Project Report

Health Infrastructure and Health Care Delivery System in Tribal Areas of Jammu and Kashmir

Submitted by

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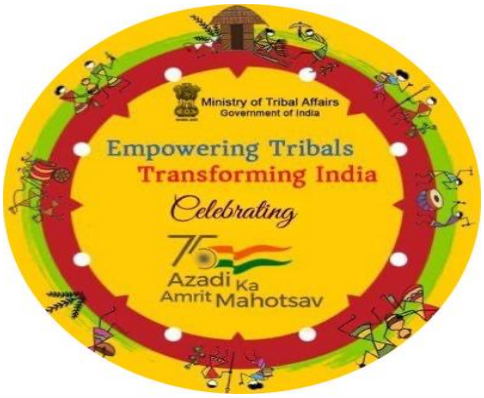

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Introduction:

Health is one of the vital indicators reflecting the quality of human life. It is a basic need along with food, shelter and education and is a pre-condition for productivity and growth. Even the 17 Sustainable development goals adopted by United Nation include health as one of the most trans-versal goals. Sustainable development goal no.3 talks of ensuring a healthy life and promoting well-being for all ages. Moreover, health status is often corelated with the economic growth as well. Healthy citizenry are the key forces in nation building process.

Keeping the above facts in view this paper has the following objectives ;(i) to understand the status of health infrastructure in Tribal areas of Jammu and Kashmir in, (ii) to understand the problems faced by health infrastructure and (iii) to consider policy alternatives.

Status of Health in India

As per the United Nations Development Programme's (UNDP) Global Human Development Report (HDR) 2022, India ranks at 131 among the countries with medium human development out of 189 countries of the world. In terms of Global Gender Gap Report, India ranks 135 out of 146 countries. India's HDI rank reflects low relative achievement in the level of human development and it also indicative that the country has done better in terms of per capita income than in other components of human development.

The status of health indicators in India is in improving day by day but still lot needs to be done. Crude birth rate in India is 17.44, total fertility rate is 2.20, life expectancy at birth in India is 69.66, infant mortality rate is 28.771 and maternal mortality rate is 113. From these figures we can understand the condition of health status of our country.

Table 1: Selected Indicators of Health in India

Details	**1951**	**1981**	**1991**	**Current level**
Crude birth rate (Per 1000 population)	40.8	33.9	29.5	17.44 (2022)
Crude death rate (Per 1000 population)	25.1	12.5	9.8	7.380 (2022)
Total fertility rate (Per 1000 woman)	6.0	4.5	3.6	2.20 (2022)
Maternal mortality rate (Per 100,000 live births)	NA	NA	437 (1992-93)	113 (2022)
Infant mortality rate (Per 1000 live births)	146 (1951-61)	110	80	28.771 (2022)

Problems in the Health infrastructure

Following are the some of the reasons for the poor growth of health infrastructure in India.

1. Inadequate financial resource

The paucity of financial resources because of poor allocations has often proved to be a major obstacle in the execution of health programmes. Public health investment on health infrastructure in the country over the years has been comparatively low. India spends about 1.8% of its GDP on health in 2020-21, but 82% of total health care expenditure is spent by the private sector and almost all of this represents private out of pocket expenditure (Acharya and Ranson,2005). Moreover, with shrinking budgetary support and fiscal shortage most state governments are finding it difficult to expand their public facilities to cater to the growing health care needs of their population. Thus, the state health sector only partially serves the needs of rural and urban poor in the informal sector. So lack of adequate finance has become the strong reason for the under development of the infrastructural facilities.

2. Inadequate buildings

Health sector also faces the problem of shortage of buildings for health centres. Many health centres are functioning in buildings whether government or rented which have limited available space. In rural areas about 49.7 per cent of the sub-centres, 78.0 per cent of the PHCs and 91.5 per cent of CHCs are located in the government buildings. The rest are located either in rented buildings or rent free Panchayat/Voluntary Society buildings. Besides these there is no sufficient availability of residential accommodation in remote rural areas, which are acting as a great deterrent in motivating medical officers to work in such areas.

3. Inadequate physical infrastructures

Health facilities in India face many operational difficulties. These include inadequate funding for drugs supplies, diagnostic facilities, laboratory equipment, urinals, latrines, bathrooms, ambulances, phone, fax etc and these are in extremely hopeless condition which a very sad reflection on the functioning of health centres and a general deterioration of physical infrastructure. Lack of adequate hospitals and clinical persons is another problem. According to HDR 2020, in India ranked 155 out of 167 countries in terms of bed availability. This clearly reveals the poor condition of health infrastructure in India.The country has 5.8 doctors per 10,000 population. A survey by the International Institute of Population Sciences found that

only 20% of PHCs have a telephone. So not only is the infrastructure inadequate, we don't even have the staff to use the existing infrastructure (Srinivasan, Sandhya, 2005).

