

**SOCIO-ECONOMIC IMPACT OF NATIONAL RURAL
HEALTH MISSION IN KASHMIR DIVISION OF
JAMMU AND KASHMIR**

Thesis submitted to the Central University of Punjab

For the award of
Master of Philosophy

In

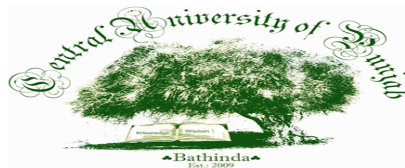
Development Economics

By

RIZWAN AHMAD LONE

Supervisor

DR. A. S. KAHLON



Centre for Economic Studies
School of Social Sciences
Central University of Punjab, Bathinda

2014 February

CERTIFICATE

I declare that the thesis/dissertation entitled “**SOCIO-ECONOMIC IMPACT OF NATIONAL RURAL HEALTH MISSION IN KASHMIR DIVISION OF JAMMU AND KASHMIR**” has been prepared by me under the guidance of Dr. A. S. Kahlon, Associate Professor cum coordinator, Centre for Economic Studies, School of Social Sciences, Central University of Punjab. No part of this dissertation has formed the basis for the award of any degree or fellowship previously.

RIZWAN AHMAD LONE

Centre for Economic Studies
School of Social Sciences
Central University of Punjab,
Bathinda - 151001.

Date: February 17,2014

CERTIFICATE

I certify that Mr. RIZWAN AHMAD LONE has prepared his dissertation entitled **“SOCIO-ECONOMIC IMPACT OF NATIONAL RURAL HEALTH MISSION IN KASHMIR DIVISION OF JAMMU AND KASHMIR”**, for the award of M.Phil. degree of the Central University of Punjab, under my guidance. He has carried out this work at the Centre for Economic Studies, School of Social Sciences, Central University of Punjab.

Dr. A. S. Kahlon

Centre for Economic Studies,
School of Social Sciences,
Central University of Punjab,
Bathinda - 151001.

DATE: February 17, 2014

ABSTRACT

SOCIO-ECONOMIC IMPACT OF NATIONAL RURAL HEALTH MISSION IN KASHMIR DIVISION OF JAMMU AND KASHMIR

Name of student: Rizwan Ahmad lone
Registration Number: CUPB/MPH-PHD/SSS/CES/2012-13/04
Degree for which submitted: Master of Philosophy
Name of supervisor: Dr. A. S. Kahlon
Centre: Centre for Economic Studies
School of Studies: School of Social Sciences

Key words: Infant mortality rate, Maternal mortality rate, NRHM, Human asset, Indian Public Health Standard

The majority of population of India lives in villages and the poverty is relatively more in rural areas as compared to urban. Health has a cumulative effect on individual's life through human capital formation but unfortunately this vulnerable population is deprived from their basic right of health care that makes India to loss its human assets in the form of high maternal mortality rate, high infant mortality rate and low life expectancy. These rural and poverty ridden population can access their basic right of health care from public sector. This requires sound public health care sector especially in rural areas. With a view to reduce the rural-urban gap in health care, Government of India launched National Rural Health Mission in 2005 which aimed at decentralization of public health care sector, removing horizontal and vertical imbalance in public health care sector.

The main aim of this study was to assess the financial performance, human power augmentation and community participation for promoting health care sector in Kashmir division of Jammu and Kashmir State. One non- high focus Srinagar district and one high focus Kupwara district were randomly selected for comparative analysis of public health care sector. Both primary as well as secondary data were collected. Primary data were collected by administering different schedules for Community Health Centre, Primary Health Centre, Sub – Centre, Accredited Social Health Activist, Janani Suraksha Yojana beneficiaries, health manpower, households and Village Health Sanitation and Nutrition Committee.

The allocation and utilisation of NRHM funds at State level have shown a mixed trend during the years 2005-06 to 2012-13. At the District level, there was relatively higher allocation to high focus district Kupwara as compared to non-high focus Srinagar district while in terms of utilisation there was marginal difference in utilisation between the two selected Districts. The percentage of JSY beneficiaries to total institutional deliveries was relatively higher in high focus District Kupwara (73.59%) while it was only 17.74% in non- high focus Srinagar district during 2008-2012. The shortfall of health manpower was 8.55% in non- high focus District Srinagar while in high focus District Kupwara, the short fall of health manpower was 21.67%. At Block level, the shortfall of specialists as per Indian Public Health Standard at Community Health Centre Kralpora of high focus District Kupwara was 100% in Physician, Gynaecologist, Pediatrician and Dental surgeon while in Srinagar district all the health specialists were posted except the pediatrician. Further all the four sub centres had inadequate availability of medicine, water supply and electricity except Sub centre Nandpora.

The stipulated guidelines were also violated as per NRHM norm of one ASHA per thousand population, marital status of ASHAs (married) and in terms of timely incentives (10th of every month). Also as per NRHM norm, none of the selected Accredited Social Health Activist got their medicine kits restocked during 2012-13. Under NRHM norm, every village Health Sanitation and Nutrition Committee should be allocated Rs10000 per annum. However, it was found that all the four selected Village Health Sanitation and Nutrition committee (VHSNC) from both the Districts received only Rs 5000 per annum. Therefore, the functioning of VHSNC in promoting rural health was not satisfactory in terms of generating awareness about NRHM and also regarding sanitation at the village level. It was also observed that there was a lack of coordination among the officials of NRHM.

All in all, this study has highlighted some violations of NRHM guidelines in terms of financial and manpower stipulations. However the launching of NRHM in the State has brought about significant improvement in public health care sector yet it is not up to the Indian Public Health Standard.

(RIZWAN AHMAD LONE)

(Dr. A. S. KAHLON)

ACKNOWLEDGEMENT

Alhamdulillah, Almighty Allah has been very kind to me for providing such an opportunity to bring about this research work. I am extremely thankful to my Supervisor Dr. A. S. Kahlon, Co-ordinator Centre for Economic Studies and Associate Dean, Central University of Punjab, Bathinda for his valuable guidance. In fact it was his sincere efforts and unforgettable advice that helped me in completing this research work.

I am deeply thankful and kindful to my family members especially to my parents for their encouragement and right guidance. I am highly thankful to my brother, sisters and sisters-in-law for their encouragement.

I felt it moral obligation to extend my heartfelt thanks to my teachers for their hard work and affection in providing qualitative education .

Besides, I am sincerely thankful to NRHM officials especially to Mission Director NRHM J&K, Nodal officer Kashmir division. Dy. CMO Srinagar, BMO Kralpora, BMO Hazratbal, Dr Asma, Dr Shubreena, Shanaza, Uzma, Iqra, Shabnam shafi, Anisa, Mohamad Turabi, Idrees Ahmad, Latif Ahmad, Altaf Ahmad and N A Shah for their cordial support.

My sincere and special thanks are due to my colleagues Raof Ahmad, Mudasir Gulam, Hilal Ahmad, Mansoor Ahmad, Fayaz Ahmad, Mumtaz Ahmad, Mohamad Sadiq, Gulam Mohiudin, Parvaiz Ahmad, Mohamad Hussain and Sheikh Abdul Haq.

I would also like to pay my gratitude to my friends Manzoor Ahmad, Shahid Ahmad, Khurshid Ahmad, Wasim Ahmad, Gulam Nabi, Mudasir Ahmad Mohamad Aarif, Biswa Bhusan, Krishan Sing, and my Quasin Qayoom Ahmad for their help.

I am highly indebted to respondents of my study such as health officials, ASHAs, JSY beneficiaries, VHSNC and Households for sharing their valuable information. Without their cordial support and right information, the study would have been incomplete and inconsistent.

TABLE OF CONTENTS

SERIAL NUMBER	CHAPTER	PAGE NUMBER
1	INTRODUCTION	1-12
2	REVIEW OF LITERATURE	13-22
3	OBJECTIVES AND METHODOLOGY	23-25
4	RESULTS AND DISCUSSION	26-71
5	SUMMARY	72-78
6	REFERENCES	79-81
7	ANNEXURE I	82
8	ANNEXURE II	83
9	ANNEXURE III	84
10	ANNEXURE IV	85-98
11	ANNEXURE V	99
12	ANNEXURE VI	100
13	ANNEXURE VII	101

LIST OF TABLES

TABLE NUMBER	PARTICULARS	PAGE NUMBER
4.1	FINANCIAL PERFORMANCE of NRHM IN JAMMU AND KASHMIR	27
4.2	INSTITUTIONAL DELIVERIES AND JSY BENEFICIARIES IN STATE OF JAMMU AND KASHMIR	29
4.3	MAN POWER UNDER NRHM IN JAMMU AND KASHMIR	30
4.4	FINANCIAL PERFORMANCE OF NRHM FUNDS IN SRINAGAR AND KUPWARA DISTRICT	31
4.5	FINNACIAL PERFORMANCE OF UNTIED FUNDS IN COMMUNITY HEALTH CENTRE KHANYAR AND KRALPORA	33
4.6	FINNACIAL PERFORMANCE OF ANNUAL MAINTENANCE GRANT IN COMMUNITY HEALTH CENTRE KHANYAR AND KRALPORA	36
4.7	FINNACIAL PERFORMANCE OF UNTIED FUNDS IN PRIMARY HEALTH CENTRE HAZRATBAL AND PANZGAM	38
4.8	FINNACIAL PERFORMANCE OF ANNUAL MAINTENANCE GRANT IN PRIMARYHEALTH CENTRE HAZRATBAL AND PANZGAM	40
4.9	FINNACIAL PERFORMANCE OF UNTIED FUNDS IN SUB CENTRE SHANPORA AND CHOWKIBAL	42
4.10	FINNACIAL PERFORMANCE OF UNTIED FUNDS IN SUB CENTRE NANDPORA AND ALOOSA	44
4.11	INSTITUTIONAL DELIVERIES IN SRINAGAR AND KUPWARA DISTRICTS	46

4.12	TOTAL INSTITUTIONAL DELIVERIES AND JANANI SURAKSHA YOJANA BENEFICIARIES IN SRINAGAR AND KUPWARA DISTRICTS	47
4.13	INSTITUTIONAL DELIVERIES AT BLOCK LEVEL	48
4.14	INSTITUTIONAL DELIVERIES IN COMMUNITY HEALTH CENTRES AND PRIMARY HEALTH CENTRES	49
4.15	PHYSICAL INFRASTRUCTURE OF COMMUNITY HEALTH CENTRES IN SRINAGAR AND KUPWARA DISTRICTS	50
4.16	PHYSICAL INFRASTRUCTURE OF PRIMARY HEALTH CENTRES IN SRINAGAR AND KUPWARA DISTRICTS	51
4.17	PHYSICAL INFRASTRUCTURE OF SUB CENTRES IN SRINAGAR AND KUPWARA DISTRICTS	52
4.18	HEALTH MANPOWER IN SRINAGAR AND KUPWARA DISTRICTS	53
4.19	HEALTH MANPOWER IN COMMUNITY HEALTH CENTRES OF SRINAGAR AND KUPWARA DISTRICTS	56
4.20	HEALTH MANPOWER IN PRIMARY HEALTH CENTRES OF SRINAGAR AND KUPWARA DISTRICTS	58
4.21	HEALTH MANPOWER IN SUB CENTRES OF SRINAGAR AND KUPWARA DISTRICTS	59
4.22	SOURCE OF AWARENESS ABOUT JANANI SURAKSHA YOJANA SCHEME	61
4.23	DIFFERENT CHARACTERISTICS OF ACREDITED SOCIAL HEALTH ACTIVIST IN SRINAGAR AND KUPWARA DISTRICTS	63
4.24	DIFFERENT CHARACTERISTICS OF JANANI SURAKSHA YOJANA BENEFICIARIES IN SRINAGAR AND KUPWARA DISTRICTS	66
4.25	AVERAGE MONTHLY INCENTIVES AND EXPENDITURE OF ACREDITED SOCIAL HEALTH ACTIVIST IN SRINAGAR AND KUPWARA DISTRICTS	68
4.26	AWARENESS OF HOUSEHOLDS ABOUT NRHM	68

LIST OF ABBREVIATIONS

1	ANNUAL MAINTENANCE GRANT	AMG
2	AUXILARY NURSE MIDWIFE	ANM
3	ACREDITED SOCIAL HEALTH ACTIVIST	ASHA
4	BLOCK MEDICAL OFFICER	BMO
5	BASIC HEALTH WORKER	BHW
6	COMMUNITY HEALTH CENTRE	CHC
7	GENERAL DUTY MEDICAL OFFICER	GDMO
8	FEMALE MULTI PURPOSE HEALTH WORKER	FMPHW
9	FIRST REFERAL UNITS	FRUs
10	GENDER DEVELOPMENT INDEX	GDI
11	GROSS DOMISTIC PRODUCT	GDP
12	JANANI SURAKSHA YOJANA	JSY
13	HUMAN DEVELOPMENT INDEX	HDI
14	INFANT MORTALITY RATE	IMR
15	INDIAN SYSTEM OF MEDICINE AND HOMOPATHY	ISM&H
16	LADY HEALTH VISITOR	LHV
17	LIFE EXPECTANCY	LE
18	MATERNAL MORTALITY RATE	MMR
19	NATIONAL RURAL HEALTH MISSION	NRHM
20	NATIONAL HEALTH POLICY	NHP
21	OPERATION THEATER	OT
22	PRIMARY HEALTH CENTRES	PHC
23	ROGI KALYAN SAMITHI	RKS
24	Sub Centre	SC
25	VILLAGE HEALTH SANITATITON AND NUTRITION COMMITTEE	VHSNC
26	WORLD HEALTH ORGANISATION	WHO

CHAPTER—1

INTRODUCTION

As per World Bank classification, India is a low middle income country having majority of its population dependent on rural economy. The population of India as per census 2011 is 1.21 billion with a share of 17.3% in the World population that places the country at second place in terms of population. The total dependency ratio¹ in India is 55% (Economic survey, 2011-12). In terms of geographical area, the country contributes 2.4% at the global level and is placed at the seventh position. India ranks 63 out of 120 nations in terms of Global Hunger Index² during 2013 with a value of 21.3 that places it in alarming position. This value is higher than China, Srilanka, Nepal, Pakistan and Bangladesh (Global Hunger Index, 2013). The country ranks 132 out of 147 nations in terms of Gender Inequality Index having a value of 0.617, higher than at Global level of 0.463 (HDI: A statistical report, 2012). This ranking is also higher than some of its neighboring countries. The percentage of population below poverty line for 2011-12 is 21.92%. However, there is significant gap between rural and urban poverty with 25.70% in rural and 13.70% in urban India respectively. Similarly, the average Monthly Per Capita Expenditure (AMPCE) as per mixed reference period for 2011-12 is Rs 1287.17 for rural and Rs 2477.02 for urban respectively (NSS 68th round, planning commission, 2013).

In developing nations like India, a considerable chunk of its population is poverty ridden and having weak health. This poor health has become burden in their life because part of their income is spent on the health care expenditure. On the other hand their ill health results in the loss of working days pushing them to poverty. This poor health is mainly due to low public health care expenditure. In India, out of pocket expenditure on health may alone push 2.21% of population below poverty line in each year (World Bank, 2001). India is losing 6% of GDP

¹ Dependency Ratio is the proportion of population which is economically dependent on active age group. It is calculated as the sum of the 0-14 years old and over 60 years old divided by the number of people aged between 15 and 59 years respectively.

² Global Hunger Index is calculated by averaging the percentage of population that is undernourished, the percentage of under nourished children younger than five years and the percentage of children dying before the age of five. Its value lies between 0-100. 0 is best score indicating no hunger and 100 the worst.

annually due to premature death and illness (World Bank report, 2010). This results in the relative low level human development index. Capital formation is the key indicator of development and this is impossible without good human health. According to Nobel laureate Amartya Sen, "Empowerment of people comes from the freedom they enjoy and this includes among others, freedom from poverty, hunger and malnutrition and freedom to work and lead a healthy life". To measure standard of living of individuals, various indices have been developed so far but the common accepted measure of human development is human development index (HDI). The HDI designed as per the UNDP human development report of 1995 constitutes three important parameters of human development that are:

- Long and healthy life measured by life expectancy.
- Knowledge measured by adult literacy rate and gross enrollment ratio.
- GDP per capita.

The health being one of the parameters of HDI also determines the other two parameters of HDI. To give an education to an individual is to make human capital formation but this education cannot be fruitful until we have healthy population as the well known saying goes 'A sound mind in a sound body'. Similarly the other parameter of HDI i.e. GDP Per capita is also affected by human health standard. The individual can learn and earn when he is in healthy condition. There is a direct and positive correlation between human health and his economic development. Good health will lead to more productivity and more working hours that will lead more earnings and better standard of life. But unfortunately India has huge burden of diseases that mar this relation. India accounts for 21% of burden of diseases at the global level (WHO Country cooperation strategy India 2012-17). To combat these diseases, India spends only 3.7% of its GDP (World Health Statistics, 2013).

The private expenditure on health as percentage of total expenditure is 71.8% and per capita total expenditure on health is \$51 in which Government contributes only \$14 (World Health Statistics, 2013)(ANNEXUR I). This percentage of health expenditure has been unable to reduce the level of mortality and morbidity as compared to its neighboring countries. The Infant mortality rate³ (IMR)of country is

³ IMR is the probability of dying between birth and exactly one year of age expressed per thousand live births.

42/1000 live births and maternal mortality rate⁴ (MMR) is 212/ 100000 live births which is far above the level committed under Millennium Development Goal of Infant mortality rate of 28/ 1000 live births and maternal mortality rate of 109 /100000 live births by 2015 (National Health Policy, 2012)(ANNEXURE II & III). A study based on World Health Organisation projections of Mortality trajectory associated with non communicable diseases done by Harvard School of Public Health showed that single Ischemic heart disease can cause \$ 1.21 trillion over 2012-30. Similarly as mentioned by the same study, the economic burden of non communicable diseases will be close to \$6.5 trillion for 2012-30. This amount will be nearly equivalent to nine times the total health expenditure during the previous nineteen years⁵. The Government of India has given due importance to health sector since the First Five Year Plan the areas of health care sector were located mainly in urban areas ignoring the health needs of its vast rural population. The first Five Year Plan on health chapter states "Health is a fundamental to national progress in any sphere. In terms of resources for economic development ,nothing can be considered of higher importance than the health of the people .For the efficiency of agriculture and industry, the health of the worker is essential consideration .However the loss caused by morbidity is enormous . To this must be added the expenditure to the individual and state in the provision of medical care .The cause of this low state of health are many including lack of hygienic environment conducive to healthy living, low resistance to infectious diseases primarily due to poor nutrition, lack of safe water supply and the proper removal of human waste and more importantly the lack of appropriate health care .These are serious impediments to progress".

Thus giving due importance to the health factor for economic development and wellbeing of an individual , the First Five Year Plan made a target of increasing the number of doctors from 2401 in 1950-51 to 2782 in 1955-56 i.e. during the First Planning period by 11%. Similarly the target was also to increase the number of compounders from 894 to 1621 (81.3%), nurses from 2212 to 3000 (35.6%), midwives from 1407 to 1932 (37.3%), hospitals from 2014 to 2062 (2.4%) and number of dispensaries from 6587 to 7535(14.39%) during the same period. The

⁴ MMR is the ratio of maternal deaths during a given time period per lakh live births during the same period.

⁵ "Life style diseases cost India to \$6 trillion" (*Times of India*, September 7, 2013) available at <http://timesofindia.com/India/life-style-study-estimate/articles-how-122385056.cms> assessed on 03 march 2014.

main thrust of this plan was to combat the diseases like malaria and water borne diseases. Thus in 1954 National Malaria Eradication Programme was launched. The total outlay of Rs 65.3 crore was made on public health care sector which constituted only 3.4% of total public expenditure. In the Second Five Year plan, the main emphasis was on expanding the existing health services to improve the level of national health through development of professional man power, family planning and other such programmes. An additional outlay of Rs 3 crore was made for setting up of 2100 maternity and child centers and besides this, Rs 6 corers were allocated for training of paramedical staff and Rs 38 corer for combating communicable diseases. The total outlay on health sector during this plan was Rs145.8 crore which was 3.1 % of total public expenditure. At the end of Second Five Year plan the number of hospitals increased from 10000 in 1955-56 to 12600 in 1960-61 i.e. by (26%). Similarly the health man power increased to 19900 from 12780 i.e. by (57.71%) during the same period.

