smaller meetings and one-on-one discussions were organized from February to August 2010 for the development of the final strategy.

The first consultation took place February 19, 2010, and was chaired by Dr. Nitin Madan Kulkarni, then Mission Director of Jharkhand’s Rural Health Mission Society. At the meeting, staff members from DoHFW and the Health Policy Initiative presented the overall methodology for the qualitative assessment and sought approval for the research process. Further analysis of secondary data (NFHS-3 and DLHS-3) was presented and recommended and research topics were fine-tuned.

The second consultation, conducted with FP taskforce members, was held on March 9, 2010, and chaired by the State Reproductive and Child Health Officer. The main objectives were to discuss a realistic timeframe for the development of the FP strategy and identify priority FP issues and strategies, particularly those affecting the urban and rural poor. The Health Policy Initiative presented three different population growth scenarios using DemProj and FamPlan from its Spectrum System of Policy Models. These tools helped to generate the CPRs and determine the estimated CPR increases required to achieve replacement-level fertility under different scenarios by the years 2020, 2025, and 2030. The three scenarios were as follows:

1. A required annual increase of 1.53 percent in the current CPR (versus the current required annual increase of 0.4%) to achieve replacement-level fertility by 2020, and an increase in overall CPR to 53.72 percent by the year 2020.
2. A required annual CPR increase of 1.11 percent and an increase in overall CPR to 53.21 percent by the year 2025.
3. A required annual CPR increase of 0.73 percent and an increase in overall CPR to 52.72 percent by the year 2030.

The second consultation was extremely useful in bringing together data analysts and decisionmakers to interpret key findings of the quantitative and qualitative analyses in order to facilitate evidence-based decisionmaking. The consultation process strengthened multisectoral links and the level of engagement in FP issues in urban and rural areas and encouraged meaningful involvement of the poor in designing and

implementing policies. It also informed the FP strategy development by providing recommendations on approaches and activities for removing barriers to access among the urban and rural poor.

Development of the FP strategy

After the larger meetings were held, a number of smaller meetings and discussions were carried out with DoHFW officials and FP taskforce members to guide drafting of the strategy and its key action points. In May 2010, the Health Policy Initiative consolidated the FP strategy document and submitted it to DoHFW. FP taskforce members and DoHFW officials reviewed the draft, comments and suggestions were incorporated, and the Family Planning Strategy for the State of Jharkhand was finalized in August 2010.

On August 17, 2010, the DoHFW of Jharkhand officially launched the FP strategy. The launch was a part of an event organized to mark the official closing of Family Planning Week, July 11–17, 2010. The event, known as the Recognition Function (*Samman Samaroh*), was organized to recognize and award the efforts of DoHFW service providers for their exceptional performance during FP Week. The function was chaired by Shri. R.R. Prasad, Advisor to the Honorable Governor of Jharkhand. Other senior officials present were Ms. Lakshmi Singh, Chairman, Jharkhand Academic Counsel; Dr. D.K. Tiwari, Secretary, DoHFW; Ms. Aradhana Patnaik, Mission Director, NRHM; Dr. Anjali, Director in Chief–Health; and Mr. Manoj Kumar, District Collector, Chatra. More than 200 people, including surgeons, medical officers, nurses, auxiliary nurse-midwives (ANMs), Sahiyyas, private healthcare providers, development partners, civil societies, and members of the media attended the event.

The FP strategy covers the period 2010–2020 and provides strategic directions for health systems strengthening, strategic program interventions, and the operational plan for priority districts. Priority districts are specifically identified and targeted as those with poor developmental indicators and a large proportion of poor in both rural and urban areas.

II. FINDINGS OF ANALYSES

Barriers Analysis

Engaging the poor to understand barriers to service access and use

A qualitative assessment was carried out in six districts selected according to differential proportions of tribal populations and feasibility factors for conducting the assessment. The purpose of the qualitative assessment was threefold: (1) to gather information and evidence on operational and implementation aspects of FP services; (2) to identify barriers to accessing FP services, especially among urban and rural poor, above and below 30 years of age; and (3) to identify potential strategies to address these barriers. Districts covered in the assessment include Simdega and West Singhbhum (which have a high ST population); East Singhbhum (which has a medium ST population); Dumka (representing Santal Pargana); and Bokaro and Giridih (which have a low ST population).

The assessment was conducted primarily through three methods: semi-structured interviews, FGDs, and individual informal discussions. The semi-structured interviews were conducted with civil surgeons, medical officers in charge at Sadar Hospitals and PHCs, district community health officers, and district program managers. FGDs were conducted with ANMs, Sahiyyas, and community women. Individual informal discussions were conducted with multi-purpose workers (MPWs), Anganwadi workers (AWWs), and male health workers (MHWs) (where possible). Stakeholders were identified in a variety of locations. District PHCs were chosen based on availability of medical officers in charge, performance, workload on particular days, and feasibility factors. ANMs were chosen based on the Medical Officer's advice and availability. Sahiyyas were reached at specific locations in PHCs, sub-centers, weekly markets (*haats*), and medical mobile units (through medical officers), and through ANMs and MPWs. Community

members were chosen at weekly marketplaces with the help of block extension educators, medical mobile unit coordinators, and MPWs. Participation was voluntary and based on full oral consent.