4. Absence of effective personnel and materials planning

In most of the hospitals there is no personnel planning resulting in the underutilisation of resources. The hospital authorities must ensure that the existing staff in the various departments has been deployed consistent with the workload and are according to the prescribed norms. Periodic studies of the functioning of hospitals are needed to enable the administrators to manage them effectively.

5. Absence of good transport facilities

Another problem of health infrastructure is the lack of good transport facilities between the villages and hospitals. The data reveals that only 73.9% of villages are well connected with the roads to health centres (Laveesh Bhandari and Siddhartha Dutta, 2007). According to the NCAER, nearly 20% of cases rural households travelled more than 10 km for treatment. It has become very ardours for the tribal and the down trodden people to reach the PHC's as there are no link roads in most of the villages (Himanshu Sekhar and Prashant Kumar Panda, 2007). The unavailability of proper connectivity also effects the transportation of expecting mothers in far flung areas.

6. Imbalance between the rural and urban areas

There has been an imbalance in the availability of medical facilities and health manpower in rural area and urban areas. The National Health Policy (NHP) 1983 envisaged a three-tier structure of primary, secondary and tertiary healthcare facilities to bring the services within the reach of the rural population. In spite of the three-tier system of rural health infrastructure the condition of rural health infrastructure has been deplorable.

Need for study:

Taking into consideration the above problems, need has been felt to analyse the health infrastructure and health care delivery system in Tribal areas of Jammu and Kashmir.

Research methodology:

To conduct the present study descriptive research method has been used. For the purpose of analysis data from authentic secondary sources such as government reports (National Family Health Survey and Census of India), reports from international organisations like UNDP (Human Development Report), data from government schemes and departments (Janani Suraksha Yojana, PM-ASHA, NRHM) along with data from journals and magazines have been used. The data thus collected has been thoroughly analysed to draw conclusions and put forward policy recommendations.

Report 1

Report on Health Infrastructure and health care delivery systems in Rajouri district.

Submitted by
Dr. Annie Jamwal (Fellow TRI)
Hashmat Habib (Assistant Fellow)

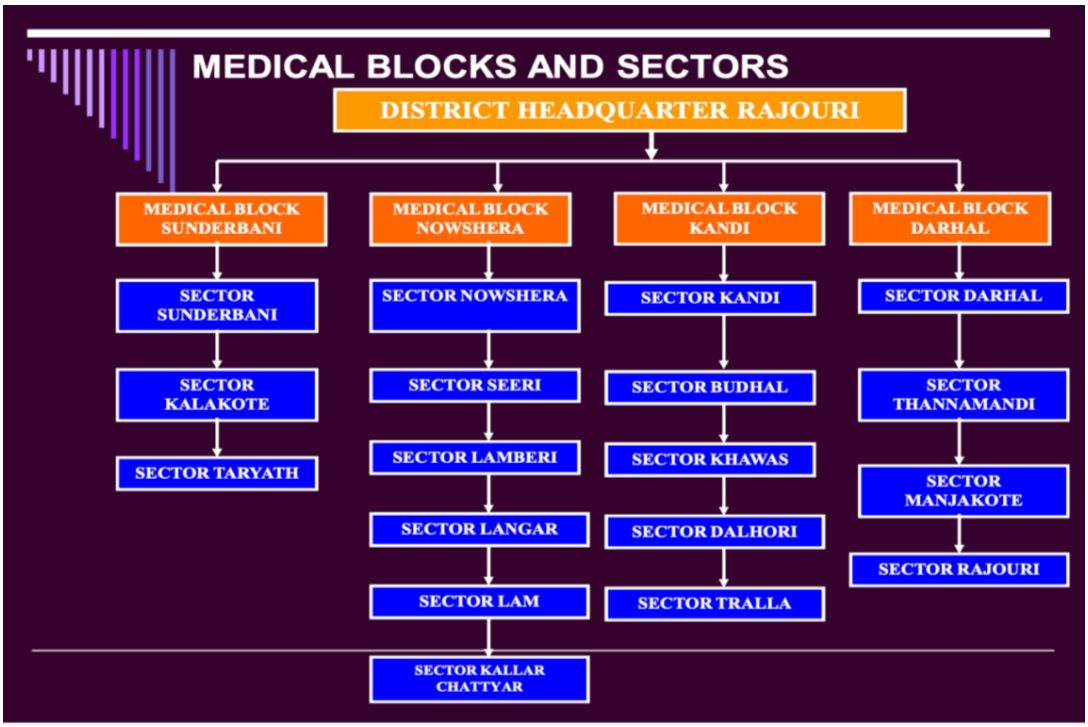
Profile of District Rajouri:

District Rajouri has been carved out of the district of Poonch in 1968 to facilitate process of development and better supervision. It has an area of 2630 Sq. km. The district is flanked by Poonch and Shopian district in the north, Jammu district in the south, Udhampur district in the east and Mirpur area of the Pakistan Occupied Kashmir in the west. Rajouri district has peculiar physical features. The Dhaula Dhar range runs across the north eastern part of the district and topography of Rajouri, Budhal and part of Kalakote tehsils consists of numerous hills and small valleys. The tehsils of Sunderbani, Nowshera and part of Kalakote is mostly plain. The climate of the district varies from sub-tropical in the southern part comprising Nowshera, Sunderbani and Kalakote to temperate in the northern part encompassing the areas of Rajouri, Budhal and Darhal blocks of the district. The district receives an average rainfall of 500 mm and the average temperature varies from a minimum of 7.4 to a maximum of 37.4 degree Celsius. Historically, Rajouri gained popularity during the day of Mughal Empire as the Mughal rulers used to stay at Rajouri for couple of days while on movement from Delhi to Srinagar and Srinagar to Delhi.

The District Rajouri has been administratively divided into six Tehsils namely Rajouri, Kalakote, Budhal, Thannamandi, Nowshera and Sunderbani. The entire District having 382 villages and six important Towns is sub-divided into seven Rural Development Department Blocks namely Rajouri, Manjakote, Darhal, Budhal, Kalakote Nowshera and Sunderbani. The Head Quarter of the District is a Rajouri.

The District has been divided into 4 medical blocks to provide health care services. The medical blocks are Sunderbani, Nowshera, Kandi and Darhal. Each block is divided into 3-6

sectors (Figure 1). Nowshera is the largest block with 6 sectors and Sunderbani is the smallest block and has 3 sectors. Kandi block has 5 sectors and Darhal block has 4 sectors.



Population:

The population of the district in 1981 was 3.02 lakhs which went up 4.8 lakhs as per 2001 Census. Thus the district has registered a growth rate of 58.2 percent during 1981-2001 as against 68.2 percent in the state as a whole. As per the latest estimates, the population of the district has increased to around 5.8 lakhs. According to 2001 Census, density of the population in the district was 184 persons per sq. kilometres as against 46 persons in Jammu and Kashmir. The district is predominantly rural in character as only 7 percent of the total population lives in urban areas as compared to 25 percent in the State. The literacy percentage as per 2001 census was 58 percent, which is slightly higher than the State average of 55 percent. Female literacy in the district (44 Percent) is at par with the State average (43 percent). The literacy rate in urban areas (87 percent) is one and half times more than the literacy rate in rural areas (55 percent). According to 2001 census, the district recorded a sex ratio of 878, which is lower than the state sex ratio of 892 females per thousand males. Urban sex ratio of 726 females

per thousand males in the district is the lowest in the state. Scheduled Castes account for 8 percent of the total population of the district which is same as in the State. Scheduled Tribe population account for 33 per cent of the total population of the district as against 11 percent in the State. District Rajouri offers a representative character of the State in clime, culture and secular outlook. The district presents a composite culture-Pahari, Gojri, Dogri and Kashmiri. Irrespective of ethnic groups all speak the Pahari language with ease.

Health infrastructure

There is a District Hospital, 7 Sub-District Hospitals/CHCs, 22 Primary Health Centres, 15 Allopathic Dispensaries, 25 Ayurvedic & Unani Dispensaries (ISM), 143 Sub Centres, 1 Urban Health Centres (Evening Clinic) and 2 Mobile Medical Aid Centre which are catering to health and family welfare needs of the population. Besides, there is a Private Nursing Home (KRS Nursing Home) at Sunderbani which has not yet been accredited for JSY. Of the 7 Sub District Hospitals/CHCs, 2 (Sunderbani and Darhal) are functioning as First Referral Units and the process is on to upgrade the remaining 5 CHCs (Thanamandi, Kandi, Nowshera, Teryath and Kalakote) to function as FRUs in the second phase. Of the 22 PHCs, 2 (Manjakote and Budhal) have been upgraded to function as 24X7 PHCs in the First phase. PHCs Shahdara Sharief, Lamberi, Siot, Moughla will be made functional on 24X7 basis in the second phase. The district hospital is accommodated in the old building and a new building for DH is under construction at Kheora. All 7 CHCs have government buildings. To mitigate the problems of accommodation of CHCs, 2 new buildings are under construction for 2 CHCs. Of the 22 PHCs, though 5 are housed in rented buildings but buildings are under construction for 3 PHCs. Of the 143 SCs, 65 have government building and the remaining have rented accommodation, however buildings for 12 SCs are under different stages of completion. IPHS facility Surveys have not yet been initiated in the district and therefore in none of the facilities IPHS up gradation has been completed.