However, before the commencement of Third Five Year plan, it was found that there still existed the regional disparities in health sector as the level of institutional facilities were inadequate and adequate health manpower including doctors were not positioned evenly in rural areas. Thus, the Third Five Year plan made the sole aim of reducing the shortages and deficiencies in health sector with great emphasis on preventive public health services. To meet this end in health sector, an outlay of Rs 250.8 crore was incurred. Fourth Five Year plan which started in 1969 to 1973-74 made its primary objective of providing an effective base in rural areas by strengthening Primary health centres. Total outlay of Rs 613.5 crore i.e. a 3.9% of total public expenditure was made during this period which was an increase of 100% the earlier period. During this period number of medical colleges has been increased from 57 in Third Five Year plan to 93 during this plan. (NHP, 2012, Planning Commission)

In the Fifth Five Year plan, a total outlay of Rs1252.6 crore was made on health care sector which constituted only 3.1% of total public expenditure. This was 0.8% less than the earlier Five year plan. Cancer control programme and National AIDS programme was launched during this period in 1975. The number of Sub centres increased from 33509 to 50000 i.e. by (49.21%) and the number of Primary health centres to 5400 from 5250 i.e. an increase of (2.87%). During this

period India has become the signatory of Alma Ata⁶ declaration in 1978 which provided for “Health for All by 2000 A.D”. It was an international conference on primary health care held on 12 of September 1978 in Alma Ata, USSR. The declaration recognized health as fundamental right and primary health care key to country’s health system in achieving “Health for All by 2000” through reducing the existing inequality in health status particularly between developed and developing countries. (NHP, 2012, Planning Commission)

The Sixth Five Year plan started in 1980-85 with the objective of increasing accessibility of health services in rural areas, thereby removing regional imbalances and qualitative improvement in education and training of health professionals. Total public expenditure on health sector was 3412.2 crore which was 3.1% of total public expenditure. During this planning period National Leprosy Eradication Programme was introduced during the year 1983 and Universal Immunization Programme during the year 1985.

The draft of the Seventh Five Year plan emphasized human resources as the country’s most precious endowment. The success of the plan depends on the extent to which human resources are developed in terms of education, skill, health and wellbeing. To promote the level of human health, Primary health center has been accepted to be of crucial importance. Thus the total public health expenditure of this plan was Rs 6809.4 crores that shares 3.1% of total public expenditure. The achievements of this plan were that the number of sub centres (SCs) increased to 83000 and number of Primary health centers (PHCs) to 11000 and Community health centers to 650. The other achievements of this planning period was that small pox was eradicated and life expectancy increased to 58 years and Infant mortality rate reduced to 80/1000 population. During this plan, National diabetes programme was launched during 1987 in the districts of Saia mans South Arcot in Tamil Nadu on a pilot bases. (NHP, 2012, Planning Commission)

The Eighth Five Year plan total outlay on health sector was Rs14102.2 crore that constituted 3.2% of total public outlays. During this planning period Indian system of Medicine and Homeopathy (ISM&H) was further strengthened and first phase of National AIDS Control Programme was implemented. Infant mortality rate reduced to 70/1000 population, birth rate 26/1000, crude death rate reduced to

⁶ Allen L. Hixon, MD; Gregory G. Maskarinec (2008). Essays and Commentaries. *Farm Med Vol.40 (8): 585-8*

9.0/1000 and life expectancy increased to 60.9. However before the commencement of Ninth Five Year plan, it was reported that the short fall in the number of SCs functioning was 29.20%, PHCs and CHCs 22% and 9.35% respectively. The Ninth plan period laid the emphasis on the improvement on functional efficiency of health care system with decentralization of health programmes through development of disease surveillance and response mechanism on rapid recognition, support and response at district level and improvement in health management and information system. During this plan it was found that the number of doctors at Primary health center exceeded as per norms of requirement but still there existed disparities in their distribution as it was found that about 10% of Community health center were without doctors situated in rural areas. However, at Community health centers, the shortfall of specialists was 60.19%. In terms of physical infrastructure, there was short fall of 13.16% in case of sub centers, 18.46% in case of Primary health centers and 40.87% in case of Community health centers (Bulletin of Rural Health Statistics, MOHFW, GOI, 2006). More over under this planning period, a specific objective was made to meet the requirement of Reproductive and Child health care of tribal population. Total outlay under this five year plan on health sector was Rs 35204.95 crore which was 4.09 % of total public health outlay. A second phase of National AIDS Control Programme was introduced at the national level during the year 1992. (NHP, 2012, Planning Commission)

The draft of the Tenth Five Year plan was based on providing qualitative and cost effective health care with emphasis on reorganization and restructuring of existing public health care system and decentralization of functioning and monitoring of health care sector at Panchayat Raj Institute level. This was done based on the findings made during Ninth Five Year plan that the coverage of Public health care and pace of implementation was very poor and uneven across states. Out of 181 medical colleges in June 2001, Andhra Pradesh, Karnataka, Tamil Nadu and Maharashtra account for 81 colleges. The doctor population ratio was 1/1800 in case of Allopathy and 1/800 in case of Indian System of Medicine and Homopathy. During this plan NRHM was launched on 12 April, 2005 to provide effective and affordable health care to the population especially to the rural poor and women of the country with special focus on eighteen states as also

National commission on Macro Economics and Health⁷ was set up. An allocation of Rs 58920.3 crore i.e. 3.97 % of total public expenditure was made during this planning period. The preamble of the Eleventh Five Year plan mentions “Health of nation as an essential component of development, vital to nations economic growth, and internal stability”. This Five Year plan aimed at bridging the gap between rich and poor, urban and rural as this plan was based on inclusive and faster growth. The target of the plan was reducing Maternal Mortality Ratio (MMR) to 1/1000, Infant Mortality Rate (IMR) to 28/1000 and total fertility rate to 2.1 and also decreases in anemia among women by 50% and increase in sex ratio to 935 by the end of this plan. To meet these requirements, an outlay on health sector was increased to Rs 140135.0 crores i.e. 6.05% of total public expenditure (NHP, 2012, Planning Commission)

Healthcare sector demands equity principle. The equity concern in health emerges because health is universally a merit good, a minimum of which each individual is entitled regardless of his/her ability to pay (WHO, 1978). In health care markets, the equity issue is manifested by wide spread of public subsidization or direct provision of health care .The case for health subsidies is particularly strong because evidently, an individual needs some minimum amount of health human capital to survive (Frogel,1997).

In terms of financial protection to health, India’s position is not satisfactory because more than 70% of health financing is by individual households through their own money .The share of private sector is 78.05% followed by public sector at a rate of 19.67% and external flows contributed to 2.28%(NHA,2004-05, Report of the Working Group on NRHM for 2012-2017). Total health expenditure in India as a percentage of GDP is 4.1% out of which 2.9% is private health expenditure and 1.2% is public health expenditure(OECD Factbook,2013). India ranks 173 among 177 countries in terms of public expenditure on health (UNDP Human development report, 2004, Choudhury, 2006). The eleventh five year plan document identified a requirement of 158792 sub centers with a short fall of

⁷ National Commission on Macro economics and Health was set up in 2005 under the chairmanship P. Chidambaram, the then Finance Minister and Dr Anbumamani Ramadoas, the then Health Minister. The emphasis was to promote equity by reducing household expenditure on health, restructuring the existing primary health care sector to make it more accountable , reducing disease burden and investing in technology and human resources for having a capable work force.

13.36%. In case of Primary Health Centres (PHCs), the requirement is 22022 with short fall of 18.46% and in Community Health Centre's (CHCs) it is 6491 with short fall of 40.87%. Thus recognizing the need and importance of human health, Government of India has taken many initiatives to improve the public health care of the country. One among them is the National Rural Health Mission (NRHM), the landmark reform in health sector.

NATIONAL RURAL HEALTH MISSION (NRHM)

This health mission was launched on 12 April, 2005 throughout the country. The purpose of National Rural Health Mission is to provide effective and affordable health care to the population especially to the rural poor and women of the country with special focus on eighteen states that includes Arunachal Pradesh , Assam, Bihar Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Madhya Pradesh, Meghalaya, Manipur, Mizoram, Nagaland, Odhisa, Rajasthan, Sikkim, Tripura, Uttar Pradesh and Uttrakhand. The NRHM is a Central flagship programme aimed to allocate the funds to these states for strengthening of their physical and human infrastructure. This commitment has been made by the Government to increase the share of public health expenditure to 2-3% of GDP during the period of 2005-2012. It is a flexible decentralized programme comprising the following components.

- A mission flexi pool.
- A reproductive and child health flexi pool.
- Pulse polio immunization
- Infrastructure maintenance, and
- A national disease control programme.

In order to ensure that the funds would be transferred to the implementing agencies without delay, the transfers are made directly to state level societies, bypassing the budget. Under this scheme every sub centre, primary health centre and community health centre receives Rs 10000, Rs 25000 and Rs 50000 annually to meet the local health activity. These funds are deposited in the joint account of Auxiliary Nurse Midwife and local Surpanch. In case of primary health centers and community health centers these funds are deposited in the accounts of Rogi Kalyan Smithies (RKS). Rogi Kalyan Smithi is a patient welfare committee

whose members are people from community, Panchayat Raj representatives, NGOs, Health professionals. Besides these funds every sub centre, primary health centre and community health centre are given an amount of Rupees 10000, Rupees 50000 and Rupees 100000 for construction and maintenance of these health centres. Every Village Health Sanitation and Nutrition Committee (VHSNC) is given 10000 per annum to meet the local needs such as sanitation campaign.

To make the NRHM programme more accessible, the Government of India has introduced following sub schemes.

Janani Suraksha Yojana (JSY)

One of the innovative schemes under NRHM is Janani Suraksha Yojana that aims at reducing maternal mortality rate by ensuring safe institutional delivery. Under this scheme a beneficiary receives Rs 600 in urban areas and Rs 700 in rural areas in low focus states. In high focus states the beneficiaries are entitled Rs 1000 in urban areas and Rs 1400 in rural areas. In non –high focus states women are eligible for the cash benefit only for their two live births and only if they belong to below poverty line, schedule caste and schedule tribe. There is also cash assistance up to Rs 250 for transport facility and is paid on their arrival to hospital. This scheme is implemented through Accredited Social Health Activist (ASHA) who receives Rs 400 in urban areas and Rs 600 in rural areas. This scheme has made significant change in institutional deliveries which was 0.74 million in 2005-06 to 10 million in 2009-10 (Modugu et al, 2012).

Janani Shishu Suraksha Karyakaram (JSSK)

Under this scheme all pregnant women are entitled for free delivery , drugs and consumables, and also free transport from home to health centre , between health centres in case of referral and drop back to home.

Accredited Social Health Activist (ASHA): ASHA is a female health activist selected by and accountable to panchayat, is the first port of call for any health related demands in the rural community by acting as a bridge between ANM and community. There should be one ASHA per 1000 population or ASHA per habitation in case of hilly and tribal areas as per NRHM norms and is provided with necessary drug kit to meet and provide the health needs at the door steps of households. ASHA will be receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH,

construction of household toilets, and other healthcare delivery programmes. She will act as core component in implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the village Health Committee of the Panchayat. She will be given Induction training of 23 days in all, spread over 12 months and on the job training would continue throughout the year.

GOALS OF NRHM

- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Access to integrated comprehensive primary healthcare.
- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
 - Revitalize local health traditions and mainstream AYUSH.
 - Prevention and control of communicable and non -communicable diseases, including locally endemic diseases.
 - Population stabilization, gender and demographic balance.
 - Task Group to improve guidelines/details.

EXPECTED OUTCOMES OF NRHM

(a) National Level:

- ✚ Reduction of Infant Mortality Rate to 30/1000 live births by 2012
- ✚ Reduction of Maternal Mortality Ratio to 100/100,000 by 2012
- ✚ Reduction of Total Fertility Rate to 2.1
- ✚ Malaria mortality reduction rate –50% up to 2010, additional 10% by 2012
- ✚ Kala Azar mortality reduction rate: 100% by 2010 and sustaining elimination until 2012
- ✚ Filariasis/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015
- ✚ Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- ✚ Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- ✚ Cataract Operation: increasing to 46 lakhs per year until 2012.
- ✚ Leprosy prevalence rate: reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter.

- ✚ Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.
- ✚ Upgrading Community Health Centers to Indian Public Health Standards (IPHS).
- ✚ Increase utilization of First Referral Units from less than 20% to 75%

(b) **Community Level:**

- ✚ Availability of trained community level worker at village level, with a drug kit for generic ailments.
- ✚ Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.
- ✚ Availability of generic drugs for common ailments at Sub-centre and hospital level
- ✚ Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level · Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme
- ✚ Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families.
- ✚ Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission.
- ✚ Provision of household toilets.
- ✚ Improved Outreach services through mobile medical unit at district level

MONITORING AND EVALUATION

- ❖ Health MIS to be developed up to Community Health Centre (CHC) level, and web-enabled for citizen scrutiny.
- ❖ Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad · The District Health Mission to monitor compliance to Citizen's Charter at CHC level.

- ❖ Annual District Reports on People's Health (to be prepared by Government /NGO collaboration).
- ❖ State and National Reports on People's Health to be tabled in Assemblies, Parliament.
- ❖ External evaluation/social audit through professional bodies/NGOs· Mid Course reviews and appropriate correction.

NRHM operates through different components and under various guidelines at different stages of Sub Centre (SC), Primary Health Centre (PHC), Community Health Centre (CHC), Village Health and Sanitation Committee (VHSC), Rogi Kalyan Samiti (RKS) so as to attain its goals uninterruptly. The details of these components and various guidelines regarding constitution of Village Health and Sanitation committee and allocation, and Utilization of untied funds and Annual Maintenance Grants for different health centres and for Indian Public Health Standard (IPHS) are given in annexure IV. The profile of Jammu and Kashmir State, Srinagar and Kupwara districts are given in (ANNEXURE V, VI and VII).

CHAPTER 2

REVIEW OF LITERATURE

Kumar (2005) in an article entitled "Budgeting for Health :Some considerations" revealed that low level of public health expenditure on one hand and mismanagement on other in delivering quality service had put India's health standard on knife edge. The study has underlined the need for the standardization of health care sector as the level of Infant Mortality Rate was much higher than other developing and neighboring nations such as Srilanka, Malaysia, China and Bangladesh as per HDI report 2004. The level of rural- urban disparities is shocking in case of health care sector. In Andhra Pradesh rural Infant Mortality Rate was 71/1000 and in urban it was 35/1000. Similarly in Karnataka it was 65/1000 in rural and 25/1000 in urban. The study suggested the need for improvements in adequate financing, inducing health workers such as Accredited Social Health Activist and social accountability besides strengthening the physical and human infrastructure that can improve the India's health standard.

In an another study entitled "Public spending on health in low income states and central transfers" by Chowdhary (2006). The author interpreted the data of HDI report 2004 and pinpointed that the level of public health expenditure was the lowest in India as it ranks 173 out of 177 countries. The level of expenditure as a percentage of Gross Domestic Product was only 0.9% which was insufficient to meet even the basic requirement of health care services. The requirement level of public expenditure as a percentage of Gross State Domestic Product also varied from State to State. This requirement as percentage of Gross States Domestic Product is 3% in case of Madhya Pradesh, Chhattisgarh, Utter Pradesh and Uttaranchal and more than 3% in case of Bihar, Jharkhand, Orissa, Rajasthan and Assam. Further most of the financial resources in these states are utilised in meeting their committed liabilities including wages, salaries interest payment and pensions. In Orissa, Bihar and Assam, this component constitutes more than 95%, in Utter Pradesh, it is 85% and in Madhya Pradesh it is more than 75%. Therefore the study focused on the need that level of central transfers to the low income states should be increased to meet the good quality service of health care sector as

also to achieve the targets of Millennium Development Goals and National Rural Health Mission.

Ashtekhar (2008) revealed in their study entitled “The National Rural Health Mission: A stocktaking” that NRHM leaves little freedom for states to provide effective health care because of its centralized framework even though flexibility its key word. The study mentioned that financial mechanism under NRHM which allocates funds from Centre to State and from State to Districts has only in corruption and financial failure. Further the study found that improving human resources to IPHS is still lagging behind. Regarding ASHAs the study revealed that the tasks given to them exists only for namesake. Drug kits to ASHAs are either not given or not restocked and are just earning a meager income. The author in study suggested for the need of implementation of IPHS on practical grounds to achieve the goals set under NRHM.

Berman and Ahuja (2008) conducted a study entitled “Government health spending in India”. Their findings are based on Pre-NRHM and Post-NRHM reform. The study identified that during Pre-NRHM reform total health spending had increased by 38% during 1999-2000 to 2004-05 and in real per capita terms total health spending had increased marginally as it increased from Rs 205 to Rs 215 during the same period. During post NRHM reform, the total health expenditure of government increased by 41% between 2004 -05 to 2006-07. In real per capita terms it has increased from Rs 215 to Rs 268 during the same period. The study also found that Post-NRHM government health expenditure as percentage of GDP has not increased too much between 2005-2007. It has increased to only 1.05% in 2006 -07. However the study was made only for two years after the implementation of NRHM. The Government’s commitment was to increase the share of GDP on public health expenditure for the period of five years after implementation of NRHM. Further the study has not taken in to account the other beneficial activities under NRHM like cash transfer through JSY scheme and role of ASHAs in rural health care.

Devadasan et al (2008) in his study entitled “A conditional cash assistance programme for promoting institutional deliveries among the poor in India: Process evaluation results” discussed the inclusiveness of Janani Suraksha

Yojana scheme. It was found that most of the poor women were not aware of the programme, submitting the necessary document was a difficult task. There was also a long delay in receiving the benefits. The study also revealed that the amount of cash benefit varied from State to State. This was Rs 1400 in rural areas of Karnataka and Rs 700 in Maharashtra. The eligibility criteria for cash benefit also varied from State to State. In states like Orissa and Chhattisgarh, all pregnant women were entitled for the cash benefit irrespective of their economic status. However in Karnataka and Maharashtra the focus was mainly on poor women. The duration of payment to Jananai Suraksha Yojna beneficiary showed a significant variation among these states. In Maharashtra Janani Suraksha Yojana beneficiary received the cash assistance at the time of submission of bio-data while in case of Karnataka, the women were entitled to cash benefit even after one year of giving birth to a child. The study also focused on the need of creating the level of awareness through social accountability as it was found that in some States like Karnataka, the JSY beneficiaries did not receive the full cash benefit. In Orissa these beneficiaries received only Rs 350.

Ahmad et al (2009) in their study entitled “Rapid appraisal of National Rural Health Mission in Baramulla District of Jammu and Kashmir” revealed the short fall of manpower of different positions in the Baramulla District was 29%. The physical infrastructure like blood bank, doctors duty room, treatment room, pharmacy were adequate. The study also found the inequity in man power at two CHCs. It was sufficient at CHC Pattan and insufficient at Chandoosa CHC. The admission of IPD-inpatient department at PHCs was non existing. The study also mentioned about low standard of SCs as per Indian Public Health Standard regulations. JSY programme was found to be ineffective in maternity care. It was found that 96% of JSY beneficiaries used the private transport to reach the health centre. The study also mentioned that 82% of ASHAs received ASHA kits but they were not filled regularly.

Bhattacharya (2009) conducted a study on “Intra-state disparity in Government expenditure” The study found that Bihar, Jharkhand and Chhattisgarh had the lowest per capita monthly expenditure on both education and health in rural sector followed by Madhya Pradesh. Their combined

expenditure on health and education was less than 9% as against the national average of 9.28% while in Bihar it was only 5%. The per capita house hold expenditure on education and health in rural areas of Utter Pradesh and West Bengal was higher than the national average. In urban areas, it was found that per capita household expenditure in all the states except Bihar was much higher than the national average. The lowest monthly per capita government expenditure on education and health was found in Bihar. Expenditure on health in rural and urban areas was 3% and 9% respectively in these states. The reason for relatively high expenditure on health was due to inadequate health care facilities in rural areas. The findings also show that Utter Pradesh has the highest disparity with regard to medical expenditure followed by Bihar, Madhya Pradesh and West Bengal. In Bihar 37 Districts out of 38 were having per capita expenditure on health care between 0-20% while in one District, the expenditure on health care varied between 80-100%. In case of Jharkhand 13 out of 18 Districts had per capita expenditure on health care between 0-20% while four Districts had per capita health care expenditure between 20-49% and in the remaining one District per capita per capita expenditure on health care varied between 80-100%. Similarly in Utter Pradesh, 68 Districts out of 70 had health care expenditure between 0-20% and remaining 2 Districts had health care expenditure between 40-60% and 80-100% respectively. Therefore the author stressed the need of reducing inequity in health care expenditure so that everyone has equal health care access.