The general conclusion of the qualitative assessment was that poverty is a key factor in creating barriers to accessing FP/RH services. Specific problems cited include illiteracy, and lack of livelihoods. There are certain pockets of poor populations and communities that have been resistant to accepting FP/RH services, primarily due to cultural factors. Family planning is now emerging as a priority in all districts, and FP delivery strategies have been effective across districts and the state. Staff members at multiple levels of various institutions are enthusiastic and eager to work, despite often grueling working hours and conditions. Sahiyyas in particular have been playing a pivotal role in providing FP/RH services.

Specific findings include the following:

Facilities and infrastructure. Many facilities—including PHCs, health sub-centres, and district and peripheral hospitals—are under construction and repair. Other facilities are simply inadequate, such as the majority of health sub-centres that function from rented premises or the homes of ANMs, with variable supply of vital utilities such as water, electricity, and toilets for women. There are serious concerns regarding the appropriateness of space for FP/RH services; the storage of supplies; security and safety for staff (especially female staff); and the lack of transportation facilities for lady health visitors, ANMs, Sahiyyas, and MPWs. Communication tools (e.g., cell phones) are not available for coordination.

Equipment and supplies. Regular maintenance of equipment is lacking due to an insufficient number of technicians. Supplies are adequate, but quality assurance for products at PHCs is not. Inadequate storage facilities lead to wastage of supplies. Logistics and coordination for transporting supplies from state headquarters to facilities also need improvement.

Deployment of human resources. There is a need for more specialist doctors; surgeons; gynecologists; anesthetists; “A” grade nurses; MHWs; MPWs; block extension educators; mass media officers; block program managers; and block accounts managers. The relationships between permanent staff and contract staff are complicated. The deputation of doctors to rural areas is arbitrary, with no fixed duration in appointments. Staff members are all multitasking, and quality of care suffers as a result. There are also some problems with community mobilization in areas where women from well-to-do households in villages have been selected as Sahiyyas. ANMs are over-worked in all locations. Work is irregularly timed and scheduled.

Human resource capacity and skills. There is a need for capacity building and skill enhancement at all levels. Medical doctors need training in laparoscopic surgery; ANMs need training in intrauterine contraceptive device (IUCD) insertion and counseling on FP products, IUCDs, and injectables; and Sahiyyas, MPWs, and MHWs need information on FP products as well as counseling skills. There is limited, poor male involvement in family planning and in addressing male needs. Health educators need training in communication for family planning. There is no separate cadre for FP service provision.

Financial resources. Although adequate financial resources for FP programming are slated for Jharkhand (from the NRHM), the state currently lacks effective financial management at both the district and block level due to a lack of trained staff. Clarification of appropriate flow and use of funds may be helpful, particularly at the block level, where current management of monetary matters by lady health visitors and ANMs is not efficient. There are also a number of problems related to honoraria, including competition between Sahiyyas and ANMs for the same resources, and lack of timely disbursement.

Communication efforts in FP. Information, education, and communication (IEC) efforts in FP need to place greater emphasis on information and education and develop strategies for communication methods for

awareness campaigns and for reaching remote areas. Specific information on FP products, especially for couples, is also needed.

Poverty and Market Analysis

Quantifying the levels of inequality in healthcare use and health status

The principal aim of the poverty analysis was to identify and define the poor in both rural and urban areas of Jharkhand. In the quantitative poverty research, the focus was on disaggregating health indicators for different groups within urban and rural areas of Jharkhand through analysis of NFHS-3 datasets and DLHS-3, 2007–2008. Results of the analysis, defining the FP needs of the urban and rural poor, are summarized in Annex A (*Family Planning Indicators by Wealth Quintiles and Rural/Urban Residence in Jharkhand, 2007–2008*). The findings from the barriers and poverty analysis provided the foundation for design of more effective targeting of FP interventions suited to the needs of the poor and presented in the FP strategy.

Results of the analysis confirm a strong connection between caste, class, and poverty in Jharkhand. Compared with other states in India, Jharkhand has very high poverty levels—the second-highest BPL population. Almost half of the rural population (46.3%) and a fifth of the urban population (20.2%) were BPL in 2004–2005.¹⁰ The vast majority of the poorest people in the state belong to STs, SCs, and other groups with low socioeconomic status. In urban areas, almost half of the poorest group (47.1%) is composed of other members of the lower classes, almost one-fifth are from SCs (19.4%), and about one-tenth are from STs (10.1%).¹¹ In the rural areas, almost half of the poorest group is composed of STs (48.1%), almost a third is from other groups with low socioeconomic status (28.7%), and almost a fifth are from SCs (19.1%).