Facilities for institutional delivery

The facilities for institutional delivery both normal and caesarean are available in the District Hospital Rajouri. Normal delivery facilities are also available in CHC Sunderbani, Darhal, Kandi and Nowshera. Operation theatre for caesarean deliveries are available in some of the CHCs

but due to non-availability of Gynaecologists, anaesthetists, blood bank, regular electric supply and support staff, C-section deliveries are not conducted in Darhal and Kandi CHCs. Complete BeMoc are available in the District Hospital. BeMoc facilities except for neonatal hypothermia jaundice are also available in 4 CHCs (Sunderbani, Darhal, Kandi and Nowshera). CeMoc facilities are provided by DH and to some extent by CHC Sunderbani. New Born Care Units have been established in DH, CHC Sunderbani and Darhal and PHC Manjakote Moughla.

Health Infrastructure at the level of District Hospital Rajouri:

In the hierarchical health care system of the Government of India in a district, the district hospital is the apex body, which provides specialised health care services to people on subsidised costs. Every district is expected to have a District Hospital (DH).

District Hospital Rajouri has been established in the year 1967 and is housed in a building which is nowadays called Old Block. This building was constructed by the Mughal Emperors and was used by them as a Saria (Rest House) while visiting Kashmir from Delhi and back. Another Building which is called the New Block was constructed in 1989 and houses the Gynaecological Section.

District Hospital Rajouri caters to the heath care needs of about 6 lakh population. The Hospital was the only source of treatment for majority of the population till 1974-75. The Hospital is located within the city on the road side and is less than 0.5 Kms from the bus stand. The nearest CHC is Darhal located at a distance of about 25 Kms from Rajouri and the farthest CHC is Kandi (Kottranka) which is at a distance of about 60 kms. However, due to terrain topography it takes about 2 hours by public transport to reach Rajouri from Kandi and 1 hour from Darhal. IPHS facility survey has not been carried out in the district hospital.

Staff quarters

There are residential quarters for medical staff and Para-medical staff available in the hospital complex and all these residential quarters are occupied by the medical and paramedical staff. Parking place is adequately available in the hospital.

Medical Records

The hospital has a Medical records section but not only the space is limited but also the staff working in the medical records section has not received any special training in maintaining medical records of the hospital.

Obstetric and gynaecological services

Information regarding Obstetric and Gynaecological Section was collected from the Female Multipurpose Worker in the gynaecology section. The hospital has a separate ward for females. The hospital has a separate Operation Theatre available for Gynaecological and Obstetrics Section. Services for MTP, mid trimester abortion, ectopic pregnancy and retained placenta and hysterectomy are available in the hospital. Facilities for the management of eclampsia, suturing and infertility treatment are not adequate in the hospital.

Surgical services

The hospital provides facilities pertaining to both routine as well as emergency matters. Facilities for spleen and portal hypertension surgery, abdomen surgery, breast surgery, hysterectomy and piles are available in the hospital. Facilities for pancreas and leprosy reconstructive surgery are not available at the District Hospital.

Medical services

Information pertaining to Medical Section of DH Rajouri was collected from the Medical Officer and FMPW of the Medical Section. Facilities for the treatment of Dermatology and Venerology (skin and VD) RTI/STI are not available in the DH. Similarly, hospital has limited expertise to provide services for Pleural Aspiration, Pleural Biopsy, Bronchoscopy, Lumbar Puncture, Pericardial tapping, Skin scrapping for fungus/AFB, Bone Marrow Biopsy, Endoscopic Specialised Procedures and Psychiatric Disorders.

Paediatric services

Information pertaining to Paediatric Section was collected from the Medical Officer in charge of paediatric section. The OPD section has provided services to good number of children during the last three months. Medical Officer reported that facilities for Asphyxia

management, management of severe malnourished children, management of Neo Natal Sepsis, Management of Dehydration and Diarrhoeal cases and Management of Respiratory Tract Infection/Pneumonia cases are available in the paediatric section.