Duggal (2009) conducted a study entitled "Sinking flagships and health budgets in India". In his study he found that the principal cause of underdevelopment of health and health care is inadequate allocations to health sector in Government budgets. World health report 2008 shows that in low and middle income countries ,over 6.5 billion people have to finance health care by borrowing and sale of assets for over a half of their health expenditure.

Another study by Husain (2009) entitled "Health of National Rural Health Mission" revealed that public health care sector in India has shortage of manpower .He mentioned that at 11% PHCs ,the shortage of doctors was 17% in high focus states. At CHCs only 49% of required specialists have been sanctioned and 25% were positioned. The study also mentioned misallocation of united funds to sub

centres. It was only 49% at SCs and 36% at PHCs that received such funds during 2008-09.

Krupp and Madhivanan (2009) in his study "Leveraging human capital to reduce MMR in India: Enhanced public health system or private public partnership" discussed the various human resources strategies of various states in achieving Minimum Development Goals. It was revealed that roughly 27 million women in India give birth each year in which 136000 dies as a direct result of their pregnancy and delivery. In India 46.6% of births are attended by skilled birth attendants while it was 33.5% in rural areas. Of course India has comparatively good human resource than that of neighboring countries as there were 7 physician and 8 nurses per 10000 population. In case of Pakistan it was 7.4 physician and 4.7 nurses per 10000 population. However, the public health care that is prerequisite to meet the health needs of poor constitute only 2 physicians per 10000 population. In India more than 73% of all health spending is out of pocket expenditure, 6% from insurers and remaining by Government. It was found that the success of health system depends up on factors such as level of financing, human resource and governance but the most crucial factor determining the health standard is human resource. This was found in case of Gujarat which is among the top states in terms of per capita income but behind in terms of health standard. In 2005 its MMR was 172/100000 live births. This was far above than the Kerala which was having 110/100000 and in case of Tamil Nadu it is 138/100000. In case of IMR it was 54 /1000 in Gujarat and 14/1000 and 37 /1000 in case of Kerala and Tamil Nadu respectively. This all was mainly due to human resource in Gujarat despite being a developed state.

Lahariya (2009) article entitled "Cash incentive for institutional delivery : linking with antenatal care and post natal care may insure continuum of care in India" revealed that the country although may not be able to achieve the goals set in National Population Policy is almost making a progress in reducing the MMR and IMR. The study interpreted the data of NFHS-3 which shows that MMR has decreased to 301per lakh live births from 540 per lakh live births. This has been due to ante natal care, skilled birth attendance and institutional deliveries. The implementation of National Rural Health Mission with its core component Janani Suraksha Yojana scheme has been very effective in

reducing Infant Mortality Rate and Maternal Mortality Rate of a country. However the study focused on promoting quality of service to pregnant woman rather than on institutional alone. Further it was suggested that sufficient infrastructure should also be developed to reduce poor quality delivery, also the money given to Janani Suraksha Yojana beneficiary should be given prior to delivery so that family need not to borrow from any source . The study stressed on strong monitoring and evaluation mechanism under the JSY so that there is no space for corruption to ensure better quality health care service.

Dhillon (2012) in the entitled study “From policy to periphery: A look at India’s National Rural Health Mission” found that PHCs which is basis for rural health care are far away from norms set by IPHS. The study revealed that officials of only 50% PHCs were aware about the term IPHS in Kangra district of Himachal Pradesh. The positions of human resources as set by IPHS were not met. Thus the author suggested that successful implementation of NRHM and IPHS for PHCs lies only sound and proper communication strategy from top policy makers to bottom real implementers.

Joshy and George (2012) in their study entitled “Health care through community participation: Role of ASHAs” revealed that the ASHAs in Thane district of Maharashtra did not perform their proper functions. The study mentioned that the common task of ASAHs was escorting pregnant women to nearest hospital and also distribution of drugs. The author also found the socio- economic background of rural women as important factor for choosing the job as ASHA as 92.5% ASHAs reported that they joined the ASHA scheme to support their families. The author in this study suggested that ASHA being community worker should involve herself in other developmental activities as per the need of community.

Modugu (2012) examined the house hold health expenditure on deliveries and the process of cash transfer to pregnant women in JSY. The study found that 52% of all deliveries in India occurred at private health centres during 2007-08 and that was three times expensive than the public health care sector. The cost of normal delivery was Rs 1624 at public healthcare sector as against Rs 4458 in the private health care sector. The findings of the study also shows that the implementation

JSY programme made significant change in institutional delivery during 2005-06 to 2009-10 as the number of beneficiaries' increased from 0.74 million in 2005-06 to 10 million in 2009-10.

Prinja et al (2012) in his study entitled "Equity in hospital services utilisation in India" found the lack of horizontal equity in access to health care. They pointed out that over all hospitalization services were largely reaped by wealthy population. The study found that the rate of hospitalization /1000 person was 69.4 among the poorest households as against 105 among the richest households. In public sector, hospitalization rate for the poorest and richest quintile households was 3.9% and 3.6% respectively. In private sector it was high in case of richest population. It was 6.8 % for richest and 2.9% for poorest quintiles. The study also shows that public health care facilities were more equitable in urban areas than in rural areas. It suggests the need for strengthening the rural public health care sector.

Rao and Choudhary (2012) conducted a study on "Health care financing reforms in India". The study found relatively low level of public spending even after implementation of NRHM as it increased marginally from 0.94% of GDP in 1999-2000 to 1.2% of GDP during 2005-06 to 2009 -10. Poor quality health care services and poor health status of population and the insufficient level of public health provisions pave the way for high private health expenditures having adverse impact on health of poor population. The study also found divergence in allocation and spending of funds as level of actual expenditure incurred on programme by central government during 2009-2010 was 46.6 billion as against the allocation of 115.9 billion. The study also found the variation in distribution of funds due to delay in providing utilization certificates to the central government. Therefore the study emphasizes on fiscal space for public health care in India.

Rao (2012) in his study entitled "District wise allocation of funds in Hyderabad Karnataka region under the NRHM" found poor planning and execution of NRHM funds resulted in short fall of funds over the amount released. In higher income district growth rate of released funds was 260.89 % in 2008-09 over that of 2007-08 as against actual expenditure of 89.67% during the same period. Similarly in Gulbarga district, percentage of released fund was 206.95% but growth of

expenditure was 140.06% only. The study also mentioned the regional disparities in per capita public health expenditure in this district. Thus the study emphasis on effective planning and execution of NRHM funds to improve the rural health.

Rajalakshmi (2012) in his study entitled “Public Health: A battle half won” found that to reduce MMR by providing institutional support alone is not the only way but the other factors such as interpersonal behavior of service provider ,accessibility of health institution ,availability of medicine and cost of service also determine the level of reducing MMR in the country. The survey recorded that institutional deliveries under Janani SurakshaYojana increased from 53% of all deliveries in 2005 to 73% in 2009. In Jharkhand, the increase was from 19% in 2005 to 40% in 2009-10. 22% of respondents reported that institutional delivery was done by husbands will, 69% believed in better out come in case of institutional delivery and 33% deliveries at institutions were due to cash incentive. Moreover 40% preferred home deliveries on account of better comfort and privacy. Regarding cash benefit 40% women reported that they spent more than Rs 1400 on institutional delivery alone. Average expenditure on institutional delivery was Rs 1050 compared with Rs 700 at home delivery. The reason for opting home delivery despite the risk was high health care expenditure at institutional delivery including bribes to staff, transport expenditure.

Sing and Tamulee (2012) in an article entitled “Janani Suraksha Yojana: Impact on socio- economic conditions among beneficiary females”. The study covered two districts of Bihar and the study revealed significant impact of JSY programme on institutional deliveries. The paper also showed the socio- economic impact on JSY programme on institutional delivery which was 56.8% among scheduled castes, 2.1% among scheduled tribes, 34% among other backward classes and 6.4% to the general category.

Srinath and Veena (2012) in a study entitled “NRHM and IPHS” found insufficient training to the staffs of PHCs regarding the I.P.H.S norms. It was noted that the functionality of man power ranged from 25% at PHC 1 as high as 81% at

PHC 2. At two PHC it was also found that the medical officers were unaware about I.P.H.S.

Pap et al (2012) done a study on “improving maternal health through social accountability: A case study from Orissa”. It was found that primary level awareness of maternal health entitlements is low and is influenced more likely by the economic, geographic and social nature of population. The study mentioned that the state has implemented the NRHM scheme but its guidelines have not been enforced in proper way. Even the health official does not know the name of the village of his medical block. The most significant factor was lack of awareness of marginalized women as well as leaders and service providers and the great obstacle in the success of good health care system was lack of social accountability. Therefore the study focused on social accountability as critical to the progress and as a means of improving the maternal health policies through generating demand, leveraging intermediaries, sensitising leaders and health service providers besides improving the basic health infrastructure.

Sidney et al (2012) in a study entitled “India’s JSY cash transfer programme for maternal health: who participates and who does not –a report from Ujjain District” found that half (51%) of the mothers belonged to BPL families and 28% of the women were from disadvantaged group. It was found that 90% of women were aware about Janani Suraksha Yojana scheme. The level of awareness was made through the public health facility (40%), village crèche worker (30%) and Accredited Social Health Activist (21%). It has been found that 70% deliveries were at home. The percentage of Janani Suraksha Yojana beneficiary was highest among BPL constituting 81% and only 24% of the reported deliveries were attracted by JSY cash incentive and 17% institutional delivery was on basis of perception that good service is provided through Janani Suraksha Yojana programme. The findings also showed that only 86% received the cash benefit within the two weeks of delivery. 65% of women claimed that the main reason for delivering at home was non availability of transport and 26% on the experience of previous easy delivery. The study also highlighted the role of Accredited Social Health Activist in promoting institutional delivery. 86% of mothers who were visited by Accredited Social Health once in a month and 77% of these delivered through Janani Suraksha Yojana scheme. Further, 49% of mothers were accompanied by

Accredited Social Health Activist during hospitalization. However it was that only 4% that reported that Accredited Social Health Activist visited after delivery.

Patra (2013) conducted a study entitled “National Rural Health Mission and Health Status of Odhisha: An economic analysis”. The study underlined the improvements made after the implementation of National Rural Health Mission in Odhisha. The study found that the number of SCs and PHCs increased during 2005-09 but the number of CHCs has not increased during the same period. There was also increase in the number of health personnel except in case of lab technicians and doctors. In terms of financial assistance, it has also increased substantially to meet the health needs of the people in Odhisha. All these developments made significant improvements in the level of health standard of the state as the number of Crude Death Rate has reduced from 9.6 in 2004 to 9.0 in 2008 and Infant Mortality Rate reduced from 77 in 2004 to 69 in 2008 . However the study suggested the need to create the baseline awareness among the illiterate, poor people of rural region of Odhisha.

CHAPTER 3

OBJECTIVES AND METHODOLOGY

Health is a fundamental right of every human being. However the disparity between urban and rural health care sector still exists which is evident from relatively higher maternal mortality rate and infant mortality rate in rural India. Not only weak health care sector in rural areas leads to higher maternal mortality rate and infant mortality rate but also is one of the causes of rural indebtedness. Thus National Rural Health Mission (NRHM) was launched to provide the fundamental right of health to the poorest of the poor by augmenting health manpower, decentralized financing and removing the vertical and horizontal imbalances in health care sector especially in rural areas.

To remove the imbalances in health care sector, Government of India divided States into high focus and non- high focus states. NRHM was launched in the month of December, 2005 in Jammu and Kashmir State and was given a high focus status due to its weak health indicators and difficult topography. National Rural Health Mission has completed its first journey (2005-2012) of removing the imbalances existing in the health care sector across the states and within the State. A couple of studies have been done in Jammu and Kashmir to assess the implementation of NRHM in the State. However there was no such study that reflected the implementation of NRHM by analysing the rural- urban health care disparity based on comparative analysis.

OBJECTIVES OF STUDY

- To examine the financial performance of untied funds and Annual Maintenance Grant under National Rural Health Mission.
- To assess the impact of National Rural Health Mission in reducing urban-rural health care gap in terms of manpower and physical infrastructure.
- To analyse the effectiveness of cash incentive given through Janani Suraksha Yojana for promoting institutional deliveries.

HYPOTHESES

- NRHM has reduced the rural- urban health care inequality gap.
- There is gap between allocation and utilisation of NRHM funds.

METHODOLOGY

To fulfill the stated objectives, multistage random sampling technique was applied.

Selection of the District

Two districts namely Srinagar district from non high focus districts and Kupwara district from the high focus districts were randomly selected.

Selection of Blocks

Two blocks namely Hazratbal block from Srinager district and Kralpora block from Kupwara district were randomly selected.

Selection of the Villages

Two villages from each block were randomly selected.

Selection of Health Centres: One CHC and one PHC from each block and one Sub- Centre from each of four villages of selected blocks were randomly selected.

Sample from Hazratbal and Kralpora block

A sample of 30 ASHAs and 30 JSY beneficiaries from each CHC and PHC of each block were randomly selected. In addition to this sample, twenty IPD Patients from the each CHC and PHC of each block were interviewed. Further 2 doctors, 2 Female multipurpose health workers (FMPHW), and 2 Male multipurpose health workers (MMPHW) from each CHC, PHC and Sub centre were randomly selected and interviewed. Two Village Health Sanitation and Nutrition Committee were also interviewed to assess their role in promoting rural health as also 30 households from two villages of each block were also randomly selected to assess their awareness level of NRHM.

DATA COLLECTION

Both primary as well as secondary data were collected. The secondary data were collected from Divisional office NRHM Srinagar J&K, Directorate of Economics and Statistics, J&K, CMO office Srinagar, Dy. CMO office Srinagar, CMO office Kupwara, BMO office Hazratbal, BMO office Kralpora. Besides this, secondary data were also collected from Publications of NRHM, Websites etc. Primary data was collected through different Interview schedules. These interview schedules were prepared separately for different stake holders namely Accredited Social Health Activists, Janani Suraksha Yojana beneficiary, Households, IPD patients, Health manpower comprising doctors, Female Multi Purpose Health Worker and Male Multi Purpose Health Worker.

CHAPTER 4

RESULTS AND DISCUSSION

This chapter attempts to make analysis and presents results of “Socio-Economic impact of National Rural Health Mission in Kashmir division of Jammu and Kashmir”. This chapter has been divided into four sections. Section– A provides an overview performance of National Rural Health Mission in the State. Section– B provides financial performance of untied funds and Annual maintenance grant in the two selected districts of Srinagar and Kupwara district. Section – C provides institutional deliveries and infrastructure development under Nation Rural Health Mission in the Srinagar and Kupwara districts and Section – D provides man power position in the two selected Districts.

SECTION – A

An overview performance of NRHM in the state of Jammu and Kashmir

Health has been recognized as an important indicator of national progress. In the era of 21st century nothing is considered higher in value than the human development of a country. This human development is impossible without the healthy population. Due to weak Public health care sector, India loses a human asset in the form of low life expectancy, high infant mortality rate and maternal mortality rate. To combat this problem of low life expectancy, high infant and maternal mortality rate, various health committees were constituted from time to time but still there existed a wide disparity in urban- rural health care sector. Therefore, Government of India launched revolutionary mission in the form of National Rural Health Mission to bridge the gap existing in Urban- Rural health care sector. The mission has been implemented throughout the country with the stated objectives and strategies. The mission works through various mechanism such as financial mechanism, man power mechanism and performance based incentive mechanism to achieve inclusiveness of the mission.

In the State of Jammu and Kashmir, National Rural Health Mission was launched in December 2005 with a view to provide effective Public healthcare and ensure inclusiveness of the mission, the State of Jammu and Kashmir has divided

districts in to high focus and non- high focus districts. There are 12 high focus Districts and 10 non high focus districts in Jammu and Kashmir State.

Table 4.1

Financial Performance of National Rural Health Mission in Jammu and Kashmir

(Amt. in Crore)

Year	Allocation	Available funds	Utilization	Unspent
2005-06	69.36	69.36	17.52 (25.26%)*	51.84
2006-07	49.14	100.98	51.42 (50.92%)	49.56
2007-08	160.45	210.01	75.27 (35.84%)	134.74
2008-09	76.48	211.22	111.94 (53%)	99.28
2009-10	130.33	229.61	155.6 (67.7%)	74.01
2010-11	173.81	247.82	210.75 (85.04%)	37.07
2011-12	249.75	286.82	225.2 (78.52%)	61.62
2012-13	43.16	104.78	78.16 (74.59%)	26.62

Source: State wise progress, NRHM Facility Centre

*The data in parenthesis shows percentage utilisation of available fund.

Table 4.1 shows that there has been a significant variation in the total allocated funds under different components subsumed under National Rural Health Mission. The allocation of the fund under National Rural Health Mission was Rs 69 .36 crore during 2005-06. Out of this available fund, the utilisation by the State was Rs17.52 crore (25.26%). The allocation of these funds declined to Rs 49.14 crore (-29.15%) from the previous year and the utilisation of the total available funds

was Rs 51.42 crores (50.92%) during 2006-07. The fund allocated to the State was again increased to Rs 160.45 crore during 2007-08 that means an increase of 226.52% from the preceding year. The State utilised Rs 75.27 crore (35.84%) out of total available fund Rs 210.01 during 2007-08. The State got an allocated fund of Rs 76.48 crore during 2008-09 The funds utilised during the year 2008-09 was Rs 111.94 crore (53%) out of the total fund Rs 211.22 crore available with the State. The fund allocated to the State was Rs 130.33 crore during 2009-10. Out of the available fund of Rs 229.61 crore State utilised Rs 155.60 crore (67.76%) during 2009-10. The State received an amount of Rs 173.81crore and utilisation by the state was Rs 210.75 crore (85.04%) out of the total available fund of Rs 247.82 crore during 2010-11. The State was allocated a sum of Rs 249.75 crore during 2011-12 and State utilised Rs 225.20 crore (78.52%) out of available fund of Rs 286.82 crore during the same period. The State received an amount of Rs 43.16 crore during 2012-13. Out of the State's total available fund of Rs 104.8 crore, the utilisation was Rs 78.16 crore which was 74.59% of this total available fund.

Thus, all in all, the allocation and utilisation of funds have shown a mixed trend during the years 2005-06 to 2012-13. However the utilisation of funds increased from 25.26% of the available funds during 2005-06 to 74.59% of available funds during 2012-13.

Table 4.2**Institutional deliveries and Janani Suraksha Yojana beneficiaries (JSY) in Jammu and Kashmir State**

Year	Institutional deliveries	JSY beneficiary	% age of JSY beneficiaries.
2005-06	91000	2134	2.35
2006-07	131000	13127	10.02
2007-08	151144	10568	6.99
2008-09	151783	8000	5.28
2009-10	152000	91000	59.87
2010-11	142000	112210	79.02
2011-12	152998	132645	86.7
Total	971925	369684	38.03

Source: State wise progress, NRHM Facility Centre

Table 4.2 shows the number of institutional deliveries and the percentage of JSY beneficiaries who received incentives under Janani Suraksha Yojana scheme. The institutional deliveries were increased from 91000 during 2005-06 to 152000 during 2009-10 and thereafter it declined to 142000 during 2010-11. It again increased to 152998 during 2011-12 thereby registering an increase of 7.75% from the preceding year. The Janani Suraksha Yojana beneficiaries and percentage of Janani Suraksha Yojana beneficiaries to total institutional deliveries have shown a mixed trend. The highest percentage (86.7%) of Janani Suraksha Yojana beneficiaries to total institutional deliveries was recorded during 2011-12 as against the lowest 2.35% during 2005-06. This shows that the percentage of JSY beneficiaries to total institutional deliveries have significantly increased from 2005-06 to 2011-12.