Place of residence is also an important factor in poverty levels and socioeconomic characteristics. The most striking differences in socioeconomic factors between urban and rural areas are in the area of education. In the urban areas, 59 percent of the poorest group has no education at all, and in the rural areas, almost 87.7 percent of the poorest group has no education at all. In the urban and rural areas, about 80 percent or more of the poorest group is married.

Market Analysis

Districts with large concentrations of vulnerable populations tend to have lower use of contraception. In terms of FP use, in districts where SC/ST populations are high (e.g., Pakur and Simdega), current CPR is low. In districts with low proportions of SC/ST populations (e.g., Bokaro and Dhanbad), current CPR is high. The pattern is not uniform, however; some districts with low SC/ST populations also have low contraceptive use (e.g., Giridih, Chatra, and Koderma).

Modern contraceptive use is lower among the poorest women. According to DLHS-3 (2007–2008), in the urban areas, about 26 percent of the poorest group use modern contraceptive methods and about 74 percent of the poorest currently use no method at all. In contrast, more than 55 percent of the wealthiest women in urban areas use modern contraceptive methods, while about 40 percent use no method. Use of folkloric methods by any quintile group is negligible and use of traditional methods is fairly small. In the rural areas, only 19.3 percent of the poorest women use modern contraceptive methods, and 76 percent of the poorest women use no method of contraception at all. Similar to the contrast seen by socioeconomic status in the urban areas, almost 54 percent of the wealthiest women in rural areas use modern contraception, while 42 percent of the wealthiest women use no method. As in urban areas, use of

¹⁰ Government of India. 2007. "Poverty Estimates for 2004–05." New Delhi: GoI; March 2007.

¹¹ Jharkhand, NFHS-3 (2005–2006).

traditional or folkloric methods in rural areas is quite small across all population groups. In terms of contraceptive methods, rural women of all quintiles overwhelmingly prefer female sterilization, with the pill as the second most preferred method (see Annex C).

Poor women are more likely to prefer unhealthy intervals between births in rural areas. In rural areas, about a third of women in the poorest group preferred to wait less than 12 months for another pregnancy, higher than any other quintile group. The World Health Organization recommends a minimum of two years or more spacing between childbirth and another pregnancy to improve the health of the mother and child.¹² Another third of poor rural women reported a desire to wait one or two years for another pregnancy. A referred waiting time of two to three years was common among all quintiles. In urban areas, the findings are more complex, with almost 39 percent of the second-poorest group, and about 24 percent of the poorest, second-wealthiest, and wealthiest sub-groups reporting a preferred waiting period of less than 12 months.

Poor women have higher levels of unmet need for family planning, especially in rural areas. In Jharkhand's urban areas, there is significant disparity in the prevalence of unmet need between poorer and wealthier groups. About 25 percent of poor women have an unmet need to limit childbearing, and about 15 percent have an unmet need for child spacing. In contrast, among the wealthiest women, there is only about 14 percent of unmet need for limiting childbearing, and only about 8 percent of unmet need for spacing. In the rural areas, about 26 percent of the poorest women have an unmet need to limit childbearing, and about 15 percent have an unmet need to space children. In contrast, in the wealthier groups, unmet need is much lower; only about 13 percent of women in these groups have an unmet need to limit childbearing, and only about 10 percent have an unmet need to space children (see Annex A).

Policy and FP Program Analyses

Reviewing the FP program to inform the integration of equity goals in the new strategy

A review of the FP situation in Jharkhand highlighted the current status of FP services at various levels of the public and private sector and the state's capacity for implementing a broad and comprehensive family planning program.¹³ The purpose of the analysis of policy and existing FP program services was to inform the advocacy and dialogue aimed at supporting greater integration of equity goals in the new FP strategy. The process included document review; clinical services observations; the use of standardized instruments and checklists at a wide range of facilities; and key informant interviews with policymakers, stakeholders, providers, and NGOs involved in maternal and child health FP services, private providers, and mothers and fathers in the district. FGDs were held with auxiliary workers and mothers in various district locations.

The general conclusion was that there were many strengths in Jharkhand's family planning program, but a number of areas needed improvement. Opportunities for expansion of FP services were also identified. In general, the team found that FP services were available and providers were busy and active, but other health priorities frequently overshadowed FP efforts in public, NGO, and private sectors. Further, the focus of FP services was on "limiting" childbearing through sterilization, with a less robust approach to provision of spacing methods. The assessment revealed a need to improve the quality of services and management and to upgrade the physical space.

Previously [within the NRHM-Program Implementation Plan (PIP)], Jharkhand had placed only minor emphasis on family planning at the state level (although specific FP objectives were included in the 2009–

¹² World Health Organization. 2005. "Report of a WHO Technical Consultation on Birth Spacing." Paper presented at the June 2005 meeting of the Making Pregnancy Safer, Department of Reproductive Health and Research (RHR). Geneva: WHO.