Diagnostic section

X-ray, ECG and Ultrasound facilities are available in the Hospital. Ultrasound guided Biopsy is not available in the DH. A total number of 2494 X-Rays, 573 Ultrasounds and 273 ECGs have been carried out in the hospital during the last 3 months.

Laboratory services

Information regarding laboratory was collected from the Pathologists of the Hospital. A total number of around 7000 Haematology tests (HB, TLC, DLC, CT, ESR etc) were conducted in the District Hospital laboratory during the last 3 months. Besides, urine, stool and semen tests were also carried out in the hospital. Besides, tests were carried out for CSF Analysis and Aspirated fluids.

Human resource

Information regarding the No. of Sanctioned posts and No. of posts in position was collected from the office of Medical Superintendent. The overall situation is fairly satisfactory in the case of Specialists. The hospital has sanctioned positions of Specialists in each of the fields of Medicine, Surgery, Anaesthesiology, Orthopaedics and Dental Surgery. All these positions are in place in the DH.

Status of Community Health Centres (CHCs):

Community Health Centre (CHC) or Sub District Hospital function as the secondary level of health care and is designed to provide first referral curative as well as specialized health care to rural population. It caters to approximately 80,000 population in tribal/hilly areas and 1,20,000 population in plain areas. It also provides facilities for obstetric care and specialist consultation. CHCs are generally 30 bedded hospitals with Operation Theatre, X-ray, Labour room and Laboratory facilities. It is manned by 4 medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician. It provides specialized care in medicine, obstetric and

Genecology, Surgery and Paediatrics. Rajouri district has a total of 7 CHCs/Sub District Hospitals. These are Sunderbani, Darhal, Nowshera, Kandi, Thanamandi, Kalakote and Teryath. Of these 7 CHCs, Sunderbani and Darhal are functioning as First Referral Units (FRU's) and the remaining 5 are being gradually upgraded to function as FRUs.

The infrastructural facilities available in the CHC's include their own building, toilet facility, continuous supply of tap water, electricity, labour room, laboratory, Pharmacy, OPD rooms, Telephone, computer, internet, diagnostic facilities, ambulance etc.

Status of Sub-Centres:

Sub-Canters (SCs) are the most peripheral health institutions catering to the health care needs of the rural population. It is the most peripheral contact point between the Primary Health Care system and the community. It is manned by one Multi-Purpose Worker (male) and one Multi-Purpose Worker (female) /ANM. Even though the sub-centre wise population norm at the national level has been met, there are wide interstate variations. A SC on average in Rajouri district covers 2978 population which is at par with the government of India guidelines of having a SC for every 3000 population in hilly areas. On an average a SC covers 4 villages/habitations in the district. The basic infrastructural facilities are available at sub-centres. The presence of the ANM in the Sub Centre area round the clock is essential for the people to avail the health services. A Stock of vaccines, contraceptives and prophylactic drugs are adequately supplied.

Status and Performance of ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist-ASHA' or Accredited Social Health Activist. These ASHAs are supposed to act as a 'bridge' between the rural people and health service outlets and play a central role, in achieving national health and population policy goals. ASHA is to be selected from the village itself and accountable to it. The ASHAs are trained to work as an interface between community and the public health system. They are supposed to work on voluntary basis, although compensation is provided to them for specific activities and services. In Rajouri district, Capacity building of ASHA is being seen as a continuous process. ASHA is supposed to undergo series of training episodes to acquire the

necessary knowledge, skills and confidence for performing her spelled out roles. ASHAs are empowered with knowledge and a drug- kit to deliver first-contact healthcare in her village. She will act as a depot holder for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. ASHAs are directed to provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services. She generally counsels women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child. ASHA workers also mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centres, such as immunisation, ante natal check-up (ANC), post-natal check-up (PNC), supplementary nutrition, sanitation and other services being provided by the government.