Table 4.3**Man Power under National Rural Health Mission in State of Jammu and Kashmir**

(As on October 2012)

Man power	Sanctioned	In position	Shortfall	% Shortfall
Specialists	65	47	18	27.69
MBBS Doctors	531	355	176	33.14
ISM Doctors	471	452	19	4.03
Staff Nurses	931	555	376	40.39
Other Para medical staff	3533	3227	256	8.66
Total	5531	4636	895	15.28

Source: Directorate of Economics and Statistics, J&K.

Total manpower under NRHM in Jammu and Kashmir is given in table 4.3. It shows the shortfall of sanctioned manpower under different capacities in the State of Jammu and Kashmir as on October 2012. It reveals highest percentage of shortfall to the sanctioned manpower in Staff nurses (40.39%) followed by shortfall of MBBS Doctors (33.14%) while the shortfall of 27.69% occurred in case of Specialists. The lowest shortfall of manpower to the sanctioned man power under NRHM was found in ISM Doctors (4.03%) and other paramedical staff (Lab technicians, X-ray technicians, Auxiliary Nurse Midwife etc) having shortfall of 8.66%. The total percentage shortfall of health man power to the sanctioned man power is 15.28%. The data clearly reveals that there still exists discrepancy in existing health man power and sanctioned man power under NRHM even after the completion of first journey (2005-12) of eliminating the shortages in man power and generating the man power to the level of Indian Public Health Standard.

SECTION – B

This section provides the financial performance of NRHM funds in the Srinagar and Kupwara districts of Jammu and Kashmir.

Table 4.4

Financial Performance of NRHM funds in Srinagar and Kupwara district

(Amt. in Lakh)

Year	Srinagar district (Non -high focus District)			Kupwara district (High focus District)		
	Allocation	Utilisation	utilisation %	Allocation	Utilisation	utilisation %
2005-06	24.60	1.31	5.33	17.14	0.91	5.31
2006-07	106.49	15.62	14.67	104.39	15.31	14.67
2007-08	306.54	78.94	25.75	343.67	88.49	25.75
2008-09	311.55	130.39	41.86	477.63	199.89	41.85
2009-10	480.01	274.66	57.20	596.99	341.6	57.22
2010-11	584.86	355.30	60.75	803.41	488.07	60.75
2011-12	583.34	349.42	59.89	959.92	574.99	59.89
2012-13	708.73	526.87	74.34	1298.73	965.48	74.34
2013-14	319.33	158.58	49.67	616.23	306.02	49.66
Total	3425.45	1891.09	55.21	5218.11	2980.77	57.13

Source: Divisional office NRHM, Srinager.

Table 4.4 shows the allocation of funds given under NRHM to high focus District Kupwara and non- high focus District Srinagar. The data reveals that the total allocation given to high focus District Kupwara (Rs 5218.11 lakh) was higher than the allocation of NRHM funds given to non- high focus District Srinager (Rs

342545 lakh) during the year 2005-06 to 2012-13. However, in terms of utilization there was a marginal increase in case of high focus District Kupwara. The highest allocation of Rs 708.33 lakh was given to non- high District Srinager during 2012-13. The highest rate of utilization (74.34%) of the allocated funds in the Srinagar district was during 2012-13.

Similarly in case of high focus District Kupwara the highest total allocated fund of Rs 1298.73 crore was given during 2012-13 and the highest total utilisation of allocated fund of Rs 965.48 lakh (74.34%) was during the same year. The lowest rate of utilization was during the year 2005-06 having utilization rate of 5.31% of the allocated fund. As per coincidence, both Srinagar and Kupwara district has the same rate of utilization of 60.75%, 59.89% and 74.34% of the allocated fund during 2010-11, 2011-12 and 2012-13 respectively. All in all , the data shows that the percentage of utilisation of allocated funds increased significantly over the years from 2005-06 to 2012-13.

TABLE 4.5 Financial performance of Untied funds of Community Health Centres of two Districts

(Amt in Rs)

Year	CHC Khanyar Zone Khanyar Non- high focus District (Srinagar)				CHC Kralpora High focus District (Kupwara)			
	Allocation	Available funds	Utilization	Unspent	Allocation	Available funds	Utilization	Unspent
2007-08	50000	50000	Nil (0%)	50000	50000	50000	50000 (100%)	0
2008-09	50000	100000	76924 (76.92%)	23076	50000	50000	50000 (100%)	0
2009-10	50000	73076	1769 (2.42%)	71307	50000	50000	50000 (100%)	0
2010-11	50000	121307	121307 (100%)	0	50000	50000	31360 (62.72%)	18640
2011-12	50000	50000	50000 (100%)	0	25658	44298	44007 (99.34%)	291
2012-13	50000	50000	50000 (100%)	0	30014	30305	30305 (100%)	0
2013-14	22000	22000	22000 (100%)	0	6000	6000	Nil (0%)	6000
Total	322000		322000		261672		255672	

Source: Office of Medical Superintendent CHC Khanyar, BMO office Kralpora

Table 4.5 provides the comparative analysis of the financial performance of Community Health Centres (CHCs) of non- high focus district Srinagar and high focus district Kupwara. The untied fund allocated to CHC Khanyar was Rs 50000 during 2007-08 and the amount was not utilized during this financial year. The CHC Khanyar utilised Rs 76924 (76.92%) out of total available funds of Rs 100000 during 2008-09. The CHC Khanyar has been allocated a sum of Rs 50000 as untied fund but the utilisation at the CHC was only Rs 1769 (2.42%) of the total available fund during 2009-10. Again, the CHC Khanyar received an allocated amount of untied fund of Rs 50000 during 2010-11. The utilisation of untied fund at CHC Khanyar was Rs 121307 (100%) of the available fund of Rs 121307 during the year 2010-11. There was full utilisation of allocated untied fund during the years of 2011-12 and 2012-13. However there was decline in the allocation of untied fund to Rs 22000 during 2013-14 to CHC Khanyar which was fully utilised during the same period.

The allocation of untied funds to CHC Kralpora was Rs 50000 during year 2007-08 and the available fund at CHC Kralpora was fully utilised. The same amount of Rs 50000 was again allocated as untied fund to CHC Kralpora during the year 2008-09 and 2009-10 respectively. Out of the available fund, the CHC Kralpora utilised the full amount during the same years. However there has been decline in the utilization of these untied funds to the CHC Kralpora as the CHC received an untied fund of Rs 50000 and the utilisation was Rs 31360 (62.72%) during the year 2010-11. There was significant decline in the allocation of untied fund to CHC Kralpora as the CHC had received only an amount of Rs 25658 during year 2011-12 while the utilisation during the same year was Rs 44007 (99.34%) out of total available fund of Rs 44298. Again the CHC Kralpora did not receive the stipulated amount of untied fund during year of 2012-13 and there was significant decline in the allocated amount during 2013-14. The CHC Kralpora received an amount of Rs 30014 and Rs 6000 as untied fund during the year 2012-13 and 2013-14 respectively while the utilisation of the available untied fund of Rs 30305 was fully utilised during 2012-13. However the CHC Kralpora had not utilised the allocated untied fund of Rs 6000 till the end of year 2013. The total allocation of untied funds of CHC Khanyar of Srinagar district found to be higher at

Rs 322000 than that of CHC Kralpora of Kupwara district at Rs 261672 during the years 2007-08 to 2013-14.

The cause of this unspent fund was due to late allocation and delay in approval from the Rogi Kalyan Samithi (RKS).

TABLE 4.6 Financial performance of Annual maintenance Grant of Community Health Centres of Srinagar and Kupwara districts

Year	CHC Khanyar Non -high focus District (Srinagar)				CHC Kralpora High focus District (Kupwara)			
	Allocation	Available funds	Utilization	Unspent	Allocation	Available fund	Utilization	Unspent
2007-08	100000	100000	0 (0%)	100000	100000	100000	100000 (100%)	0
2008-09	100000	200000	0 (0%)	100000	100000	100000	100000 (100%)	0
2009-10	100000	300000	0 (0%)	100000	100000	100000	100000 (100)	0
2010-11	100000	400000	400000 (100%)	0	100000	100000	100000 (100%)	0
2011-12	100000	100000	100000 (100%)	0	69535	69535	69535 (100%)	0
2012-13	100000	100000	100000 (100%)	0	64000	64000	64000 (100%)	0
2013-14	43000	43000	nil (0%)	43000	7000	7000	Nil (0%)	7000
Total	643000		600000		540535		533535	

Source: Office of Medical Superintendent CHC Khanyar, BMO office Kralpora.

*The data in parentheses shows percentage utilisation of available fund

Table 4.6 reveals that the Community Health Centre (CHC) Khanyar received an Annual Maintenance Grant of Rs 100000 per year except during the year of 2013-14. However the Annual Maintenance Grant was not utilised till the year 2009-10 and the whole amount remained unspent. The utilisation of Annual Maintenance Grant at the CHC Khanyar was Rs 400000 (100%) out of the available fund during year 2010-11. Similarly the utilisation of Annual Maintenance Grant at CHC Khanyar was 100% out of the available Annual Maintenance Grant during the years of 2010-11, 2011-12 and 2012-13. However there was decline in the allocation of Annual Maintenance Grant during the year 2013-14 as the CHC Khanyar received only Rs 43000 and the funds were not utilized till the end of year 2013.

It is evident from table 4.6 that the Community health Centre (CHC) Kralpora received an Annual Maintenance Grant of Rs 100000 per annum from 2007-08 to 2010-11 and the same was fully utilised during these years. The CHC Kralpora received an allocated Annual Maintenance Grant of Rs 69535 during the year 2011-12 which was less than the actual allocation of Annual Maintenance Grant of Rs 100000 per annum given to CHCs. The Utilization of these funds during the same year was 100%. The fund allocation under Annual Maintenance Grant to the CHC Kralpora was Rs 64000 during 2012-13 which was fully utilized during the same period. Thereafter there was significant decline in the allocation of Annual Maintenance Grant to the CHC Kralpora of Rs 7000 which comprises only 7% of actual allocated fund under Annual Maintenance Grant. However, even this fund was not utilised till December 2013.

Thus it can be concluded from the given data that there was disparity in the allocation of Annual Maintenance Grant between CHCs of high focus district and non-high focus district as the stipulated allocation to CHC Khanyar was 100% even witnessing nil utilisation during 2007-08 to 2010-11 whereas the allocation to CHC Kralpora was diminished during 2011-12 even after registering the full utilisation during the preceding year 2010-11 and again during 2011-12 and 2012-13.

TABLE 4.7**Financial Performance of Untied Funds of Primary Health Centres (PHCs) of Srinagar and Kupwara district**

(Amt. in Rs)

Year	PHC Hazratbal Non- high focus District (Srinagar)				PHC Panzgam High focus District (Kupwara)			
	Allocation	Available	Utilization (percent)	Unspent	Allocation	Available	Utilization (percent)	Unspent
2007-08	NG	NG	NG	NG	25000	25000	23200 (92.88%)	1800
2008-09	25000	25000	15000 (60%)	10000	25000	26800	13000 (48.51)	13800
2009-10	25000	35000	35000 (100%)	0	25000	38800	18000 (46.39)	20800
2010-11	25000	25000	25000 (100%)	0	25000	45800	16000 (34.93)	29800
2011-12	25000	25000	25000 (100%)	0	NG	29800	26017 (87.31)	3783
2012-13	25000	25000	25000 (100%)	0	20000	23783	12000 (50.45)	11783
2013-14	10750	10750	nil [#] (0%)	10750	7000	18783	nil [#] (0%)	18783
Total	135750		125000		127000		108217	

Source: BMO office Hazratbal, NRHM office PHC Panzgam.

shows as on January 2014.

The data in parentheses shows percentage utilisation of available funds.

NA means not available. NG means not given.

Table 4.7 shows that the allocation of untied funds has been decentralized at Primary Health Centre Hazratbal during 2008-09 and has been uniformly given

each year except during 2013 -14 in which it declined to Rs 10750. At this Primary Health Centre Hazratbal, the utilisation made out of total available untied fund was Rs 15000 (60%) during 2008-09. The total available untied fund at Primary Health Centre Hazratbal was Rs 35000 which was fully utilized during 2009-10. The PHC Hazratbal got an allocated untied amount of Rs 25000 per year during 2010-11, 2011-12 and 2012-13 and the amount was fully utilised every year. However there was an allocation of untied fund to Primary Health Centre Hazratbal at Rs 10750 during 2013-14 which remained unutilised till December 2013.

The PHC Panzgam got an allocation of untied funds from the year 2007-08. This Primary Health Centre received the stipulated amount given under NRHM up to the financial year of 2010-11. There after, there was no allocation of untied fund during the financial year 2011-12 and it declined during 2012-13 and 2013-14. The Primary Health Centre Panzgam has received an amount of Rs 20000 and Rs 7000 during the year 2012-13 and 2013-14 respectively. So far as utilisation is concerned, Primary Health Centre Panzgam utilised Rs 23200 (92.88%) out of the available funds during the year 2007-08. The utilisation was Rs 13000 (48.51%) out of total available fund of Rs 26800 during 2008-09 whereas the utilisation of this untied fund was Rs 18000 (46.39%) of the available fund during financial 2009-10. The available amount of untied fund with the Primary Health Centre Panzgam was Rs 45800 during 2010-11 and utilisation was Rs 16000 (34.93%). There was no allocation of untied fund to PHC Panzgam during 2011-12. However Primary Health Centre utilised Rs 26017 (87.31%) of the available untied fund of Rs 29800 during the same year. The PHC Panzgam made the utilization of Rs 12000 (50.46%) of the available fund of Rs 23786 during the year 2012-13. There was no utilization of untied fund during the financial year 2013-14.

According to Block Accounts Manager, the main reason for this unutilized amount was in its late allocation. The funds were generally released at the end of financial year.

TABLE 4.8**Financial Performance of Annual Maintenance Grant (AMG) of Primary Health Centres of Srinagar and Kupwara district**

(Amt. in Rs)

Year	PHC Hazratbal Non high focus District (Srinagar)				PHC Panzgam High focus District (Kupwara)			
	Allocation	Available	Utilization (percent)	Unspent	Allocation	Available	Utilization (percent)	Unspent
2007-08	NR	NR	NR	NR	50000	50000	32000 (64)	18000
2008-09	50000	50000	10000 (20)	40000	50000	68000	16000 (23.53)	52000
2009-10	50000	90000	90000 (100)	0	50000	102000	28000 (27.45)	74000
2010-11	50000	50000	50000 (100)	0	50000	124000	36000 (29.03)	88000
2011-12	50000	50000	50000 (100)	0	NR	88000	51319 (58.32)	36681
2012-13	50000	50000	50000 (100)	0	30000	66681	21000 (31.49)	45681
2013-14	17200	17200	nil [#] (0%)	17200	5000	50681	nil [#] (0%)	50681
Total	267200		250000		235000		184319	

Source: BMO office Hazratbal, NRHM office PHC Panzgam.

NR means not received. # indicates up to January 2014.

The data in parentheses shows utilisation percentage of available Annual Maintenance Grant

As given in table 4.8, Primary Health Centre Hazratbal got an allocation of Annual Maintenance Grant of Rs 50000 per annum from 2008-09 to 2012-13. However there was decline in the allocation of Annual Maintenance Grant at Rs 17200 during 2013-14. The PHC Hazratbal utilised only Rs 10000 (20%) out of available Annual Maintenance Grant during the year 2008-09. The PHC Hazratbal was

given an Annual Maintenance Grant of Rs 50000 and the available Annual Maintenance Grant with Primary Health Hazratbal was Rupees 90000 during 2009-10 and this Available fund of Annual Maintenance Grant was fully utilised during the same year. The Primary Centre Hazratbal received the stipulated amount of Rs 50000 during the years 2010-11 to 2012-13 and the same was fully utilised during these years. However, there was a significant decline in the allocation of Annual Maintenance Grant to PHC Hazratbal at Rs 17200 during 2013-14. This available Annual Maintenance Grant were not utilized and remained unspent till 31 December 2013. .

The Primary Health Centre (PHC) Panzgam received the stipulated amount of Rs 50000 per annum from 2007-08 to 2010-11. Thereafter, there was a significant decline in the specified amount during the financial year 2012-13 and 2013-14 respectively. The utilisation at the PHC Panzgam was Rs 32000 (64%) of the available fund of Rs 50000 during the year 2007-08. The available fund with the PHC Panzgam was Rs 68000 and the utilisation was Rs 16000 (23.52%) during year 2008-09. Similarly, the utilisation of Annual Maintenance Grant at PHC Panzgam was Rs 28000 (27.45%) out of total available Annual Maintenance Fund of Rs 102000 during 2009-10. The available Annual Maintenance Grant with Primary Health Centre Panzgam was Rs 124000 and utilisation was only Rs 36000 (29.03%) during 2010-11. There was no allocation of Annual Maintenance Grant to PHC Panzgam during 2011-12. However, the PHC Panzgam utilised Rs 51319 (58.32%) out of the available fund of Rs 88000 during the same year. There was decline in the allocation of Annual Maintenance Grant at Rs 30000 and Rs 5000 to PHC Panzgam during 2012-13 and 2013-14 respectively. The PHC Panzgam utilised an Annual Maintenance Grant of Rs 21000(31.49%) during 2012-13. However, the allocated and available funds of Annual Maintenance Grant of Rs 5000 had remained unutilised till 31 January 2014.

All in all, the financial performance of PHC Hazratbal was relatively better than the financial performance of PHC Panzgam.

TABLE 4.9**Financial Performances of untied funds of Sub Centres of Srinagar and Kupwara district**

(Amt. in Rs)

Year	SC Shanpora Habak Non- high focus District (Srinager)				SC Chowkibal High focus District (Kupwara)			
	Allocation	Available funds +	Utilization (percent)	Unspent	Allocation	Available funds	Utilization (percent)	Unspent
2008-09	10000	10000	8813 (88.13)	1187	10000	10000	10000 (100)	0
2009-10	10000	11187	7901 (70.63)	3286	10000	10000	10000 (100)	0
2010-11	10000	13724	13121 (95.61)	603	10000	10000	10000 (100)	0
2011-12	10000	11179	10600 (94.82)	579	5000	5000	5000 (100)	0
2012-13	9395	10000	9744 (97.44)	226	NR	NR	NR	NR
2013-14	1900	2223	nil (0%)	2223	1000	1000	nil (0%)	1000
Total	51295		50179		36000		35000	

Source: ANM Sub Centre Shanpora, ANM Sub Centre Chowkibal

NR (not received) indicates no allocation of untied funds to Sub Centre.

+ shows the available amount with rate of interest.

indicates up to January 2014.

The data in parentheses shows percentage utilisation of available fund.

Table 4.9 reveals the Sub Centre Shanpora Habak received the amount of untied fund at rate of 10000 per annum from 2008-09 to 2011-12 and after that there was a decline in allocation to this Sub- Centre. The Sub Centre Shanpora

received Rs 9395 and Rs 1900 as untied fund during 2012-13 and 2013-14 respectively. The Sub Centre Shanpora utilised Rs 8813 (88.13%) out of available untied fund of Rs 10000 during the year 2008-09. The utilisation of available funds at Rs 11187 at the Sub -Centre Shanpora was Rs 7901(70.63%) during 2009-10. Similarly, the utilisation of untied fund by Sub Centre Shanpora was Rs 13121 (95.61%) out of available fund of Rs 13724 during 2010-11. The Sub centre Shanpora utilised Rs 10600 (94.82%) out of total available untied fund of Rs 11179 during 2011-12. The utilisation of untied fund at Sub centre Shanpora was Rs 9744 (97.44%) out of available untied fund of Rs 10000 during 2012-13. The allocated amount of untied fund of Rs 1900 remained unspent till the end December 2013.

Sub centre Chowkibal received the full allocation of untied fund up to the year 2010-1, thereafter, there was 50% decline in allocation during the year 2011-12. There was no allocation of untied fund to Sub Centre Chowkibal during year 2012-13 and again there was 90% reduction in allocation of untied fund during 2013-14. On utilisation side, Sub -Centre Chowkibal made full utilization of this untied fund per annum from 2008-09 to 2011-12. However, the available untied fund of Rs 1000 remained unutilised till December 2013.

Thus the given data shows the gap in the allocation of stipulated amount of Rs 10000 per annum to every Sub- centre as the decline in allocation was more at Sub- Centre Chowkibal as compared to Sub- Centre Shanpora even after recording 100% utilisation during all the years.