¹³ USAID, ACCESS Project. 2009. "Assessment of Family Planning Services, Jharkhand, India (Draft Copy)."

2010 PIP). Although the Government of Jharkhand (GoJ) adopted the Indian Public Health Standards, the guidelines were not consistently available or operationalized at the district level. In addition, the FP unit was not found to be functioning to a standard that allowed for statewide coordination, management, or monitoring. Recommendations from the assessment included the need to (1) conduct advocacy at state and district levels to reposition family planning in relation to both maternal and child health and reproductive health and (2) prioritize family planning within the State Health Program. A focus on the quality of services and human resource planning was also needed.

In terms of public sector provision of FP services, the GoJ had considerable human resources to draw on, but FP providers' counseling as well as service knowledge and skills needed strengthening. At the community level, ANMs, Sahiyas, and AWWs were often too busy to provide family planning and many seemed to have little or no training. At the first referral level, the focus was on limiting methods rather than spacing methods. Use of the IUCD was minimal, although both the GoJ and Population Services International had implemented new programs to reinvigorate its use. Commodities storage and organization seemed to need improvement. Overall recommendations for this sector included introducing the concept of pregnancy spacing and the benefits of family planning and developing FP-related counseling, clinical, and training skills at community and district levels.

To address missed opportunities, recommendations also called for integration of family planning into ongoing services and programs. This would include maternal health, child health and immunization, HIV/AIDS testing and counseling, and Village Health and Nutrition Days, among others.

To improve the training and education of the health workforce, it was agreed that a state or district FP training strategy should be developed to enhance state and district planning approaches. The strategy should focus on urgently addressing gaps in quality of care, expanding efforts in clinical FP training for all providers at all levels, and providing comprehensive support to ANM education in Jharkhand.

To collaborate with the private sector, the GoJ should encourage partnerships. For example, private providers should be included in Contraceptive Technology Updates and clinical skills development. Professional associations (IMA and FOGSI) could be invited to mobilize their networks to update members on current contraceptive technology, and the network could promote cascade training in FP skills among members.

Although commodities were available at all levels of the system, training was needed on proper storage, use, and expiry dates. As mentioned above, commodity management also required some improvement.

Greater attention was needed to improve social marketing, franchising, and behavior change communication (BCC). In particular, there was a need for more and higher-quality IEC materials and training, and wider dissemination, in accordance with the BCC strategy. Minority groups and tribes should be target audiences for IEC materials. All levels of providers need job aids. The GoJ should coordinate messages communicated by public and private organizations.

The new Health Management Information System should be supported to enhance its use as a source of data for decisionmaking and a means of sharing analyses.

IV. POLICY DIALOGUE AND DESIGN OF THE FP STRATEGY

Integrating Equity Goals into the FP Strategy

The main purpose of the FP strategy is to establish the strategic approach to achieving Jharkhand's population management objectives of replacement-level fertility and population stabilization thereafter, within the proposed timeframe. The development of an FP strategy was designed by the DoHFW around the mission of promoting informed choice of contraceptive methods; widening the choice of contraceptives available; empowering communities and women in family planning; involving all stakeholders from the public, private, NGO, and organized and cooperative sectors; and encouraging the use of modern contraception, particularly spacing methods.

The Health Policy Initiative provided support for a series of policy dialogues to design, discuss, and finalize the FP strategy. There were three major consultative meetings: March 2009 (for presentation and discussion of evidence on the status of the FP program); March 2010 (to review research findings, with a focus on establishing priorities for the draft FP strategy and discussing challenges and potential approaches to FP interventions); and July 2010 (to review, discuss, and finalize the draft FP strategy).

The design and development of an FP strategy for the state was facilitated by a number of advantages. First, an enabling policy framework was already in place in Jharkhand (e.g., policies reflected recognition of the role of FP in meeting health and development goals, adequate financial resources are slated for FP funding (under the NRHM), and implementation support was available from both the FP Cell and the FP Taskforce). Second, evidence indicated that couples in Jharkhand want fewer children, and family planning services. Development of the FP strategy provided an opportunity to determine how to meet this demand.

During the development and dialogue phase, strategic planning for the FP strategy focused on the key areas of concern for the program. The following areas were addressed: defining actions in support of health systems strengthening to allow for expansion of FP service delivery; defining key priority areas for the FP program; clarifying financial flow and use of funds to the FP program; and identifying priority districts (those with low CPR and limited FP access to services) for immediate attention and concerted action.

In health systems strengthening, the focus was on building leadership at all levels to support program implementation. Key challenges and issues in human resource planning and development were identified, primarily in examining staff shortages and capacity for program implementation. Human resource issues include shortages of OB/GYN specialists and a lack of program managers in position. Issues include the existence of multitasking responsibilities and the resultant impact on quality; potential strategies for operationalizing an FP strategy, such as mapping of FP providers and meeting training needs; promotion of contractual appointments; differential salary packages for remote and tribal areas; and private sector involvement and other resources in service delivery. In terms of human resource capacities, specific inadequacies exist in the in-service training program (e.g., ANMs are trained in the old curriculum). Potential strategies included tailored training for key staff and specialized FP counseling skills development.