Report 2

Report on Health Infrastructure and Health Care Delivery Systems in Kupwara District

Submitted by

Dr. Annie Jamwal (Fellow)

Hashmat Habib (Assistant Fellow)

District Profile Kupwara

District Kupwara was carved out from the erstwhile District Baramulla in the year 1979 to develop the socio-economic pattern by addressing the far-flung and remote areas in the District Kupwara the backward frontier District of Kashmir Valley, full of scenic beauty. Dense forests and rich wildlife make it significant from a tourism and wildlife point of view. The District Headquarter "Kupwara" is situated at a distance of 90 km from the Srinagar (summer capital of J&K state. The northwest part of the district is bound by the line of actual control (L.O.C)) while the southern portion of the district is hilly/semi hilly. There are some famous passes of the Himalayan range like Rajdhani Passes joining Guraze with Bandipora District and others like SadnaGali, Farkiyan Gali, Nachan Gali and Jar Gali connecting Leepa valley (POK) keran, karnah and Machil Areas with Kupwara District. There is only the Kishan Ganga River originating from the Himalayan range that passes through Keran, Teetwal and finally falls into Jehlum at Domial in Muzaffarabad. The snow bounded areas like Machil, Keran and Karnah remain cut off from the rest of the district during the winter season for about six months. There are some other areas located at barbed distances and remain cut off from District Headquarter for a considerable time, like Kumkadi, Lashdat, Jumgund, Kethanwali and Budnambal.

District Kupwara Consists of 15 Tehsils that include Karnah, Keran, Kralpora, Machil, Trehgam, Kupwara, Drugmulla, Lalpora, Sogam, Handwara, Langate, Qaziabad Kralgund, Zachaldara, Villagam and Ramhall Tarathpora.Blocks: District Kupwara consists of 24 Rural Developments Blocks that include Drugmulla, Handwara, Hirri Qadirabad, Hyhama, Kalarooch, Keran, Kralpora, Kupwara, Langate, Machil, Magam, Qalamabad, Meelyal, Natnussa, Qaziabad, Rajwar, Ramhal, Reddi Chowkibal, Sogam, Tangdhar, Teethwal, Tarathpora, Tregham and Wavoora

Profile of District Kupwara

S.No	District	Population	Growth Rate	Sex Ratio	Literacy	Density
1.	Kupwara	870354	33.82%	835	64.51%	366

(Directorate of Health Services)

Geography

The geographical area of the district is 2379 km^2. The district is situated at an average altitude of 5300 feet from sea level. This district is located between 34.17 to 34.21 North Latitude and 73.10 to 73.16 East Longitude. The famous river Kishan Ganga separates Pakistan Occupied Kashmir and Jammu and Kashmir in Machil, Keran and Teetwal areas. Kupwara district lies on the northwest side of Kashmir valley with borders lying on the Line of Control that divides India and Pakistan. On the eastern and southern borders of Kupwara lie Sopore, Bandipore and Baramulla. The main source of water is in winter snowfall in the mountains. Summers are short, though they are long enough to grow crops. The temperature ranges from (to 36 degrees in Summer and the minimums range from minus 9 to -8 degrees in Winter.

Demography

As of the 2011 census, Kupwara had a population of 8,70,354 with 474,190 males and 396,164 females. The total population of the district is 8.70354 lakh persons as per the census 2011 which is estimated to have risen 33.85 % approximately from the census 2001. The population mostly lives in rural areas and only 1.04 lakh souls live in urban areas as per the census of 2011, district Kupwara is having a population of 8.70 lakh souls which constitutes 14.88 % of the total population of the state. out of the total population of the district, Schedule caste is about 0.01 %, Schedule tribe are 8.08 %.

Description	2011	2011
Male	**474,190**	**341,303**
Female	**396,164**	**309,090**
Total	**870,354**	**650,393**

Kupwara has an average literacy rate of 64.51%, above the national average of 59.5%: male literacy is 64%, and female literacy is 41%. However, literacy has increased since the last census. In Kupwara, 13% of the population is under 6 years of age. The sex ratio is 835 females per 1000 males as per census 2011 in aggregate. The district has a population growth rate of 34.62 per cent during the decade 2001 to 2011. The biggest ethnic population is of Muslims and the working force accounts for 32.67 of the population. The main occupation of the population is Agriculture. A majority of the people are Muslims while there is a small community of Sikhs in both Kupwara and Handwara tehsils. Kashmiris are the major ethnic group and speak the Kashmiri language.