TABLE 4.10**Financial Performance of untied funds of Sub Centres of Srinagar and Kupwara district**

Year	SC Nandpora Non high focus District (Srinager)				SC Aloosa Block High focus District (Kupwara)			
	Allocation	Available ⁺	Utilization (percent)	Unspent	Allocation	Available	Utilization (percent)	Unspent
2008-09	20000	20000	14681 (73.41)	5319	NG		NG	NG
2009-10	10000	17900	17520 (97.88)	380	10000	10000	10000 (100)	0
2010-11	10000	10380	8700 (83.82)	1680	10000	10000	10000 (100)	0
2011-12	10000	11927	11630 (97.51)	297	5000	5000	10000 (100)	0
2012-13	9686	10207	9617 (94.22)	590	5000	5000	5000 (100)	0
2013-14 [#]	2100	2690	nil [#] (0)	2690	3000	3000	nil [#] (0)	3000
Total	61786				33000			

Source: ANM Sub Centre Nandpora, ANM Sub Centre Aloosa.

Note: # shows available of untied fund as on December 2013.

+ shows the available amount with rate of interest. The data in parentheses shows percentage utilisation of available funds

Table 4.10 shows that there has been a variation in the allocation of untied funds to both SCs of selected Districts. The Sub Centre Nandpora of District Srinager got an allocated amount of Rs 20000 during 2008-09 which is double than the specified amount given under National Rural Health Mission per Sub Centre. Out of this allocated untied fund, the Sub Centre Nandpora utilised Rs 14681 (73.41%)

during 2008-09. Sub Centre Nandpora got an allocation of specified fund of Rs 10000 per annum during 2009-10, 2010-11 and 2011-12 while the utilisation was Rs 17520 (97.88%), Rs 10380 (83.89%) and Rs 11630 (97.51%) during the same years respectively. However, Sub centre Nandpora received untied fund of Rs 2100 and the whole amount remained unspent during the year 2013-14.

Sub centre Aloosa of Kupwara district did not receive the allocated amount of untied fund during 2008-09 as the Sub centre Aloosa was not registered as Sub centre till 2008-09. The Sub centre Aloosa got full allocation of untied fund only during 2009-10 and 2010-11 respectively. However, there was 50% decline in the allocation of untied fund to Sub centre Aloosa during 2011-12 and 2012-13 and 70% decline in the allocated untied fund during 2013-14. The utilisation rate of this allocated untied fund was 100% per annum during all the years except during 2013 in which the allocated amount remained unspent due to late allocation.

By summarizing the above given data, it can be revealed that financial performance was relatively better at Sub- Centre Aloosa as compared to Sub-Centre Nandpora. However, the allocation of stipulated amount of Rs 10000 per annum was not given to Sub- Centre Aloosa of high focus district Kupwara during 2011-12 to 2013.

SECTION— C

PERFORMANCE OF INSTITUTIONAL DELIVERIES AND INFRASTRUCTURAL DEVELOPMENT

This section attempts to analyse the performance of NRHM in promoting institutional deliveries as well as infra structural development of three tier health care centres.

TABLE 4.11

Institutional deliveries in Srinagar and Kupwara district during 2008-1012.

Year	Non- high focus (District Srinager)		High focus District (Kupwara)	
	Institutional deliveries#	Percentage change	Institutional deliveries	Percentage change
2008	31497	0	6653	0
2009	29768	-5.49	7857	18.10
2010	26121	-12.25	9979	27.01
2011	24839	-4.91	10601	6.23
2012	30498	22.78	7920	-25.29
Total	142723		43010	
Growth rate	-3.17		19.04	

Source: Performance Review 2011 and 2013, Department of Health and Family welfare, Government of Jammu and Kashmir.

Total institutional deliveries including Institutional deliveries of both Public as well as Private institutions.

Table 4.11 shows the institutional deliveries in Srinagar and Kupwara districts from 2008 to 2012. In case of non- high focus district Srinagar the total institutional deliveries are more than three times the institutional deliveries of high focus district Kupwara. The institutional deliveries had shown declining trend during 2008 to 2011 and thereafter there was 22.78% increase in institutional deliveries during 2012 while the institutional deliveries showed an increasing trend from 2008 to 2011 in Kupwara district. Later, it declined by -25.29% during 2012. The highest institutional deliveries in case of high focus district Kupwara was during 2011 in which the institutional deliveries were 10601. The growth rate of

institutional deliveries in case of Srinagar district is negative whereas in case of Kupwara district it has witnessed growth rate of 19.04% during 2008-12 respectively. The reason of negative growth rate in institutional deliveries in case of Srinagar district may be due to improvements in health care system in other Districts that reduced the workload of institutional deliveries in Srinagar district which is the hub of health institutions in Kashmir division of Jammu and Kashmir State.

Janani Suraksha Yojana (JSY) scheme has been the first ever innovative scheme implemented through NRHM to promote institutional deliveries in order to stabilise IMR and MMR at state level as country level. To promote more and more institutional deliveries under this scheme a beneficiary is given Rs 1400 in case of rural areas and Rs 1000 per delivery in case of urbanised area.

TABLE 4.12

Total Institutional deliveries and JSY beneficiaries in Srinagar and Kupwara districts during 2008-12

Indicator	District Srinager (Non- high focus District)	District Kupwara (High focus District)
Institutional deliveries under JSY	50495	43010
JSY beneficiaries	8960	32367
Percentage of JSY beneficiaries	17.74	75.25

Source: Performance Review 2011 and 2013, Department of Health and Family welfare, Government of Jammu and Kashmir.

Note: Total institutional deliveries only Public health institutions.

.Table 4.12 reveals the total institutional deliveries under JSY and percentage of beneficiaries benefited under JSY scheme of National Rural Health Mission during 2008 to 2012. The total number of institutional deliveries in case of non –high focuses District Srinager during 2008 to 2012 was 50495 while total number of JSY beneficiaries was 8960. Thus the percentage of JSY beneficiaries to total deliveries under JSY was only 17.74%. On the other hand, the total institutional

deliveries during 2008 to 2012 in case of high focus District Kupwara were 43010 and total JSY beneficiaries were 32367 which constitute 75.25% of institutional deliveries.

The reason behind this gap between institutional delivery under JSY and JSY beneficiaries is that they face difficulties in fulfilling the formalities, many visits to office which refrains them from receiving their benefits/ incentives given to them under the scheme.

TABLE 4.13

Institutional deliveries at Block level of two Districts.

Year	Block Hazratbal Srinagar district	Block Kralpora Kupwara district
2008	0	344
2009	0	566
2010	0	904
2011	16	694
2012	52	903
Total	68	3411

Source: Performance Review 2011 and 2013, Department of Health and Family welfare, Government of Jammu and Kashmir.

It is evident from table 4.13 that the total institutional deliveries were 3411 in block Kralpora of Kupwara district as compared to 68 in Block Hazratbal of Srinagar district. The reason behind a big gap in institutional deliveries between these two blocks of two different districts was availability of alternative health care facilities. block Kralpora has difficult terrain and is far-flung block of Kupwara district .The block has no private health institution and most of the population belongs to rural areas and are not in position to travel to developed private health care facilities. Contrary to this, Hazratbal block of Srinager district has relatively less number of institutional deliveries due to the fact that Srinager district has well developed public health care facilities besides having tertiary health care facilities and large numbers of Private Nursing Homes are centralized in this central district of Jammu

and Kashmir. Moreover, the District has highest percentage of urban population who are able to have access to private health care facilities.

To improve the institutional deliveries conducted at the PHCs and CHC level, it is envisaged under NRHM that all the Primary Health Centres having population of 20,000-30,000 population and Community Health Centre having population of 80000- 120000 should function 24x7 in a phased manner.

TABLE 4.14

Institutional deliveries in CHCs and PHCs of the selected Districts

Year	Srinagar District		Kupwara District	
	CHC Khanyar	PHC Hazratbal	CHC Kralpora	PHC Panzgam
2008	44	0	258	25
2009	88	0	475	35
2010	104	0	725	81
2011	231	16	418	137
2012	310	52	324	147
2013*	225	63	471	53
Total	1002	131	2671	478

Source: Performance Review, Department of Health and Family Welfare, J&K.

* NRHM office CHC Gousia, CHC Kralpora, PHC Hazratbal, PHC Panzgam,

#shows institutional deliveries up to December 2013.

Table 4.14 shows an increasing trend in the institutional deliveries at CHC Khanyar from 2008 to 2012. However, the deliveries declined by 27.41% during 2013. CHC Kralpora shows a mixed trend in Institutional deliveries. However, the institutional deliveries at Community Health Centre and Primary Health Centre level of Kralpora block were relatively higher (2671 and 478) respectively than that of Hazratbal block (1002 and 131) respectively. PHC Hazratbal has shown increasing trend in their institutional deliveries. At PHC level, the total number of 478 institutional deliveries were recorded at PHC Panzgam while at Primary Health Centre Hazratbal 131 institutional deliveries were recorded during 2008 to 2012. The reason behind this difference is that people at CHC Kralpora and PHC

Panzgam have no other options of healthcare facilities other than these institutions. Moreover they do not the easy access to District health care facilities or private health care facilities. On the contrary CHC Khanyar and PHC Hazratbal covers urban areas of central Srinagar District. The District has 19 private nursing homes and people generally use these health care centres as they have sound economic conditions and easy access to these health care sector.

TABLE 4.15

Physical infrastructure of Community Health Centres (CHCs) in the Srinagar and Kupwara districts

CHC Khanyar Non- high focus District(Srinagar)		CHC Kralpora High focus District (Kupwara)
Type of Building	Government	Government
Condition of Building	Good	Poor
Population cover	51000	91000
Number of OPD rooms	01	03
Specialists room	06	0
Minor OT	01	01
Major OT	01	0
Number of beds	30	12
Ambulance	02	01
Water supply	Yes	Yes (inadequate)
Electricity	Yes	Yes
Toilet	08	02*
Blood bank	No	No
Fair price shop	No	No

Source: Office of Medical Superintendent CHC Gousia Khanyar, Srinager.

BMO Office Kralpora, Kupwara.

*indicates that Toilets are jointly used by men and women.

Table 4.15 shows that both the Community health centres cover population as per Indian Public Health Standard Norms. CHC Khanyar of Srinagar

district has better physical infrastructure than that of CHC Kralpora of high focus District Kupwara. CHC Khanyar has the facility of both the minor OT as well as Major OT while CHC Kralpora has only minor OT facility. Bed occupancy of the CHC Khanyar is 30 while that of CHC Kralpora of high focus District is not functioning as per the norms of Indian Public Health Standard as the bed occupancy of the CHC is only 12. The CHC Kralpora has also inadequate water supply facilities and insufficient toilet facilities. Despite the fact that CHC Kralpora is high focus, its physical infrastructure is still unsatisfactory.

TABLE 4.16

Physical infrastructure of Primary Health Centres (PHCs) in the Srinagar and Kupwara districts

PHC Hazratbal Non -high focus District(Srinagar)		PHC Panzgam Kralpora High focus District (Kupwara)
Type of Building	Government	Government
Condition of Building	Good	Good
Population cover	9528	6000
Number of OPD rooms	03	01
Minor OT	01	No
Major OT	No	No
Number of beds	06	10
Ambulance	01	01
Water supply	Yes	Yes
Electricity	Yes	Yes
Toilet	02	04
Fair price shop	No	No

Source: BMO Office Hazratbal, Srinager. M.O.PHC Panzgam.

As per table 4.16, the physical infrastructural facilities at both the PHCs were adequate. PHC Panzgam of Kupwara district has 10 bed facility while bed occupancy of PHC Hazratbal of Srinagar district has 06 bed facility. Both the PHCs have adequate water supply as well as electricity facilities.

TABLE 4.17**Physical infrastructure of Sub Centres in Srinagar and Kupwara districts**

Non -high focus District Srinagar			High focus district Kupwara	
Sub Centres			Sub Centres	
Nandpora		Shanpora	Chowkibal	Aloosa
Type of building	Private	Private	Government	Government
Number of rooms	02	04	04	03
Toilet	Yes	No	Yes	Yes
Water supply	Yes	No	Yes	No
Electricity	Yes	No	No	No
Availability of medicine	Rare	Rare	Rare	Rare

Source: ANM Nandpora, Hazratbal block Srinager, ANM Chowkibal, Kralpora block Kupwara, ANM Shanpora, Hazratbal block Srinager, ANM Aloosa, Kralpora block Kupwara.

As per table 4.17 the two selected Sub centres of (Nandpora and Shanpora) of Srinagar districts and (Chowkibal and Aloosa) are not physically developed as per Indian Public Health Standard (IPHS). Both the Sub centres of non high focus District Srinagar are functioning in private building. Sub centre Nandpora has 02 rooms while Sub centre Shanpora has 04 rooms and facility of electricity is available only in Nandpora Sub centre. Both the Sub centres of high focus District Kupwara are functioning in Government building and the number of rooms is 04 and 03 respectively. However the facility of electricity was not available at both the Sub centres of Kupwara district. To top it all, Aloosa Sub centre did not have even the facility of water supply.

SECTION – D

MANPOWER POSITION AFTER NRHM

Health manpower is the key in making the health centres functional. The mission of the NRHM was to reduce health inequality among rural and urban areas by increasing the number of health man power in rural areas to the level of Indian Public Health Standard. The following table shows the gap in man power in the non high focus District Srinagar and high focus District Kupwara.

TABLE 4.18

Health man power position in the Srinagar and Kupwara districts of Jammu and Kashmir

Health man power	Srinagar District (Non- high focus District)				Kupwara District (High focus District)			
	Sanctioned	In Position	Shortfall	% of shortfall	Sanctioned	In Position	Shortfall	% Shortfall
Assistant Surgeons	86	81	5	5.81	150	105	45	30
Dental surgeons	18	18	0	0	42	26	16	38.10
Gynae	4	3	1	25	10	0	10	100
Pediatrician	3	2	1	33.33	6	2	4	66.67
Anatheist	3	2	1	33.33	10	4	6	60
Other specialists*	17	13	4	23.53	12	4	8	66.67
Pharmacist	556	508	48	8.63	1322	976	346	26.17
FMPHW	32	30	2	6.25	207	196	11	5.31
MMPHW	3	3	0	0	23	8	15	65.22

TABLE 4.18 Contd.

Lab Technician	23	23	0	0	48	37	11	22.92
OT	10	7	3	30	15	95	80	533+
X-ray Technician	15	15	0	0	35	21	14	40
LHV	2	1	1	50	8	5	3	37.50
Total	772	706	66	8.55	1888	1479	569	21.67

Source: Performance Review 2013, Department of Health and Family welfare, Government of Jammu and Kashmir.

Note: + indicates surplus. * includes Orthopedics, Ophthalmologist, ENT specialists.

Table 4.18 shows the Health Manpower position in the Srinagar (non- high focus) and Kupwara district (high focus). The percentage shortfall of Health manpower in Srinager district was 8.55% whereas it was 21.67% in Kupwara District. The shortfall of Health manpower was 100% in Gynaecologist in Kupwara District while it was only 25% in Srinager District. For Pediatrician and other specialists the percentage shortfall is 67.67% each in Kupwara District while as it was 33.33% and 76% respectively in Srinager District. There was zero percent shortfall of Dental surgeons in case of Srinagar District while 38.10% in Kupwara District. Shortfall of Anesthetist was 33.33% in Srinager and the same shortfall was 60% in Kupwara District. In case of Para medical staff such as MMPHW, Lab technician and X- ray technician, there was no shortfall in Srinagar district while in Kupwara district, the shortfall was 65.22%, 22.92% and 40% respectively. The shortfall of Pharmacist was 9% in Srinager District and 26% in Kupwara District. It is to be mentioned that the only surplus manpower was recorded in Operation Theatre attendant (OT) in case of Kupwara District whereas there was shortfall of 30% in case of Srinagar District.

All in all the shortfall of health manpower still persists even after the full completion of first journey of NRHM (2005-2012) and this shortfall exists in both the Districts of Srinagar and Kupwara. The mission of NRHM has not been achieved yet as the health manpower inequity still persists between urban and rural areas. No doubt NRHM has generated the man power but still it is inadequate.

Community Health Centre is the first level of health centre supplied having many health specialists. CHC acts a referral unit to 4 PHCs. Indian Public Health Standard (IPHS) provides the norms for positioning of health manpower at CHCs, PHCs and SCs. There is a provision under NRHM for appointment of specialists on contractual basis and even appointment of retired specialists making the specialist cadre in the State. There should be a Public Health Programme Manager, Eye Surgeon and nine Nurses /Midwives / Staff Nurses on contractual basis. For first referral units (FRUs) NRHM provides for the engagement of two medical officers (MBBS), two staff nurses, two OT technicians, two X-ray technicians and two laboratory technicians.

Table 4.19

Health man power positions at the Community Health Centres (CHCs) of the two Districts as on January 2014

Health Man Power	Manpower as per IPHS	CHC Khanyar Non- high focus (District Srinagar)			CHC Kralpora High focus District (Kupwara)		
		Position	rplus Shortfall/su	% shortfall	Position	Shortfall	% shortfall
Administrative staff	01	01	0	0	01	0	0
GDMO	02	07	05 ⁺	250 ⁺	04	02 ⁺	100 ⁺
Physician	01	01	0	0	0	01	100
Surgeon	01	01	0	0	01	0	0
Gynaecologist	01	01	0	0	0	01	100
Pediatrician	01	01	0	0	0	01	100
Dental surgeon	01	03 ⁺	02 ⁺	200 ⁺	0	01	100
Ophthalmologist	01	01*	0	0	0	01	100
Anaesthist	01	01	0	0	0	01	100
AYUSH	01	0	01	100	0	01	100
Community Health Officer	01	0	01	100	-	01	100
Ophthalmic assistant	01	01	0	0	01	0	0
X-ray tech.	01	02	01 ⁺	100 ⁺	03	02 ⁺	100 ⁺
Staff Nurse	10	07	03	30	08	02	20
FMPHW	01	02	01 ⁺	100 ⁺	02	01 ⁺	100 ⁺
Pharmacist	01	03	02 ⁺	200 ⁺	02	01 ⁺	100 ⁺
Lab Technician	02	03	01 ⁺	50	03	01 ⁺	50
Block Accounts Manager [#]	01	01	0	0	01	0	0
Block Monitoring and Evaluation officer Manager [#]	01	01	0	0	01	0	0

Source: office of Medical Super indent CHC Khanyar, Srinager, BMO office Kralpora, CMO office Kupwara, District NRHM office Kupwara

indicates posts sanctioned under NRHM

Table 4.19 reveals the gap in manpower even after the completion of first period (2005-12) of NRHM. At CHC Khanyar the shortfall occurs only in AYUSH man power with 100% shortfall, whereas there was 100% shortfall of manpower at CHC Kralpora as per Indian Public Health Standard for Physician, Gynaecologist, Dental surgeon, Anaesthist, Pediatrician, Ophthalmologist and in AYUSH man power. However, there occurs surplus of man power at both the CHCs as per Indian Public Health Standard and NRHM norms. This surplus (250%) in General Duty Medical Officers (GDMO) was at Community Health Centre Khanyar while it was surplus is 100% at CHC Kralpora. Surplus of manpower also existed in Lab Technician, Pharmacist and FMPHW at both the Community Health Centres. However, in case of Staff Nurses, the shortfall was 20% at CHC Kralpora and 30% at Community Health Centre Khanyar. It may be noted that the surplus that exists in Medical officers, Lab Technician and X-ray technician is due to their contractual appointment under NRHM. All in all there still exists disparity in positioning of man power at CHCs as per Indian Public Health Standard among the selected Public health care centres. The mission of NRHM was to reduce disparity between Urban-Rural Public health care sectors through augmentation of the health man power in high focus Districts. However, there still exists shortfall of manpower especially at specialists' level in high focus district of Kupwara.

Primary Health Centre acts as a first link between the community and a medical officer. Every PHC acts as referral unit for 6 Sub centres. For 24×7 PHC, NRHM envisages additional man power engagement including one medical officer (MBBS), two staff nurses, one laboratory technician.