In the financial arena, challenges and issues included limited clarity of fund utilization at the block level; inability of providers to cope and manage increased flow of funds; and operational difficulties in disbursing and spending funds. Potential strategies called for orientation of staff on financial guidelines and training on efficient handling of monetary funds for different staff.

To better target resources and efforts to reach the poor, priority districts for the FP strategy's implementation were defined as those with low CPRs and limited service access. Priority issues identified during the stakeholder dialogue process included the following:

- *Adolescent health.* About one-fourth of adolescents in Jharkhand have experienced childbearing, and the unmet need for FP among the adolescent population is high.
- *Age at marriage.* Currently, there is a low age at marriage, with about 36 percent of girls marrying before the age of 18. In rural areas, this proportion is even higher (40%) (DLHS-3, 2007–08). Cultural factors predominate in attitudes toward marriage.
- *Reaching the poor and marginalized populations.* The analysis revealed a disparity in the modern CPR by place of residence (50% of urban residents versus only about 28% of rural residents) and income (19.3% among the poorest group versus 54% among the wealthiest group in rural areas, and about 26% of the poorest group versus more than 55% in the wealthiest group in urban areas). There are important cultural barriers to increasing modern methods use. Potential strategies include designing and implementing tailored approaches for urban slums and rural poor; scaling up voucher schemes in rural and urban areas; engaging the poor in problem identification, strategy development, and implementation; and monitoring.
- *Integration of FP and maternal, newborn, and child health (MNCH).* There are numerous missed opportunities for FP counseling in maternal and child health services.
- *Promotion of use of spacing methods.* Only 6 percent of couples in Jharkhand use modern spacing methods, and the unmet need for spacing is 12.7 percent. There is also a high discontinuation rate due to side effects.
- *Promotion of long-acting or permanent methods (LAPMs).* Prevalence of unmet need for limiting births is 21 percent statewide (with various levels of disparity by sub-group and area). At the same time, there is a lack of appropriate physical space for conducting sterilizations and IUCD insertions, and low male engagement in understanding the need for limiting childbirths.
- *Greater involvement of the private sector.* There is currently a heavy reliance on the private sector, where 31 percent of users obtain FP services in rural areas, and 44 percent obtain services in urban areas (NFHS-3, 2005–2006). This creates opportunity for the support of PPPs as a means to deliver subsidized FP/RH services to the poor. Effective PPP models and initiatives introduced elsewhere in India and in other countries should be considered for adaptation to the Jharkhand context. Potential strategies include scaling up tested, effective PPP models; promoting information sharing between the public and private sectors; encouraging corporate sector initiatives and workplace interventions; and introducing incentives for greater private sector participation in remote areas.

The New Jharkhand FP Strategy

The final version of Family Planning Strategy for Jharkhand for 2010–2020 was officially adopted on August 17, 2010. The strategy includes explicit overall technical objectives to reduce the TFR from the current estimated level of 3.2 in 2008 (SRS, 2009) to 2.1 by 2020 and to increase modern CPR from its current level of about 31 percent (DLHS-3, 2007–2008) to 54 percent by 2020. The state aims for an ambitious annual increase of 1.5 percent in modern CPR, up from the current annual increase of 0.4 percent (see Tables 1–3 for the strategy's specific FP objectives).

From the tables below, it is evident that equity goals have been integrated into the FP strategy. Specific objectives aim to reduce the unmet need for spacing and permanent FP methods among different population sub-groups, including urban, rural, and SC/ST populations, as well the poorest populations, to

ensure universal coverage and access. By presenting objectives for increased modern contraceptive prevalence, reduction in unmet need for spacing methods, and reduction in unmet need for permanent methods in population sub-groups, there are specific, time-bound indicators for reaching the poorest 40 percent of the population, in addition to reaching under-served scheduled caste and scheduled tribe populations in the state. The disaggregation of indicators between urban and rural areas aims to reduce inequalities in services between these areas.

Table 1. Increase in modern CPR among eligible couples¹⁴

	DLHS-3,	Objectives (Projected)		
	2007–2008*	2010	2015	2020
Overall	31.8	38.75	46.40	54.05
Average annual increase in CPR	0.4	1.53	1.53	1.53
Urban	49.9	66.3	68.6	69.2
Rural	27.8	42.0	49.8	52.7
SC/ST	21.8	35.5	45.8	50.3
Poorest+Poor ¹⁵	23.95	38.6	47.7	52.4

*DLHS–3, 2007–2008.