Health Sector at a Glance

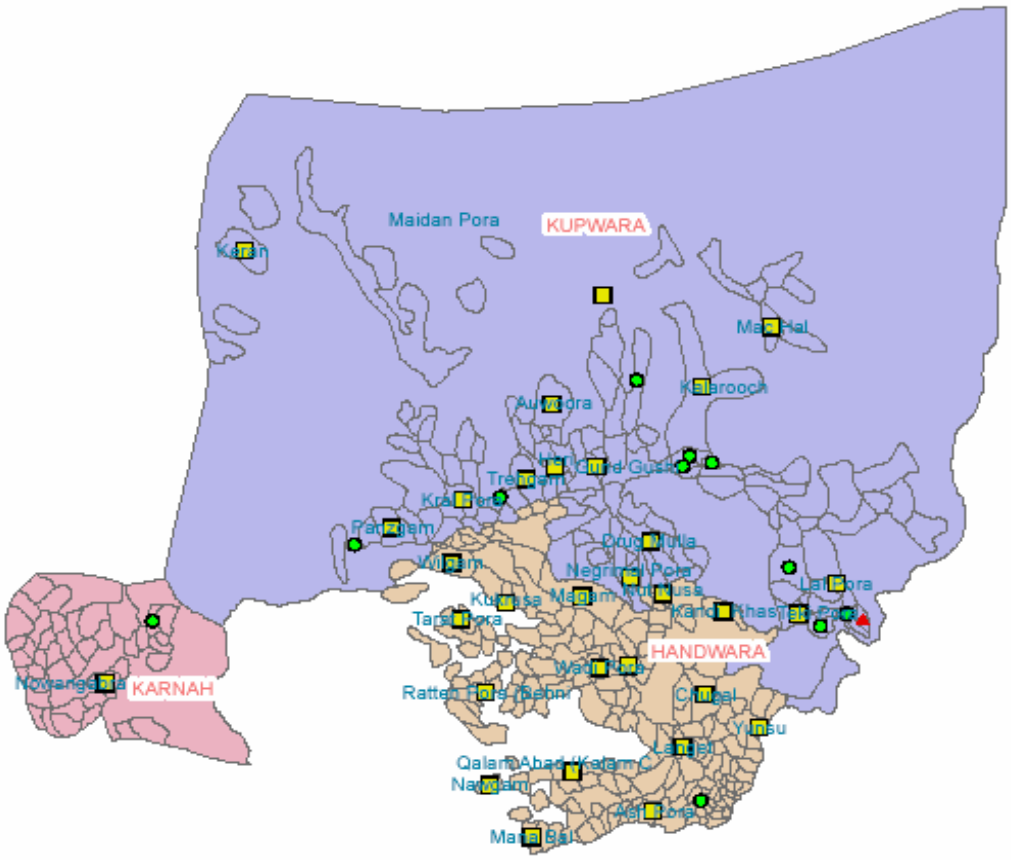
Statistics	
District Hospital	**01**
CHC/SDH	**07**
DTC	**01**
PHC	**31**
NTPHC	**23**
AD	**06**
SHC	**02**
Sub Centres	**230**
MAC	**33**
Total Health Institutions	**307**
Training Schools	
General Nursing	**01**

Human Resources of the Health Sector

S. No	Category	Sanctioned Strength	In Position	Vacant
	Gazetted			
1.	Sr. Consultant	04	03	01
2.	Consultant	56	20	36
3.	Medical Officers	180	91	89
4.	Dental Surgeons	42	22	20
5.	Administrative Posts	14	13	01
6	Para Medics	879	629	250
7	Others	532	367	165
8	Drivers	68	61	07
	G. Total:	1775	1206	569

(Directorate of Health Services)

Health facilities in District Kupwara, Jammu & Kashmir



Legend

- Health Centre
- PHC
- Sub Centre
- Towns
- Urban Areas
- Area not identified by Census

TALUK NAME

- HANDWARA
- KARNAH
- KUPWARA

Map composed by NIC

Source - RGI , SOI

1. Identifying information

Name of District		***Kupwara***
Name of District Headquarters		***Kupwara***
No. of Blocks in the District		***9 medical blocks***
No. of Gram Panchayat in the District		***224(as per census 2001)***
No. of villages as per DC office record		***369***
No. of Villages as per medical record		***492***
Size of Villages	1-500	***119***
	501-2000	***175***
	2001-5000	***169***
	5000+	***29***
Villages without motorable roads		***67 villages***
Villages without electricity		***DNA***
No. of Towns		***2***
Urban Local Bodies (ULB)	Municipal Corporation	***Municipality: 2***
	Municipality	
	Notified Area Committee	
	Others	

NRHM, 2012

2. Development Indicators of the District:

S. No.	Indicators	State	District
1	Crude Birth Rate	18.9 (SRS 2005)	28
2	Crude Death Rate	5.5 (SRS 2005)	8
3	Infant Mortality Rate	50 (SRS 2005)	60
5	TFR	2.4	2.1
6	Couple Protection Rate	61.4	33
7	Sex Ratio (General)	948 SRS-2005,	892
8	Sex Ratio (0 – 6 years)	937 Census 2001	980
9	Sex Ratio at Birth	NA	980
10	Literacy rate (overall)	54% Census 2001	
11	Literacy rate (male)	68.8 Census 2001	
12	Literacy rate (female)	41.9 (Census 2001)	