TABLE 4.20

Health Manpower positions at the Primary Health Centres (PHCs) of Srinagar and Kupwara districts as on January 2014

Health Man Power	IPHS	PHC Hazratbal Block Hazratbal (Non-high focus District)			PHC Panzgam Block Kralpora (High focus District)		
		Position	Shortfall	% shortfall	Position	Shortfall	% Shortfall
GDMO	02	01	01	50	01	01	100
Dental surgeon	01	01	0	0	0	01	100
AYUSH Doctor	-	01	0	0	01	0	0
LHV	01	01	0	0	0	01	100
Staff Nurse	03	01	02	33.33	0	03	100
FMPHW	01	0	100	700 ⁺	01	0	0
Pharmist	01	05	04 ⁺	400 ⁺	01	0	0
Health educator	01	02	01 ⁺	100 ⁺	0	01	100
Lab Technician	01	03	02 ⁺	200	0	01	100

Source: BMO office Hazratbal Srinagar, BMO office Kralpora, CMO office Kupwara.

+ shows surplus of manpower

Table 4.20 shows the gap in manpower at the selected PHCs of the two Districts as per Indian Public Health Standard. Over all there was an acute shortfall of manpower at PHC Panzgam as compared to PHC Hazratbal. However, there was shortfall of 100% in both the Primary Health Centres. The shortfall of manpower at Primary Health Centre Panzgam as per Indian Public Health Standard norms is 100% in Staff nurses, LHV, Lab technicians and health educator. Moreover Primary Health Centre Panzgam also has 50% shortfall of GDMO and Dental surgeon. The above analysis shows that the implementation of National Rural Health Mission has not fulfilled its objectives in these health centres in terms of strengthening the PHCs as per Indian Public Health Standard.

TABLE 4.21

Health Manpower position at Sub Centres of Srinagar and Kupwara district as on January 2014

Health Man Power	IPHS	Sub Centre Shanpora Habak Block Hazratbal Non-high focus District (Srinager)			Sub Centre Chowkibal Block Kralpora High focus District (Kupwara)		
		Position	Shortfall	% shortfall	Position	Shortfall	% Shortfall
ANM	2	1	01	50	1*	01	50
BHW [#]	-	1	-	0	-	-	-
Pharmacist [#]	-	-	-	-	1	-	-
Health Man Power	IPHS	Block Hazratbal Sub Centre Nandpora Non high focus District(Srinagar)			Block Kralpora Aloosa High focus District (Kupwara)		
		Position	Shortfall	% shortfall	Position	Shortfall	%shortfall
ANM	2	2	0	0	1	1	50
Pharmacist [#]	-	-	-	-	1	01 ⁺	0
MMPHW	01		01	100	1	0	0

Source: ANM Nandpora, Hazratbal block Srinagar, ANM Chowkibal, Kralpora block Kupwara, ANM Shanpora, Hazratbal block Srinager, ANM Aloosa, Kralpora block Kupwara.

Note: # means posts not recommended by IPHS

Table 4.21 clearly depicts that none of the selected sub centre has health manpower position as per Indian Public Health Standard. However, sub centre Shanpora Habak of Block Hazratbal has in position a Basic Health Worker (BHW) and Sub Centre Chowkibal of Block Kralpora has Pharmacist in position in addition

to Auxiliary Nurse Midwife (ANM). However, all the Sub centres except Nandpora had one ANM in position as against the IPHS of two ANMs per Sub centre.

PRIMARY SURVEY ANALYSIS

The major focus of National Rural Health Mission is on mother and child health care. The performance of NRHM mainly depends up on the level of reduction of Maternal mortality rate and infant mortality rate which is possible through institutional deliveries that in turn is depends on the level of human as well as physical infrastructure available at the health centres. To promote more institutional deliveries, there is provision under NRHM to appoint one ASHA per thousand population who will promote health care facility at door steps of community and acting as a link between the community and nearby health centre.

TABLE 4.22

Source of awareness of JSY beneficiaries about JSY in Srinagar and Kupwara districts

Awareness through	Block Hazratbal (Non high focus District)	Block Kralpora (High focus District)	Total
ASHA	17 (56.7%)	18 (60%)	35 (58.33%)
Media	02 (6.67%)	08 (26.67%)	10 (16.67%)
At Hospital	07 (23.33%)	02 (6.67%)	09 (15%)
Relatives	02 (6.67%)	01 (3.33%)	03 (5%)
Neighbors	02 (6.67%)	01 (3.33%)	03 (5%)
Total	30	30	60

Table 4.22 depicts the source of awareness of JSY beneficiaries about JSY in the selected blocks. As per the sample of JSY beneficiaries, ASHA as the source of awareness about JSY was reported by 56.67% and 60% of beneficiaries

in Hazratbal and Kralpora blocks respectively. Two JSY beneficiaries (6.67%) from Hazratbal block and 8 (26.67%) from Kralpora block came to know about the scheme through the media. Seven JSY beneficiaries (23.33%) of the selected JSY beneficiaries in Hazratbal block and 6.67% in Kralpora block came to know about this scheme from hospital. 6.67% and 3.33% of JSY beneficiaries knew about the scheme through relatives in Hazratbal block and Kralpora block respectively. To sum up, ASHAs and media turned out to be the major source of awareness about JSY among JSY beneficiaries.

Table 4.23 Different characteristics of Accredited Social Health Activist (ASHAs) in Srinagar and Kupwara districts

Hazratbal Block (Srinagar)		Kralpora Block (Kupwara)	
Mean age	33Years	Mean age	33 years
Category		Category	
APL	22 (73.33%)	APL	9(30%)
BPL	8 (26.67%)	BPL	21(70%)
Qualification		Qualification	
8 th	21(70%)	8 th	17(56.67%)
10 th	4(13.33%)	10 th	9(30%)
12 th	0	12 th	4(13.33%)
Illiterate	5(16.67%)	Illiterate	0
Marital status		Marital status	
Married	23 (76.67%)	Married	30
Un married	6 (20%)	Un married	0
Widowed	1 (3.33%)	Widowed	0
Divorced	0	Divorced	0
Population Cover		Population Cover	
<500	12 (40%)	<500	14 (46.67%)
500≤999	02 (6.67%)	500≤999	4(13.33%)
=1000	03 (10%)	=1000	3 (10%)
1000≤1499	06 (20%)	1000≤1499	3 (10%)
1500≤1999	04(13.33)	1500≤1999	4 (13.33%)
>2000	03 (10%)	>2000	2 (6.67%)
Incentives received		incentives received	
Less than a month	0	Less than a month	2 (6.67%)
More than a month but less than two months	22 (73.23%)	More than a month but less than two months	8 (26.67%)
More than two months	8 (26.67%)	More than two months	20 (66.67%)

Table 4.23 depicts the characteristics of ASHA in the two selected Blocks. The mean age of ASHA workers was 33 years in both the Districts. In terms of economic condition 73.33% ASHAs belonged to Above Poverty Line (APL) category in case of Srinagar district while in Kupwara district it was 30%. However, the percentage of ASHAs who belonged to Below Poverty Line category occurred in Kupwara district (70%) and 26.67% in case of Srinagar district. Thus BPL ASHAs were found to be relatively higher in Kupwara district.

Twenty one ASHAs (70%) in case of Srinagar district were 8th class pass and 4 ASHAs (13.33%) were 10th class pass. However 5 ASHAs (16.67%) were found to be illiterate in Srinagar district while in Kupwara district, the 8th, 10th and 12th pass out percentage of selected ASHAs were 57%, 30% and 13% respectively.

As per NRHM norm, every ASHA should be married one. However, in terms of Marital status 6 ASHAs (20%) out of 30 ASHAs were found to be unmarried and 1 ASHA (3.33%) was a widow in Srinagar district while in Kupwara district it was found that 30 ASHAs out of 30 selected ASHA were reported to be married.

As per NRHM norm regarding population, there should be one ASHA per 1000 population. However, the population coverage per ASHA was found to be different between the two selected Districts. In Srinagar district, 12 ASHAs (40%) of the ASHAs covered a population of less than 500, two ASHAs (6.67%) covered a population of more than 500 and equal to 999, three ASHAs (10%) of has a population coverage of 1000, 6 ASHAs (20%) covered a population more than 1000 and less than 1500 and 4 ASHAs (13.33%) ASHAs covered a population of more than 1500 and less than 2000 and 3 ASHAs (10%) covered a population more than 2000 in Kupwara district. Further, 14 ASHAs (46.67%) covered the population less than 500, four ASHAs (13.33%) had population coverage of more than 500 and less than 1000. It is to be noted that only 3 ASHAs (10%) of the selected ASHAs covers population of 1000 as per the norms of NRHM. Three ASHAs (10%) out of 30 ASHAs has population coverage of more than 1000 and equal to 1500. Similarly 4 ASHAs (13.33%) among the selected ASHAs works for population of more than 1500 and less than 2000 and 2 ASHAs (7%) serves the

population of more than 2000. Thus the population coverage per 1000 population as per NRHM norm is violated as only 3 ASHAs (10%) were found to cover the population of 1000 in both the selected Districts.

As per the operational guide line of NRHM, Jammu and Kashmir every AHSA should be given her incentives on 10th of every month. However, the given data shows that this criterion is not fulfilled in all the two selected Blocks of Kashmir Division. None of the selected ASHAs in Srinagar district received her incentives within a month. Twenty two ASHAs (73.33%) received their incentives more than a month and less than two months and 8 ASHAs (26.67%) of selected ASHAs received their incentives more than two months in same block. However, in Kupwara district, 2 ASHAs out of 30 selected ASHAs received their incentive within a month. Eight ASHAs (27%) got their incentives more than a month and less than two months and 20 ASHAs (66.67%) out of 30 selected ASHAs received their incentives more than two months. This signifies the violation of NRHM guideline of paying the ASHAs incentives on 10th of every month.

TABLE 4.24**Different characteristics of Janani Suraksha Yojana (JSY) beneficiaries in the selected blocks Srinagar and Kupwara district**

Indicators	Block Hazratbal (Non-high focus District)	Block Kralpora (High focus District)	Total
Total JSY	30	30	60
Type of JSY beneficiary			
APL	18 (60%)	9 (30%)	27 (45%)
BPL	12 (40%)	21 (70%)	33 (55%)
JSY beneficiary accompanied by ASHA	15 (50%)	24 (80%)	39 (65%)
Satisfaction with ASHA	6 (20%)	20 (66.67%)	26 (43.33%)
Incentives received			
At the time of Delivery	0	0	0
Within week	0	0	0
More than week	10 (33.33%)	6 (20%)	16 (26.67%)
More than a month	20 (66.67)	24 (80%)	44 (73.33%)
Type of expenditure			
Household expenditure	19 (63.33%)	22 (73.34%)	41 (68.33%)
Health care	6 (20%)	4 (13.33%)	10 (16.67%)
Saved	5 (16.67%)	4 (13.33%)	9 (15%)

The table 4.24 reveals that 18 JSY beneficiaries (60%) of 30 selected JSY beneficiaries belonged to APL category in Srinagar district while in Kupwara it was 9 JSY (30%) beneficiaries who belonged to APL category. On the other hand, number of JSY beneficiaries who belonged to BPL category constitutes 12 (40%) of the total selected JSY beneficiaries in Srinagar district whereas it was 21 of the total selected JSY beneficiaries (70%) in Kupwara district. Fifteen JSY (50%) beneficiaries were escorted by ASHA at the time of their delivery in Srinagar district while it was 24(80%) of the selected JSY beneficiaries in Kupwara district. In terms of satisfaction level, it was 6 JSY beneficiaries (20%) in case of Srinagar district and 20 (66%) of the selected JSY beneficiaries in case of Kupwara district.

As per guide lines of NRHM every JSY beneficiary should receive their incentives at the time of discharge from the hospital but as given in the data, it was recorded during the field survey that none of the selected JSY beneficiaries of Srinagar district received their incentives at the time of discharge from the hospital. The percentage of the selected JSY beneficiaries who received their incentives for institutional delivery for more than week were 10 JSY beneficiaries (33.33%), whereas it was 06 JSY beneficiaries (20%) received their incentives after more than a week in case of Srinagar and Kupwara districts respectively. According to Block Accounts manager NRHM, Kralpora Block of Kupwara district that one of the cause of delay in giving the incentives is non availability of funds. However, the problem of non availability of funds was not reported in the Srinager district. Thus, it indicates that none of the JSY beneficiaries received their incentives as per NRHM norm that reflects the poor implementation of NRHM in both the districts.

The incentives received by JSY beneficiary were not utilised only on health care. In Srinagar district, 19 JSY beneficiaries (63.33%) have expended the amount on household, 6 JSY beneficiaries (20%) on health care and 5 JSY beneficiaries (16.67%) saved their incentives in bank account, whereas, it was 22 JSY beneficiaries (73.33%) that spent the incentives on household, 4 JSY beneficiaries (13.33%) on health care also and 4 JSY (13.33%) saved the amount in their bank accounts in case of Kupwara district.

TABLE 4.25**Average Monthly incentives of Accredited Social Health Activist (ASHAs) in the selected Blocks of the Two Districts**

Indicator	Block Hazratbal Non-high focus District (Srinagar)	Block Kralpora High focus District (Kupwara)	Combined
Average monthly incentives (Rs)	370	740	592

Table 4.25 shows that the average monthly incentive of ASHA workers is Rs 370 in case of Srinagar district and Rs 740 in case of Kupwara district. The Srinagar district has urbanized population and the incentives given to ASHAs in case of non high focus District is low as compared to high focus District Kupwara. People generally follow the advice of Doctor of their own choice and do not like to take the service of ASHAs who generally belongs to economically backward group.

TABLE 4.26**Awareness of the Household's about the National Rural Health Mission, ASHA and Village Health Sanitation and Nutrition Committee (VHSNC)**

Response	Block Hazratbal Non high focus District(Srinagar)			Block Kralpora High focus District (Kupwara)		
	NRHM	ASHA	VHSC	NRHM	ASHA	VHSC
YES	10 (33.33%)	8 (26.67%)	0	3 (10%)	27 (90%)	0
NO	20 (66.67%)	22 (73.33%)	0	27 (90%)	3 (10%)	0

Table 4.26 shows that in Srinagar district, out of 30 selected households only 10 (33.33%) households reported that they knew about NRHM and 20(66.67%) households did not have any knowledge about NRHM. Only 8(26.67%) households knew about ASHA and 22 (73.33%) households did not have knowledge about ASHA, while in Kupwara district only 3 (1%) households who were aware about the mission and 27(90%) households were not aware about NRHM. Further, 27 (90%) households responded that they were aware about ASHA and only 3 (10%) households reported their ignorance about ASHA. It was found that not a single house hold was aware about Village Health Sanitation and Nutrition Committee in both the selected districts.

OTHER KEY FINDINGS

CHOOSING OF ASHA AS A JOB

It was reported by the respondents (ASHAs) that they joined the ASHA to provide financial support to their families and also choose because of hope to get regularized.

REPLENISHMENT OF DRUG KITS

During field survey, all the selected ASHAs in both the Blocks mentioned that they could not get their drug kits replenished during 2012-13. It is suggested that health centres should ensure the regular replenishment of drug kits.

KNOWLEDGE OF ASHAs ABOUT THEIR WORKDONE AND INCENTIVES

There were 35% of the selected ASHAs who were fully aware about their multifarious duties and incentives in case of Srinager district, whereas only 15% ASHAs were aware in Kupwara district.

DISPARITY IN INCENTIVES GIVEN TO MANPOWER

During the field survey, all the selected Para medical staff working in rural areas mentioned that they are not given incentives for working in far flung areas as doctors are given some incentives for working in far flung areas.

LINKWORKERS

In non high focus District Srinagar, there are link workers besides ASHAs who receive monthly based salary of Rs 2000 per month. Thus violating the guideline of NRHM of performance based incentives.

JSSK BENEFICIARIES

In Srinagar district 23 out of 30 expectant women (76.67%) used private vehicles to reach hospital and none of the beneficiary received transport payment whereas in Kupwara district 25 out 30 expectant (83.34%) women used private vehicles to reach hospital and 19 expectant women (63.33%) out of 30 expectant women received transport payment. Similarly all the respondents in both the Districts reported that they have been benefited under JSSK scheme except in case of drugs, the cost of which ranged between Rs 400 to Rs 2500. The cause of this cost was non availability of drugs at public health centres.

VILLAGE HEALTH AND SANITATION COMMITTEE (VHSNC)

As per the orders of Ministry of Health and Family Welfare, GOI vide their NO.Z.18015/15/2011-NRHM -11dated 25-07-2011 has renamed the Village Health and Sanitation committee (VHSC) as Village Health Sanitation and Nutrition committee (VHSNC). In each selected Block, two village Health Sanitation and Nutrition Committee were interviewed for their role and the utilisation of VHSNC funds. It was reported that they received only Rs 5000 during 2011-12 instead of Rs 10000 as mentioned in operational guide line 2012-13, State Health Society , Jammu and Kashmir. There was no allocation of funds to Village Health Sanitation and Nutrition committee (VHSNC) during 2012-13. Further none of the selected Village Health Sanitation and Nutrition committee (VHSNC) was fully aware about their roles. Further during the field survey it was found that none of the selected households expressed satisfaction level for their duties even though the selected households reported that they do not have heard about this committee as they have never conducted such a meeting at the village level.

BLOCK LEVEL NRHM SAMMELANS

The operational guidelines of NRHM 2012-13, State Health Society, Jammu and Kashmir provides for creating of Block level NRHM Sammelans for creating the awareness among the prominent citizens and health officials. As per the guideline 2012-13, a sum of Rs 20000 has been approved for each sammelan at block level. However, in practice no such Block level NRHM Sammelans were constituted in the two selected blocks. This is a sign of mismanagement.

MAINTENANCE OF REGISTER

As per the guidelines of NRHM, Untied funds shall be deposited with the joint signature of ASHA/Health Link Worker/Anganwadi Worker along with the head of the Village Health & Sanitation Committee/Pradhan of the Gram Panchayat. These joint account holders are required to maintain a register of funds received and expenditure incurred. The register shall be available for public inquiry and shall be checked from time to time by the Auxiliary Nurse Midwife/Multi Purpose Worker/Gram Panchayat. However, during field survey none of the ASHAs who were the joint account holders of these funds maintained register for untied funds.

IPD PATIENTS

During field survey, it was found that all respondents were satisfied with the service provided by health officials in both the Districts of Srinagar and Kupwara. However, regarding the level of awareness about NRHM, 5 respondents (25%) out of 20 IPD Patients in case of Srinagar district, while in Kupwara district only 3 respondents (15%) out of 20 IPD Patients were aware about the NRHM scheme respectively.

SUMMARY

This study entitled “Socio- Economic impact of National Rural Health Mission in Kashmir Division of Jammu and Kashmir State” attempts to assess the implementation of the National Rural Health Mission in Kashmir Division. The National Rural Health Mission is the first ever mission in the history of India that attempts to remove the bottlenecks existing in rural health care sector so that health care inequality gap among rural – urban India could be bridged. The mission provides funds to CHCs, PHCs and SCs as also helps in augmenting of manpower as per Indian Public Health Standard. The mission operates through financial, institutional delivery and human power mechanism.

The Government of India divided the states into high focus states and non- high focus states to ensure inclusiveness of NRHM. There are 18 high focus states and Jammu and Kashmir is one of them. National Rural Health Mission was launched during December 2005 in Jammu and Kashmir State. The State has further divided the districts into high focus and non- high focus districts. There are few studies available on the implementation of National Rural Health Mission in the State but there is no comparative study of National Rural Health Mission in the State. Thus, it was thought appropriate to conduct this study. The main objectives of this study are:

- To examine the financial performance of untied funds and Annual Maintenance Grant under National Rural Health Mission.
- To assess the impact of National Rural Health Mission in reducing urban-rural health care gap in terms of manpower and physical infrastructure.
- To analyse the effectiveness of cash incentive given through Janani SurakshaYojana for promoting institutional deliveries.

In order to achieve the stated objectives, the study utilized both primary as well as secondary data. Two districts namely Srinagar district as non high- focus district and Kupwara district as high focus district were randomly selected. Further, two Blocks namely Hazratbal Block from Srinagar District and Kralpora Block from Kupwara District were randomly selected. Two villages from each block were also randomly selected. One CHC and one PHC from each block and one Sub Centres from each four villages of selected blocks were randomly selected. A sample of 30 ASHAs and 30 JSY beneficiaries from each CHC and PHC of each Block were randomly selected. In addition to this sample, 20 IPD Patients from each CHC and PHC of each block were interviewed. Further, 2 doctors, 2 Female multipurpose health workers (FMPHW), and 2 Male multipurpose health workers (MMPHW) from each CHC, PHC and Sub centre were randomly selected and interviewed. Two Village Health Sanitation and Nutrition Committee were also interviewed to assess their role in promoting rural health as also 30 households from each village were also randomly selected from to assess their awareness level of NRHM.