Table 2. Percentage reduction in unmet need for spacing methods among eligible couples

	DLHS-3	Objectives (Projected)		
	2007–2008*	2010	2015	2020
Overall	12.7	30% (9.5)	59% (5.6)	80% (2.7)
Urban	9.5	30% (6.6)	55% (4.3)	75% (2.3)
Rural	14.2	32% (9.7)	60% (5.7)	80% (2.8)
SC/ST	14.59	35% (9.5)	62% (5.5)	80% (2.9)
Poorest+Poor	14.54	35% (9.4)	62% (5.5)	80% (2.9)

*DLHS–3, 2007–2008.

Table 3. Percentage reduction in unmet need for permanent methods among eligible couples

	DLHS-3	Objectives (Projected)		
	2007–2008*	2010	2015	2020
Overall	20.8	30% (14.8)	50% (8.7)	80% (4.2)
Urban	15.8	30% (11.1)	55% (7.1)	75% (3.9)
Rural	22.0	32% (15.0)	60% (8.8)	80% (4.4)
SC/ST	24.2	35% (15.7)	65% (9.2)	80% (4.8)
Poorest+Poor	23.61	35% (15.3)	65% (9.0)	80% (4.7)

*DLHS–3, 2007–2008.

¹⁴ Eligible couples are married couples of reproductive age.

¹⁵ Refers to poorest 40 percent or lowest two quintiles.

The three principal strategic directions of the FP strategy are (1) cross-cutting interventions for strengthening health systems; (2) strategic program interventions; and (3) operational planning for priority (poor-performing) districts. Activities to strengthen health systems will include strengthening leadership, planning for and building human resource capacity, and setting standards for appropriate financial flow and use of funds. Operational planning activities will address the need for effective and robust monitoring and evaluation and improvements in basic infrastructure, logistics, and management. Specific personnel will be charged with responsibility for program implementation and monitoring.

Targeting resources and efforts to reach the poor

In the area of FP program interventions, the following nine strategies have been developed and targeted toward specific audiences; each strategy includes targeted interventions to help meet the FP needs of the poor, as identified during analysis. Strategy 6 focuses exclusively on targeted services for the poorest and marginalized populations:

Strategy 1: Targeted interventions to reach out to adolescents: Promote community and social mobilization to increase age at marriage and delay first pregnancy; provide comprehensive FP service packages designed to meet the needs of different age groups; promote spacing methods among married adolescents; strengthen the Adolescent Reproductive and Sexual Health program by involving adolescents; introduce youth-friendly services and engage the Ministry of Youth Affairs in their planning and implementation.

Strategy 2: Promotion of use of spacing methods: Promote the use of FP methods, such as the IUCD, to increase the birth interval and ensure better maternal and child health practices; promote an increase in both age at first birth and spacing of pregnancies by improving counseling by frontline workers and providers; target interventions to the poor; focus more attention on logistics and supplies; strengthen the community-based distribution program through frontline workers; and increase demand for FP services through a BCC strategy.

Strategy 3: Promotion of LAPMs: Focus more attention on higher-order births, promote no-scalpel vasectomies, and meet the demand for limiting methods. Increase systematic outreach to couples, add camps to meet the backlog, foster community mobilization for male participation, provide training and education on LAPMs for service providers, and conduct monitoring activities.

Strategy 4: Integration of potential strategies for FP and MNCH. Develop a comprehensive package of services and maximize opportunities for integrating FP into MNCH activities. Long-term strategy includes the revival of postpartum centers at all facilities with FP counseling and services.

Strategy 5: Fostering of male engagement in the idea of “planned parenthood.” Targeting men as a key audience, promote vasectomies, design and implement workplace programs, institute community-based programs (through male health workers), and provide family life education for youth and adolescents.

Strategy 6: Service reach to poor (rural, urban, and tribal) and other marginalized populations: Define and reach out to marginalized communities by mapping urban slums and poor populations; identifying PPP mechanisms that can provide better access; creating mobile medical units; deploying female link volunteers and registered medical practitioners (for the provision of IUCDs); and identifying and training tribal women as ANMs.

Strategy 7: Greater involvement of the private sector, NGOs, and public sector undertakings. Forge meaningful partnerships in FP provision with the private sector, including key components from accredited private hospitals. For optimal PPP coordination, operationalize PPP guidelines, identify and describe PPP mechanisms and contractual and regulatory frameworks, and map local partner resources.

Strategy 8: Integration with other departments in conducting FP interventions. Conduct dialogue among allied departments on opportunities to reach out to communities in FP counseling and service delivery.

Strategy 9: Effective communication strategy. With the FP Cell taking the lead, operationalize the strategy in collaboration with the DoHFW, development partners, NGOs, and medical colleges, for oversight, implementation, and mentoring support.

The Operational Plan for the districts targets priority (poor-performing) areas based on FP performance indicators and uses a phased approach for program implementation (see Annex B). The first phase will focus on the 10 worst-performing districts in the state (Godda, Pakur, Sahibganj, Giridih, Semdega, Gumla, Jamtara, Koderma, West Singhbhum, and Dumka) to improve overall FP indicators by providing support in the following areas: training, infrastructure support, manpower development planning, large-scale community mobilization, and camps to address unmet need.