Major findings of the study are:

Financial performance at State level

Under NRHM the total allocated fund with the State during 2005-06 to 2012-13 was Rs 952.49 crore. Out of this allocated fund, only Rs 925.86 crore (97.20%) were utilized. This means that funds were almost fully utilised.

Financial performance at District level

The total allocated fund to non- high focus District Srinager during 2005-06 to 2012-13 was Rs 3425.47 lakh and utilisation was Rs 1891.09 lakh (55.21%) whereas the total allocated fund to high focus District Kupwara was Rs 5218.11 lakh and utilisation was Rs 2980.77 lakh (57.13%). All in all, the allocation was relatively higher in high focus Kupwara district but in terms utilisation there was marginal difference between the two selected districts.

Financial performance of health centres

As per NRHM guideline every CHC irrespective of high focus or non- high focus district are allocated untied fund of Rs 50000 per year on the basis of utilisation of previous years received funds. The stipulated amount of untied fund was allocated to CHC Khanyar of non- high focus district Srinager during 2007-08 to 2012-13 and there was decline in allocation to Rs 22000 during 2013-14. The utilisation was not 100% during 2007-08 to 2009-10, whereas the stipulated allocated untied fund to CHC Kralpora of high focus district Kupwara was allocated during the year 2007-08 to 2010-11 and thereafter it declined to Rs 25658, Rs 30014 and Rs 6000 during 2011-12, 2012-13 and 2013-14 respectively. There was full utilisation only during 2007-08 to 2009-10. However, there was disparity in the allocation of untied fund to CHC Kralpora even after witnessing 99.34% financial performance during 2011-12. Further, both the CHCs have shown 100% utilisation during 2012-13 but the deduction in allocation was more at CHC Kralpora during 2013-14.

Under NRHM guideline, every CHC should be allocated a specific amount of Rs 100000 per annum as Annual Maintenance Grant. However, the allocation of stipulated Annual maintenance grant to CHC Khanyar of non-high focus District Srinager was only during 2007-08 to 2012-13, whereas the stipulated allocation of Annual maintenance grant to CHC Kralpora of high focus District Kupwara was during 2007-08 to 2010-11. The utilisation at CHC Khanyar was nil during 2007-08 to 2009-10 and 100% utilisation during 2010-11 to 2013-14 while in CHC Kralpora of high focus district, the utilisation was 100% during 2007-08 to 2012-13. Thus there was again disparity in the allocation between non- high focus and high focus district even the utilisation was nil at CHC Khanyar during 2007-08 to 2009-010.

As per NRHM guideline, every PHC should be allocated a specific amount of Rs 25000 per year provided that PHC has fully utilised the specific amount during preceding year. However, the specific amount of untied fund was allocated to PHC Hazratbal of non- high focus district Srinager during 2008-09 to 2012-13, whereas PHC Panzgam of high focus District Kupwara received the specific amount of untied during 2007-08 to 2010-11. The utilisation of untied funds at PHC Hazratbal

was 100% during 2009-10 to 2012-13 while in PHC Panzgam the utilisation shown a mixed trend with highest rate of 92.8 % utilisation during 2007-08.

The stipulated amount of Rs 50000 per year as per NRHM guideline is allocated to every PHC as Annual maintenance grant. However, it was found that the stipulated amount was given to PHC Hazratbal of non- high focus District during 2007-08 to 2012-13. Out of this allocated Annual Maintenance grant, the utilisation was 100% during the same period whereas the stipulated allocation of Rs 50000 per year as Annual maintenance grant given to PHC Panzgam of high focus district was during 2007-08 to 2010-11 and no allocation during 2011-12. However the utilisation has shown a mixed trend with highest rate of (64%) utilisation during 2007-08. Thus, the financial performance of PHC Panzgam was not optimum.

Institutional deliveries and JSY beneficiaries at State level

The percentage of JSY beneficiaries to total institutional deliveries at state level during 2005-06 to 2011-12 was 38.03%.

Institutional deliveries and JSY beneficiaries at District level

The percentage of JSY beneficiaries to institutional deliveries was 17.74% in case of non high focus District Srinager and 73.59% in case of high focus District Kupwara during 2008-2012. This indicates effectiveness of JSY scheme in case of high focus Kupwara district.

Physical infrastructure

AS per Indian Public Health Standard, every CHC should be 30 bedded hospital and it was envisaged under NRHM goals to make every CHC 30 bedded hospital. However, it was found that the community health centre (CHC) Khanyar of non-high focus District Srinagar was 30 bedded hospital whereas community health centre (CHC) Kralpora of high focus District Kupwara was only 12 bedded. This reveals that physical infrastructure of community health centre (CHC) Kralpora of high focus District Kupwara is not as per Indian Public Health Standard (IPHS) even after the full completion of first journey of NRHM (2005-2012).

Man power at State level

Under NRHM the gap between sanctioned posts and filled up posts was 15.28% as per performance review of NRHM, 2013. This has made the inadequate facility of manpower at the health centres.

Manpower at District level

In case of non- high focus District Srinagar the shortfall of health manpower was 8.55% while in high focus District Kupwara the short fall of health manpower was 21.67%. This signifies the still persistence of disparity in the availability of health manpower between non - high focus district and high focus district as the shortfall of health manpower is more than twice in case of high focus Kupwara district.

Manpower at Block level

All the specialists were posted as per Indian Public Health Standard (IPHS) at CHC Khanyar of non high focus District except the Pediatrician in which the shortfall was 100% whereas the shortfall of specialists at CHC Kralpora of high focus District was 100% in Physician, Gynaecologist, Pediatrician and Dental surgeon. This indicates the poor implementation of NRHM in reducing the health manpower gap between rural- urban health care sector.

As per IPHS both the PHCs of selected districts had 50% shortfall of General duty medical officers. Further PHC Hazratbal of non high focus District Srinager has shortfall of 66.67% in case of staff nurses and this short fall is 100% at PHC Panzgam of high focus District Kupwara.

Disparity in incentives to health man power

Para medical staff's working in rural areas are not given their incentives as doctors are given their incentives for working in far flung areas.

Replenishment of Drug kit

During field survey all the selected ASHAs in both the Blocks mentioned that they did not get their medicine kits replenished during 2012-13. This indicates ignorance of ASHAs by the health officials for their proper functioning and promoting rural health care.

Incentives given to ASHAs

All the selected ASHAs in case of high focus District Kupwara did not receive their incentives as per NRHM guidelines. They were not given the mobile charges per month and for reporting of deaths and births as per NRHM norm.

Marital status of ASHAs

As per NRHM guide line every ASHA should be married. However, it was found that 6 ASHAs (30%) out of 30 selected ASHAs were found unmarried in non high focus District Srinager which is against the NRHM guidelines.

Performance of Village Health Sanitation and Nutrition Committee (VHSNC)

The main task of VHSNC is to generate the level of awareness about NRHM at the community level and is given Rs 10000 per annum for sanitation programme as per NRHM norm. However, during field survey all the 30 selected households from each District expressed their unsatisfaction towards VHSNC as they reported ignorance about this Committee because these VHSNC have never generated awareness programme at village level. Further, the selected VHSNC reported that they got Rs 5000 against Rs 10000 and that only during 2011-12. This means the violation of NRHM norm.

Maintenance of records

Under the guide lines of NRHM that every ASHA and local Surpanch who will be the account holders of untied funds should maintain proper record for public scrutiny. However it was found during the field survey that none of ASHAs and Surpanch has maintained the record who was account holders of untied funds.

However, despite several bottlenecks in the efficient implementation of National Rural Health Mission in the State, the mission has resulted in the paramount success by providing basic health care facilities to the needy rural population through augmentation of health manpower and increasing the working hours of Primary health centres (PHCs) to 24×7. The mission has resulted in some improvements in physical infrastructure through allocation of funds to CHCs, PHCs and SCs.

National Rural Health Mission is a commendable step taken by Government of India in removing the rural- urban health gap inequality and also in bringing about the inclusiveness in Public health care delivery system throughout the country. However, it was found during study that there still existed some bottlenecks in the proper and effective implementation of the mission which may be removed through the following suggestions.

- All the employees hired under NRHM are on contractual basis. At least some employees should be regularised on performance basis for the better implementation of the mission.
- Incentives should be given to Para- medical staff with a view to motivate them as they are provided to doctors.
- There should be deputation of health specialists in high focus districts as per Indian Public Health Standard so that health manpower gap inequality could be bridged.
- Funds should be timely allocated to Community Health Centres, Primary Health Centres and Sub- centres.
- Sub centres should be beefed up in terms of both health manpower as well as physical infrastructure.
- Every PHC should be computerised for proper maintenance of records of all Sub centre under its Jurisdiction.
- Incentives given to ASHAs should be increased and there should be regular replenishment of medicine kits.
- Proper monitoring and evaluation should be done at the State and District level to improve the implementation of mission.

REFERENCES

- Ahmad, S, K., Bhat, I, A, Qadri, F. (2009). Rapid Appraisal of NRHM in Baramulla district, J&K.
<http://prcs-mohfw.nic.in/showprcdetail.asp?id=655> Accessed 2013 May,08
- Ashthekar, S. (2008). The National Rural Health Mission: A stocktaking. *Economic and Political Weekly*, 43(37),23-26.
http://scholar.google.co.in/scholar?q=The+National+Rural+Health+Mission%3A+A+stocktaking&btnG=&hl=en&as_sdt=0%2C5 .
Accessed 2013 April,09
- Berman, P., & Ahuja, R. (2008). Government Health Spending in India. *Economic and Political Weekly*, 44(16),52-59
<http://www.jstor.org/stable/40278915> . Accessed 2013 April,09
- Bhattacharya, G.(2009). Intra- State disparity in Government expenditure: An analysis. *Economic and Political Weekly*, 44(26), 231-237.
<http://www.jstor.org/stable/40279788> . Accessed 2013 April,09
- Choudhry, M. (2006). Public spending on health in low income states and central transfers.
<http://www.nipfp.org.in/media/medialibrary/2013/04/policybrief1.pdf>
Accessed 2013 April,09
- Devadasan, N., Elias, M., John, D., Grahachary, S., & Ralte, L. (2008). A conditional cash assistance programme for promoting institutional deliveries among the poor in India: process evaluation results. *Reducing financial barriers to obstetric care in low-income countries*, 167-198.
- Dhillon, S. (2012). From Policy to the Periphery: A Look at India's National Rural Health Mission. *The Meducator*, 1(18), 6.
http://scholar.google.co.in/scholar?q=Dhillon%2C+S.+%282011%29.+From+Policy+to+Periphery%3A+A+look+at+India%E2%80%99s+National+Rural+Health+Mission&btnG=&hl=en&as_sdt=0%2C5

- Duggal, R. (2009). Sinking Flagships and Health Budgets in India. *Economic and Political Weekly*, 44(33), 14- 17
<http://www.jstor.org/stable/25663438> Accessed 2013 April, 09
- Hixon, L, A., & Maskarinec, G, G. (2008). The declaration of Alma Ata on its 30th anniversary: Relevance for family medicine today. *Fam Med*, 40(8), 585-588
- Husain, Z. (2011). Health of the national rural health mission. *Economic & Political Weekly*, 46(4), 53.
 . <http://www.indiaenvironmentportal.org.in/files/NRHM.pdf> Accessed 2013 April,09
- Joshi, R, S., & George, M. (2012). Health care through community participation: Role of ASHAs. *Economic and Political Weekly*, (10), 70-76.
- Kumar, S, K, A. (2005). Budgeting for health: Some considerations. *Economic and Political Weekly*, 40(14), 1391-1396.
 <<http://www.jstor.org/stable/4416419>>. Accessed 2013 March, 28
- Lahariya, C. (2009). Cash incentives for institutional delivery: Linking with ante natal and post natal care may ensure continuum of care in India. *Indian journal of community medicine*. 34 (1), 15-18.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2763661/> Accessed 2013 July,19
- Patra, K, S., Annam, L. & Ramadass (2013). National Rural Health Mission and Health status of Odisha: An economic analysis.
<http://www.languageinindia.com/april2013/sureshpatra2.pdf>
- Prinja, S., Kumar, M. I., Pinto, A. D., Jan, S., & Kumar, R. (2013). Equity in Hospital Services Utilisation in India. *Economic & Political Weekly*, 48(12), 53.
- Rajalakshmi, T, K. (2012). Public health: A battle half won.
<http://www.hindu.com/thehindu/thscrip/print.pl?file=20120921291809000.htm&date=fl2918/&prd=fline&> Accessed 2013 April,19
- Rao,G., & Choudhury, M. (2012). Healthcare Financing Reforms in India. National Institute of PublicFinance.

http://www.nipfp.org.in/media/medialibrary/2013/04/wp_2012_100.pdf
f Accessed 2014 Feb, 02.

Sidney, K., Diwan, V., El-Khatib, Z., & de Costa, A. (2012). India's JSY cash transfer program for maternal health: Who participates and who doesn't- a report from Ujjain district. *Reproductive health*, 9(1).

http://scholar.google.co.in/scholar?cluster=15534977385543359746&hl=en&as_sdt=0,5&sciodt=0,5 Accessed 2013 April,09.

Sing, S.H., & Tamulee, P.(2012). Janani Suraksha Yojna: Impact on Socio Economic conditions among Beneficiary Families. *International Journal of Scientific and Research Publications*. 2(10), 1-4.

Srinath, V., & Veena, R.(2012). NRHM and IPHS- Standards in Periphery Health Centre's. *International Journal of Pharma Medicine and Biological Sciences*. 1(2), 207-216.

Papp, S. A., Gogoi, A., & Campbell, C. (2013). Improving maternal health through social accountability: A case study from Orissa, India. *Global public health*, 8(4), 449-464.

<http://www.tandfonline.com/doi/pdf/10.1080/17441692.2012.748085> .
Accessed 2013 April,17

http://www.who.int/gho/publications/world_health_statistics/EN_WHS_2013_Full.pdf

<http://www.ifpri.org/sites/default/files/publications/ghi13.pdf>

<https://data.undp.org/dataset/Table-4-Gender-Inequality-Index/pq34-nwq7>

<http://planningcommission.nic.in/plans/planrel/fiveyr/welcome.html>

<http://nrhm.gov.in/>

ANNEXURE - I

Components of Health expenditure in Developing countries and developed countries (2010)

Country	Total expenditure on Health as% of GDP	General Government expenditure On health as % of total expenditure on health	Private expenditure on health as % of total expenditure on health	General Government expenditure on health as % of total government expenditure	Out Of Pocket expenditure as % of private expenditure on health	Per capita total expenditure on health at average exchange rate (US\$)	Per capita government exp on health at average exchange rate (US\$)
Developing Countries							
Bangladesh	3.7	36.5	63.5	8.9	96.6	25	9
China	5	54.3	45.7	12.1	77.2	219	119
India	3.7	28.2	71.8	6.8	86.0	51	14
Nepal	5.1	37.4	62.6	9.5	90.4	10	23
Pakistan	1.0	76.6	23.7	3.4	-	10	8
Srilanka	3.5	45.6	54.4	6.9	81.9	82	37
Developed countries							
Australia	9	68.5	31.5	16.8	59.4	5174	3545
Denmark	11.1	85.1	14.9	16.4	88.7	6253	5323
Japan	9.2	80.3	19.7	18.2	82.0	3958	3179
Norway	9.3	85.5	14.5	17.7	94.5	8039	6875
U.K.	9.6	83.2	16.8	15.9	53.1	3495	2908

Source: World Health Statistics 2013

ANNEXURE - II

Health indicators of high focus States in India

State	IMR 2011	Under-5 MMR 2010	MMR 2007-08	CDR	L.E.
Arunachal Pradesh	33	NA	NA	5.8	NA
Assam	55	83	390	8.0	61.9
Bihar	43	64	261	6.7	65.8
Chhattisgarh	47	61	275	7.9	NA
Himachal Pradesh	36	49	NA	6.7	70
Jammu and Kashmir	39	48	NA	5.5	70.01
Jharkhand	38	59	278	6.9	NA
Madhya Pradesh	56	82	269	8.2	62.4
Manipur	10	NA	NA	4.1	NA
Meghalaya	49	NA	NA	7.8	NA
Mizoram	35	NA	NA	4.4	NA
Nagaland	18	NA	NA	3.3	NA
Orissa	53	78	258	8.5	63
Rajasthan	49	69	318	6.7	69.3
Sikkim	24	NA	NA	5.6	NA
Tripura	28	NA	NA	5.0	NA
Utter Pradesh	53	79	359	7.9	62.7
Uttrakhand	34	NA	188	6.2	NA
Total	42	59	212	7.1	66.1

Source: SRS Bulletin, September 2013, Registrar General of India, Special Bulletin on maternal mortality, June 2011, office of Registrar General of India, SRS based Abridge Life table 2003-07 to 2006-10 Registrar General of India. NA: Non availability

ANNEXURE- III

Health indicators of Non high focus states in India

State	IMR	Under-5MR 2010	MMR 2007-08	CDR	LE
Andhra Pradesh	41	48	134	7.6	65.8
Goa	10	NA	NA	6.6	NA
Gujarat	38	61	148	6.7	66.8
Haryana	42	55	153	6.6	67
Karnataka	32	45	178	7.1	67.2
Kerala	12	15	81	7	74.2
Maharashtra	25	33	104	6.5	69.9
Punjab	28	43	172	7	69.3
Tamil Nadu	21	27	97	7.6	68.9
West Bengal	32	37	145	6.0	69
A&N Islands	24	NA	NA	4.3	NA
Chandigarh	20	NA	NA	3.9	NA
Dadra & Nagar Haveli	33	NA	NA	4.7	NA
Daman & Diu	22	NA	NA	4.9	NA
Delhi	25	34	34	4.2	NA
Lakshadweep	24	NA	NA	6.4	NA
Pudduchery	17		NA	7.4	NA
Total	42	59	212	7.1	66.1

Source: SRS Bulletin, October 2012, Registrar General of India, Special Bulletin on maternal mortality, June 2011, office of Registrar General of India, SRS based Abridge Life table 2003-07 to 2006-10 Registrar General of India.

NA: Non availability

ANNEXURE - IV

COMPONENTS AND GUIDELINES UNDER NRHM

Component (A): Accredited Social Health Activist

ASHA is a female health activist selected by and accountable to panchayat, is the first port of call for any health related demands in the rural community by acting as a bridge between ANM and community.

- There should be one ASHA per 1000 population or ASHA per habitation in case of hilly and tribal areas as per NRHM norms and is provided with necessary drug kit to meet and provide the health needs at the door steps of households.
- ASHA will be receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.
- She will act as core component in implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the village Health Committee of the Panchayat.
- She will be given Induction training of 23 days in all, spread over 12 months and on the job training would continue throughout the year.

Component (B): Strengthening Sub -Centres

- Under NRHM each sub-centre is entitled a Untied Fund of Rs. 10,000 per annum for the purpose of any local health action. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- Timely and adequate supply of essential drugs, both allopathic and AYUSH to the Sub-centres.
- Additional manpower as per requirement will be ensured.

Component (C): Strengthening Primary Health Centres

To assure the qualitative and accessible health care services, the Mission aims at Strengthening PHC through the following measures:

- Timely and adequate supply of essential quality drugs and equipments .

- Provision of Mainstreaming AYUSH manpower by addressing shortage of doctors at PHC level and to provide 24 hour service in 50% PHCs especially in high focus States.
- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, up gradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

Component (D): Strengthening CHCs for First Referral Care

A key strategy of the Mission is:

- Up gradation of 3222 existing Community Health Centres as 24 Hour First Referral Units, including posting of anaesthetists.
- Provision of health care infrastructure to Indian Public Health Standard.
- Promotion of community level participation through Rogi Kalyan Samitis for hospital management..
- Development of Citizen's Charter at CHC/PHC level to ensure more transparency.