VI. CONCLUSIONS

As of August 2010, the state of Jharkhand has an official FP strategy for the years 2010–2020. The new strategy is based on data on fertility, mortality, contraceptive use, and unmet need for family planning, by population sub-groups and place of residence (rural versus urban area); and describes the achievements and challenges of the state's FP program to date. It also provides information about state sources for contraceptive prevalence, public health infrastructure and resources, and partners and projects involved in family planning. In a bold move forward, the strategy supports and builds on the underlying concepts of the Population and Reproductive & Child Health Policy of 2004 by specifying how to achieve the policy's overall objectives with regard to family planning.

In Jharkhand, the Health Policy Initiative supported a process of analysis, advocacy, and dialogue during the preparation of the FP strategy that led to a systematic, evidence-based, country-driven process to bring attention to improving FP access among the poor as an integral part of the new FP strategy. The process was guided by the Health Policy Initiative's EQUITY Framework, which is based on engaging the poor to become involved in policy and program design, conducting research to analyze inequalities and understand barriers to service use, and organizing advocacy and dialogue to determine solutions that address the needs of the poorest populations.

Targeting resources and efforts to reach out to the rural and urban poor as well as marginalized populations to increase the availability and accessibility of FP services is a key focus of the FP strategy and one that sets it apart as a unique mechanism for addressing inequalities in FP access and service delivery. The new FP strategy is innovative in its prioritization and attention to under-served populations and includes specific objectives for increasing both service provision and modern contraceptive prevalence and reducing unmet need for spacing and limiting methods by area (rural or urban) among vulnerable sub-groups (SC/ST populations) as well as the poorest segment of the state's population. The Operational Plan calls for the initial phase of the strategy implementation process to focus on priority districts, defined as those with low CPRs and high prevalence of unmet need for family planning (see Annex B), with program resources and efforts targeted first to the poorest-performing districts.

VII. RECOMMENDATIONS

The state of Jharkhand should move forward quickly with implementing the new FP strategy, which provides a good opportunity to improve the health and development of Jharkhand's population, particularly its poorest sub-groups. The NRHM is to provide financial resources for fully operationalizing the policy. The FP Cell should play a critical role in leading multisectoral collaboration and coordination

for the strategy. Simultaneous attention to the health systems strengthening component is crucial for ensuring sustained delivery of good-quality services. Development of the FP strategy is an important milestone and should be followed up with implementation, resource allocation, and equity-based monitoring and evaluation.

ANNEX A. FAMILY PLANNING INDICATORS BY WEALTH QUINTILE AND RURAL/URBAN RESIDENCE, JHARKHAND, INDIA, 2007–2008

	Lowest Quintile (1)	Low Quintile (2)	Middle Quintile (3)	High Quintile (4)	Highest Quintile (5)
Opportunities					
% of currently married women ages 15–44 with unmet need¹⁶ for spacing (Definition I)**					
Urban	16.81	11.45	11.15	10.15	8.21
Rural	15.09	13.83	13.35	12.52	9.78
Total	15.10	13.74	13.07	11.59	8.48
% of currently married women ages 15–44 with unmet need for limiting (Definition I)**					
Urban	21.15	27.03	16.45	15.82	13.78
Rural	25.52	20.69	17.19	14.85	12.96
Total	25.49	20.92	17.09	15.23	13.64
% of currently married women ages 15–44 using modern contraceptive methods**					
Urban	26.49	34.22	45.56	46.98	55.57
Rural	19.34	30.34	38.52	47.29	53.78
Total	19.38	30.47	39.42	47.17	55.26
Mean ideal number of children by currently married women ages 15–49*					
Urban	2.82	2.64	2.45	2.28	2.03
Rural	2.92	2.74	2.52	2.38	1.70
Total	2.92	2.73	2.50	2.32	2.00
Proportion of currently married women ages 15–49 with knowledge of any modern FP method *					
Urban	94.74	96.77	100.00	99.57	100.00
Rural	90.17	96.35	97.40	100.00	100.00
Total	90.27	96.40	98.21	99.75	100.00
Challenges					
% of currently married women ages 15–44 not using any family planning methods**					
Urban	73.51	62.75	52.29	48.79	39.68
Rural	76.21	66.03	58.04	48.70	41.50
Total	76.19	65.92	57.31	48.73	39.99
Proportion of higher order births (3+) for currently married women ages 15–49**					
Urban	52.62	62.82	59.10	57.28	41.64
Rural	57.09	55.93	53.86	51.15	47.03
Total	57.06	56.17	54.53	53.58	42.53
Mean children ever born to currently married women ages 15–49**					
Urban	3.20	3.27	3.02	2.87	2.37
Rural	3.11	2.99	2.79	2.70	2.49
Total	3.11	3.00	2.82	2.77	2.39

Sources: Calculated from DLHS-3 (2007–2008) raw data using Definition I. Definition I defines prevalence of unmet need as the proportion of currently married women who are not in menopause, have not had a hysterectomy, and are not currently pregnant who 1) want more children after two years or more and are currently not using any family planning method or 2) are not sure if or when they would like to have another child. Prevalence of unmet need for "limiting" is the proportion of currently married women who are not in menopause, have not had a hysterectomy, are not currently pregnant, and do not want more children but are currently not using any family planning method.

* Calculated from NFHS-3 (2005–2006) raw data.

** Calculated from DLHS-3 (2007–2008) raw data.

¹⁶ Prevalence of unmet need for family planning is defined as the proportion of currently married women who are not using any method of family planning and (1) do not want any more children (or are not sure if and when they want more children) or (2) want to wait two or more years before having more children.

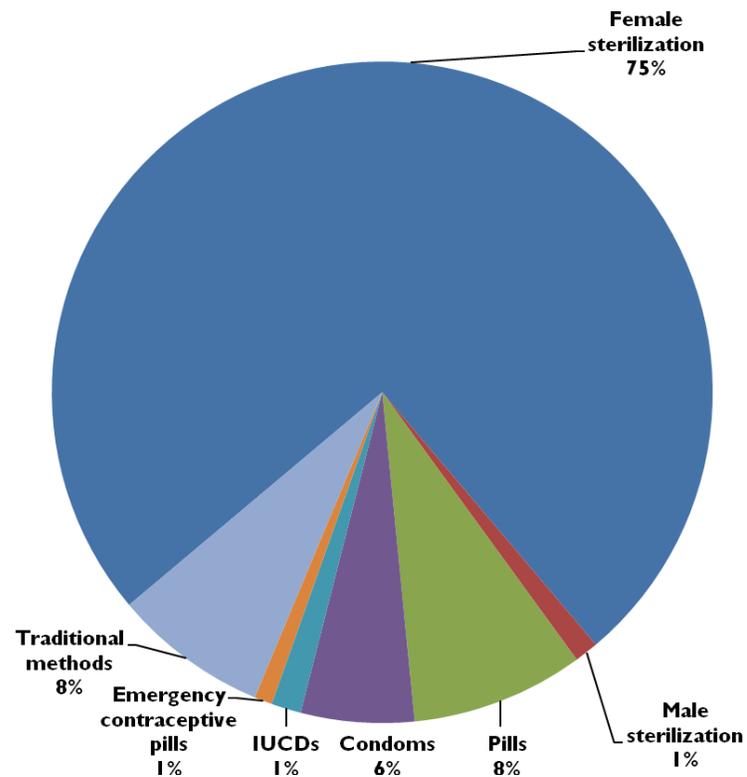
ANNEX B. PRIORITY DISTRICTS, ACCORDING TO PERFORMANCE

Proportion (%) of population using modern contraceptive methods and having an unmet need for family planning (limiting or spacing), by district (from worst- to best-performing), Jharkhand, India, 2007–2008

District	Use of modern contraceptive methods	Unmet Need for Family Planning		
		Total	Limiting	Spacing
Poor-Performing				
1. Pakur	14.4	46.0	26.3	19.7
2. Semdega	16.7	46.7	31.6	15.1
3. Godda	20.9	37.9	22.6	15.3
4. West Singhbhum	22.1	41.5	29.6	11.9
5. Giridih	23.7	43.9	25.1	18.8
6. Sahibganj	24.2	38.9	20.3	18.6
7. Gumla	24.8	38.1	23.7	14.4
8. Jamtara	26.5	36.5	22.5	14.0
9. Kodarma	27.5	43.8	26.6	17.2
10. Dumka	29.0	34.2	22.0	12.2
Medium-Performing				
11. Latehar	30.2	41.0	26.4	14.6
12. Lohardaga	30.5	39.6	24.0	15.6
13. Chatra	32.1	39.7	21.9	17.8
14. Seraikela	34.1	34.0	21.6	12.4
15. Deoghar	36.1	31.2	17.0	14.2
16. Ranchi	37.3	31.2	19.4	11.8
17. Khunti	37.3	31.2	19.4	11.8
18. Palamu	38.4	36.4	20.6	15.8
Good-Performing				
19. Garhwa	40.0	26.3	14.1	12.2
20. Dhanbad	44.9	28.3	17.4	10.9
21. Hazaribagh	45.0	26.9	13.5	13.4
22. Ramgarh	45.0	26.9	13.5	13.4
23. East Singhbhum	45.7	28.7	18.2	10.5
24. Bokaro	46.9	26.7	14.8	11.9
Jharkhand	31.9	33.5	20.8	12.7

Source: DLHS-3, 2007–2008

ANNEX C. CONTRACEPTIVE MIX, JHARKHAND, INDIA, 2007–2008



Source: DLHS-3, 2007-2008

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