Component (E): District Health Plan

- District becomes core unit of planning, budgeting and implementation.
- The basis of District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition, Subject to District Health Mission for monitoring.
- Engagement of professionals at District level and Block level having proficiency in accountancy and management for improved programme management.

Component (F): Converging Sanitation and Hygiene under NRHM

- Total Sanitation Campaign (TSC) which is presently implemented in 350 districts is proposed to cover all districts in 10th Plan.
- Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation Programme guided by District Health Mission and also through Panchayati Raj Institutions (PRIs).

Component (G): Strengthening of Disease Control Programme :

To combat the national diseases at the grass root level, the Mission aims at to improve the National Disease Control Programmes for TB, Kala Azar, Malaria, Blindness & Iodine Deficiency, Filaria and Integrated Disease Surveillance Programme through following measures.

- Disease surveillance system at village level would be strengthened.
- Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.
- For more and improved accessible health care, a provision of a mobile medical unit at District level.

Component (H): Public-Private Partnership for Public

Health Goals, Including Regulation for Private Sector

- District Institutional Mechanism for Mission must have representation of private sector.
- Need to develop guidelines for Public- Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based, thematic and geographic.
- Public sector to play the lead role in defining the framework and sustaining the partnership.
- Management plan for PPP initiatives at District/State and National levels.

Component (I): New Health Financing Mechanism

A Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:

- Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of “money follows the patient.”
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.
- All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District

Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.

- A district health accounting system to be created to monitor the District Health Fund Management.
- Adequate technical managerial and accounting support to be provided to DHM in managing risk-pooling and health security.
- Where credible Community Based Health Insurance Schemes (CBHI) exist/are launched, they will be encouraged as part of the Mission.
- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.

Component (J): Reorienting Health/Medical Education to Support Rural Health Issues

- Medical and para -medical education facilities need to be created in states, based on need assessment.
- Suggestion for Commission for Excellence in Health Care (Medical Grants Commission), National Institution for Public Health Management etc.
- Task Group to improve guidelines/details.

Institutional Mechanism

- ❖ Village Health & Sanitation committee to be formed at village level comprising of of Panchayat Representative/s, Anganwadi worker, ANM/MPW, teacher, ASHA, community health volunteers.
- ❖ Rogi Kalyan Samiti (or equivalent) to be formed at CHC level for community management of public hospitals.
- ❖ District Health Mission, under the leadership of Zila Parishad and consisting of District Health Head as Convener and all relevant departments, NGOs, private professionals as its members.
- ❖ Formation of State Health Mission Chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener and other representatives from related departments, NGOs, private professionals etc .
- ❖ Formation of National Mission Steering Group with the chairperson of Union Minister for Health & Family Welfare and comprising Deputy Chairman Planning Commission, Ministers of Panchayat Raj, Rural

Development and Human Resource Development and public health professionals as members.

- ❖ Formation of Empowered Programme Committee as the Executive Body of the Mission chaired by Secretary HFW.
- ❖ Promoting of Integration of Departments of Health and Family Welfare both at National as well as State level.
- ❖ Task of guidance and oversee on the implementation of ASHA initiative to be performed by Standing Mentoring Group.
- ❖ Formation of task groups from time to time for valuable suggestions.

Guidelines Regarding Constitution of Village Health and Sanitation Committees and Utilization of Untied Grants to these Committees.

In July, 2005, the Union Cabinet of Government of India provided a detailed guide lines for decentralizing planning for constitution and orientation of all community leaders on Village Sub Centre, Primary Health Centre and Community Health Centre Committees within the framework of Panchayati Raj Institutions.

Composition of the Village Health & Sanitation Committee: The NRHM guide lines suggests that VHSC should consist of :

- At least 50% representatives should be selected among women population.
- There should be at least 30% representation from the Non-governmental sector.
- Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.
- Notwithstanding the above, the overall composition and nomenclature of the Village Health & Sanitation Committees is left to the State Governments as long as these committees were within the umbrella of PRIs.

Orientation & Training

It is to be guideline that every Village Health & Sanitation Committee Governments needs to be oriented and trained to carry out the activities in an efficient way.

Village Health Fund

Under NRHM every VHSC is entitled to an annual untied grant of Rs.10,000/- for the following activities: -

(i) Provision of public health activity at village level like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc

(ii) These funds could even be used for health care need of the destitute woman and poor household in times of an extreme case and to be returned in installments thereafter.

(iii) The untied grant is a resource for community action at the local level and shall only be used for community activities that involve Public Health Measures such as Nutrition, Education & Sanitation, and benefit more than one household.

(iv) Every community is free to contribute additional grant towards this Committee, however in villages where the community contributes financial resources to this Committee untied grant of Rs.10,000/-,additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention.

Maintenance of Bank Account: The Untied funds to these Committees fund shall be deposited with the joint signature of ASHA/Health Link Worker/Anganwadi Worker along with the head of the Village Health & Sanitation Committee/Pradhan of the Gram Panchayat. This Village Health & Sanitation Committee, the ASHA/AWW is required to maintain a register of funds received and expenditure incurred. The register shall be available for public inquiry and shall be checked from time to time by the ANM/MPW/Gram Panchayat.

Accountability

- To enable need based interventions, it is required for every Village Health & Sanitation Committee to maintain updated Household Survey data.
- Every VHSC shall maintain a complete record of activities undertaken, expenditure incurred etc. for public scrutiny. ANM/Sarpanch should review it periodically.
- The functioning and progress of activities undertaken by the VHSC shall be reviewed by the Block level Panchayat Samiti.
- The District Mission in its meeting through its functionaries will review information on the functioning of the VHSC.
- The DPMUs can maintain data base on VHSCs.

GUIDELINES FOR USE OF SUB-CENTRE (SC) FUNDS UNDER NRHM

- Under National Rural Health Mission each sub center is provided a grant of Rs.10000 as an untied fund to for the need of meeting urgent yet discrete activities.
- The fund is to be deposited in a joint bank account of the ANM and the Sarpanch.
- Village Health Committee (VHC) will be responsible for approval of utilization of untied funds and be administered by the ANM. In areas where the sub center is not co-terminus with the Gram Panchayat (GP) and the sub center covers more than one GP, the VHC of the Gram Panchayat where the SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub center.
- Use of Untied Funds will not be made only for individual needs, except in the case of referral and transport in emergency situations.

Suggested areas where Untied Funds may be used include:

- For any modifications to sub center at micro level like, repair of taps, installation of bulbs, curtains to ensure privacy, Payments for cleaning up sub center, especially after childbirth.
- Transport of emergencies to appropriate referral centers and samples during epidemics.

- Purchase of consumables such as bandages in sub center.
- Use of disinfectant, bleaching powder for common areas of the village coming under Sub-center.
- Use of Labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
- Payment/reward to ASHA for certain identified activities
- Untied funds shall not be used for any salaries, vehicle purchase, and recurring expenditures or to meet the expenses of the Gram Panchayat.

Guidelines for Utilization of Untied Fund and Annual Maintenance Grant for Primary Health Centres (PHCS)

- ❖ As part of decentralized planning in Health sector every PHC will get Rs. 25,000/- p.a. as untied grant for local health action under NRHM besides an Annual Maintenance Grant of Rs.50,000/- for improvement and maintenance of physical infrastructure such as provision of water, toilets, their use and their maintenance has to be the priorities.
- ❖ A separate register be maintained in the PHC giving sources of funds clearly for various activities.
- ❖ The untied fund shall be deposited in the bank account of the concerned Rogi Kalyan Samitti (RKS)/ Hospital Management Committee (HMC).
- ❖ It is the responsibility of PHC level Panchayat Committee/Rogi Kalyan Samiti to undertake and supervise the work undertaken from Annual Maintenance Grant. Both the funds will be spent and monitored by RKS.

Suggested areas where Untied Fund may be used include:

- ❖ For renovation and minor modifications to the Center such as curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level .
- ❖ For purchasing of Chairs, Patient examination table, delivery table, DP apparatus, hemoglobin meter, copper-T insertion kit, instruments tray, baby tray, weighing scales for mothers and for newborn babies, plastic/rubber sheets, dressing scissors, stethoscopes, buckets, attendance stool, mackintosh sheet.
- ❖ Provision of running water supply, electricity.

- ❖ Ad hoc payments for cleaning up the Center, especially after childbirth.
- ❖ Transport of emergencies to appropriate referral centers and for transporting of samples during epidemics.
- ❖ Purchase of consumables such as bandages in the Center.
- ❖ Use of disinfectants and bleaching powder for use in common areas under the jurisdiction of the Centre.
- ❖ Use of labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
- ❖ Payment/reward to ASHA for certain identified activities. Repair/operationalising soak pits.

The following nature of expenditures should not be incurred out of the untied fund:

- Expenditure on Office Stationery and equipments, training-related equipments, Vehicles etc.
- As salary, payment of honorarium / incentives / wages of any kind.
- Purchase of drugs, consumables and furniture.
- Advertisements in any Newspaper / Journal / Magazine and IEC related expenditure.
- Organizing “Swasthya Mela” or giving stalls in any Mela for ostensible purpose of awareness generation of health schemes / programmes.
- Meeting any recurring non-plan expenditure.
- Taking up any individual based activity except in the case of referral and transport in emergency situations.

Suggested Guidelines for Implementation of Indian Public Health Standards (IPHS) in Sub-Centres (SC), Primary Health Centres (PHC) and Community Health Centres (CHC)

National Rural Health Mission (NRHM) has been launched with the objective of providing of qualitative and improving the existing health care sector through strengthening of physical as well as human infrastructure to Indian Public Health Standard. Each PHC and CHC, as part of IPHS, is required to set up a Rogi Kalyan Samity / Hospital Management Committee, which will bring in community control into the management of public hospitals with a purpose to provide sustainable quality care with accountability and people’s participation along with

total transparency. Taking these points into consideration, a set of guidelines has been framed to enable the States / UTs to bring these centres gradually to the Indian Public Health Standard (IPHS) level. National Rural Health Mission (NRHM) envisages a fully functional subcentre in coordination with the village level functionaries such as Anganwadi workers, ASHA, and the Village Health and Sanitation Committee. Similarly, all the PHCs should function as 24-hour PHCs in a gradual manner. NRHM also envisages a functional 30-bedded rural hospital at the block level providing emergency obstetric care and neonatal care in the first instance as FRU and gradually strengthen further to provide other specialists services as per the details in the IPHS. The guidelines for achieving standards for Indian Public Health Standard (IPHS) centre wise are as below:

Sub-centre:

- Compulsory for that all the existing Sub-centres to have at least one Auxiliary Nurse Midwife (ANM) in position and the services of Auxiliary Nurse Midwife (ANM) are available without any interruption by ensuring an in-built plan to take care of vacancies arising out of retirements, long leave, and other emergency situation. The vacant post arising thereof may be filled up on contractual basis.
- As per Indian Public Health Standard (IPHS) each Sub centre is required to be made appointment of second Auxiliary Nurse Midwife (ANM) locally on contractual basis as per the demand, phase wise with more emphasis on most difficult areas such as hilly and tribal areas.
- Posting of a Male Health Worker (MPW-M) is also necessary at the Sub-centre and States shall appoint them in a phased manner.
- The training capacities in the State for these MPWs also need to be enhanced.
- Utilization of untied fund for strengthening the functioning of Sub-centres.
- All the existing Sub-centers shall ensure a good source of water supply, electricity / solar power / other alternative energy sources.
- Utilization of Annual Maintenance Grant for strengthening of infrastructure and basic necessities of the Sub-centres.

- To show the achievements under NRHM as per Indian Public Health Standard (IPHS), the States may declare the names and the number of existing Sub centres for the information to the public.

Primary Health Centre (PHC) - 24 Hours Service Delivery Centre with emphasis on Institutional Delivery:

To improve the institutional deliveries conducted at the PHCs, it is envisaged under NRHM that all the Primary Health Centres having population of 20,000-30,000 population should function as a 24x7 centre in a phased manner. The steps that may be needed are as follows:

- Identifying the gaps.
- It must be ensured that there should be at least 4 Staff Nurses performing their duties on rotational basis round the clock so as to make the PHC 24x7 delivery of services and appointment of at least three Staff Nurses may be recruited on contractual basis to fill the gaps.
- Provision of labor room with appropriate equipments and drugs with round the clock referral transport support either managed by the PHC or by the NGOs / CBOs for referring patients in case of emergency is essential.
- The States may take stock of the situation of the training capacity and the facilities available in the training institutions for turning over the required number of Staff Nurses.
- Appointment of two Allopathic Medical Officers , preferably one lady doctor and one AYUSH practitioner, either by relocation or on contractual basis making the District Cadre for Medical Officers and even appointment of retired MBBS doctors on contractual basis.
- All the existing Primary Health Centres should ensure the good source of water supply, electricity / solar power / other alternative energy sources and telephone. Rain water harvesting should also be promoted in the PHC building with the help of Panchayat and related agencies.
- All the proposed new buildings should have these components in their construction plan.
- Utilization of untied fund for strengthening the functioning of PHCs.

- Utilization of Annual Maintenance Grant for strengthening the infrastructure and basic necessities.
- Each PHC must have a Rogi Kalyan Samity and display of the Citizens' Charter.
- Once a specific PHC has achieved the 24x7 / IPHS status, the district authority / state authority should declare the institution as 24x7 / IPHS.

Community Health Centre (CHC)– First Referral Unit (FRU) Assured Services:

To bring the CHCs to Indian Public Health Standard (IPHS) under NRHM, following steps may be taken up:

- Identifying the gaps the gaps.
- Envisages a 30-bedded fully functional block level rural hospital.
- The bringing up the CHC to the level of the Indian Public Health Standard(IPHS) may be carried out in stages. In the first stage it must be ensured that all the CHCs provides 24x7 services with appropriate referral transport service. To meet this criteria 24x7 service delivery, there should be four General Duty Medical Officers and seven Staff Nurses, one ANM and one Lady Health Visitor (LHV) along with other support services and physical facilities. Each CHC must be certified by the State Government District Authority that this is functioning as a 24x7 service delivery.
- In the second stage all those declared CHCs as 24x7 may be upgraded to First Referral Units (FRUs). The Minimum requirement of FRUs including manpower, i.e. gynecologist, anesthetist, pediatrician, and round the clock services of nurses and general duty officers should be ensured. Blood storage facility and other supportive services such as laboratory, X-ray, Operation Theater (OT), labour room, laundry, diet, waste management system, referral transport etc. must be ensured. Each CHC should be clearly demarcated as First Referral Unit (FRU). CHCs, as First Referral Unit (FRU), will provide the 24 Hours delivery services including normal and assisted deliveries, emergency obstetric care including surgical intervention like cesarean section and other medical intervention, newborn care, emergency care of sick children, full range of family planning services

including laparoscopic services, safe abortion services, availability of blood storage unit or effective linkage facilities with blood banks, and referral transport services.

In the third stage all those qualified CHCs as First Referral Unit (FRU), can be made to adjust the adequate number of other specialists and support manpower as per the Indian Public Health Standard (IPHS). In addition to above functions, the CHCs declared as Indian Public Health Standard (IPHS), may also provide the following services:

- Care of routine and emergency cases in surgery.
- Care of routine and emergency cases in medicine
- Services of a Public Health Manager
- Delivery of all National Health Programmes including communicable and non-communicable diseases and Reproductive and Child Health (RCH) services.

Manpower:

◆ NRHM provides for appointment of specialists on contractual basis and even appointment of retired specialists making the specialist cadre in the State and services through public private partnership. There is also provision for short term training course on anesthesiology and emergency obstetric care to the existing serving general duty doctors may also be undertaken, to see that all the CHCs have requisite manpower depending on the bed occupancy level.

◆ Appointment of Public Health Programme Manager on contractual basis.

◆ Appointment of Eye Surgeon on contractual basis.

◆ Appointment of nine Nurses Midwives / Staff Nurses on contractual basis.

◆ All the existing Community Health Centres buildings as far as possible should be made environment friendly, disabled friendly, with a good source of water supply, electricity / solar power / other alternative energy sources and telephone. Rain water harvesting should also be promoted in the CHC buildings. This can be ensured with the help of Panchayat and related sectors such as water supply

sanitation, horticulture etc. All the proposed new buildings should have these components in their construction plan.

◆ Dislocation of the existing centres for the sake of achieving the Standards may not be required, unless compulsory due to unavoidable circumstances. In that case, they could be resettled to an accessible place where the original client group could easily get the services.

As far as manpower is concerned, optimum strength should be taken into consideration.

ANNEXURE - V

PROFILE OF JAMMU AND KASHMIR

Jammu and Kashmir known as “paradise on earth” is the northern most state of India situated between 32⁰15′N to 37⁰05′N latitude and 72⁰35′E to 83⁰20′E longitude. The state has three different Agro- Climatic zones consisting of humid sub tropical region of Jammu, Temperate Kashmir Valley and cold arid desert of Ladakh. Internationally the State of Jammu and Kashmir shares its boundaries with Pakistan, China and Afghanistan and nationally the State shares its boundaries with Punjab and Himachal Pradesh. The State is divided in to three regions of Jammu, Kashmir and Ladakh. The summer capital of State Srinager and Winter capital is Jammu. The official language of the Jammu and Kashmir State is Urdu. The total number of Districts in the State of Jammu and Kashmir is 22, 142 Blocks, 03 municipalities, 6758 villages and 75 towns.

The total geographical area of the State is 222236 Km². The total forest area of the Jammu and Kashmir State is 20230 Km² and this is 9.10% of the geographical area of State. As per census 2011 the total population of the State is 1.25 crore sharing a 1% population to total population of India. The decadal percentage growth of Population of the State is 23.71%. The percentage of rural population to total population of the State is 72.79% and share of urban population is 27.21%. Sex ratio of the Jammu and Kashmir State has declined from 892 in 2001 to 883 in 2011. The total literacy rate of the state is 68.74%. According to Below Poverty Line (BPL) Survey 200, State of Jammu and Kashmir has 24.02% of Below Poverty Line (BPL) population.

The Public health sector of Jammu and Kashmir consists of 20 District hospitals, 86 Sub District hospitals/ Community health centres, 650 Primary health centres (PHCs) / Allopathic Dispensaries (ADs) and 2474 Sub centres / Medical aid centres (MACs). Besides this there are five medical colleges in State of Jammu and Kashmir (Economic Survey 2011-12).

ANNEXURE VI

PROFILE OF SRINAGER DISTRICT

Srinager District is the central District of Kashmir Valley and the summer capital of Jammu and Kashmir State. The total population of the District as per Census 2011 is 1250173 lakh. The District has 98.73% of urban population, the highest percentage of urban population in the State. Sex ratio of the Srinager District has increased to 878 in 2011 from 841 in 2001. The total geographical area of the Srinager District is 294 sq km. The density of population of the District is 703 per sq km. Total literacy rate of Srinager District is 77.95%. According to Below Poverty Line (BPL) Survey 2008, the District has lowest percentage of BPL population. The percentage of the BPL population is 9.14%, a well below from the State level poverty of 24.02%. The per capita income of the District as per Below Poverty Line (BPL) Survey 2008 is also highest in the State having per capita net District income of Rupees 24459 at prices for the year of 2004-05.

Srinager District has four medical zones and one medical block. The District has one Community health centre, 26 Primary health centres and 50 Sub centres. Besides this the District has two medical colleges and three tertiary health care hospitals. The District has also 19 private hospitals (DAP Srinager).

ANNEXURE - VII

PROFILE OF KUPWARA DISTRICT

Kupwara District is the northern most District of Jammu and Kashmir State. The total population of the District as per Census 2011 is 875564 lakh. The District has 88.67% of rural population. Sex ratio of the Kupwara District has decreased to 843 in 2011 from 906 in 2001. The total geographical area of the Kupwara District is 2379 sq km. The density of population of the District is 368 per sq km. Total literacy rate of Kupwara District is 77.95%. According to Below Poverty Line (BPL) Survey 2008, the District has highest percentage of BPL population. The percentage of the BPL population is 42.73%, a significantly higher than the State level poverty of 24.02%. The per capita income of the District as per Below Poverty Line (BPL) Survey 2008 is also lowest in the State having per capita net District income of Rupees 12672 at prices for the year of 2004-05.

Kupwara District has nine medical block. The District has 7 Community health centre, 36 Primary health centres and 205 Sub centres. The District has neither Public maternity hospital nor Private maternity hospital (DAP Kupwara).