National Census Report 2001

Name of Block	Kupwara	Handwara	Sogam	Langate	Kralpora	Zachal;dara	Trehgam	Villigam	Tangdar	Total
Number of households with access to toilets	580	NA	213	800	2000	211	3000	514	NIL	
No. of private health facilities/clinicians	NIL	NA	NIL	NIL	NIL	NIL	NIL	0	NIL	00
No. of women who have benefited through the JSY Scheme till now[1]	304	128	325	299	226	172	95	136	227	1912
No. of girls who got married last year	NA	17	NA	NA	NA	NA	NA	NA	NA	NA
No. of girls who got married last year and were <18 years at the time of marriage	NIL	NA	NA	NIL	NA	172	NA	NA	NIL	172

Health Indicators										
No. of Tubectomies conducted in the last reporting year	182	NA	68	NIL	NA	NA	NA	NA	90	340
No. of IUD insertions done in the last reporting year	763	1042	650	527	160	418	27	418	NA	4005
No. of vasectomies done in the last reporting year	NIL	NA	NIL	NIL	NIL	NIL	NIL	NIL	NIL	00
No. of pregnant women	5304	NA	7790	877	2300	215	NA	2124	1008	19618
No. of pregnant women registered for ANC during the last reporting year	5304	2538	7790	3404	2300	230	440	2124	1008	25138

District Administration Kupwara

3. Health Institutions, Population Coverage Ratios and Health Functionaries in the District

Name of Block		Kupwara	Langate	Zachaldara	Sogam	Kralpora	Tangdar	Trehgam	Handwara	Villigam	Total
No. of Speciality Hospitals		0	0	0	01	0	01	0	0	0	02
No. Referral Hospitals		01	0	0	01	01	01	01	0	0	05
No. of CHC/BPHCs		01	02	1	01	01	01	0	0	0	07
No. of Blood Banks		01	0	0	0	0	0	0	At DH	0	01
No. of CHCs (IPHS Standards)		0	01	0	01	0	0	0	0	0	02
No. of Blood Storage Units		0	0	0	0	0	0	0	0	0	00
No. of PHCs in the Block		08	06	3	05	04	01	02	4	03	36
No. of MOs in Positions		23	16	9	16	10	07	03	NA	05	79
No. of 24 hrs. PHCs		01	0	1	0	0	0	02	2	02	08
No. of MTP Centres		0	0	0	01	0	01	0	2	0	04
No. of Sub Health Centres		29	35	16	31	27	24	17	10+3=13	22	214
No. of ANMs in Position		31	35	2	30	23	07	18	12	15	173
No. of AYUSH Dispensaries		0	0	1	03	04	04	0	1	0	13
No. of Private Hospitals		0	0	0	0	0	0	0	0	0	00
No. of Beds in Govt. Institutions		100	45	40	30	31	30	10	50	15	351
No. of Beds in Pvt. Institutions		0	0	0	0	0	0	0	0	0	00
No. of Anganwari Centres		205	28	43	335	47	166	199	95	118	1236
No. of Sub-centres covering more than the norm (5000/3000)		0	01	4	28	0	4	4	1	0	42
No. of Obstetricians	Govt.	0	0	0	0	0	01	0	0	0	01
	Pvt.	0	0	0	0	0	0	0	0	0	00
No. of Gynaecologists	Govt.	0	0	0	0	0	0	0	0	0	00
	Pvt.	0	0	0	0	0	0	0	0	0	00
No. of Paed^{2}iatricians	Govt.	0	0	0	0	0	0	0	0	0	00
	Pvt.	0	0	0	0	0	0	0	0	0	00
No. of Surgeons	Govt.	03	0	0	01	0	01	0	0	0	05
	Pvt.	0	0	0	0	0	0	0	0	0	00
No. of Anaesthetists	Govt.	01	0	0	01	0	0	0	0	0	02
	Pvt.	0	0	0	0	0	0	0	0	0	00
No. of	Govt.	1	0	0	0	0	0	0	0	0	01

(Kupwara District at a Glance)

4. Scheduled Caste /Scheduled Tribe Population out of total population (Nos.)

S.No	Name of Tehsil	Name of Block / Municipal Committees	No. of census village	No. of HH	SC	ST
01	Karnah	Teetwal	30	4980	0	**4386**
02	Karnah	Tangdar	12	6442	111	**3337**
03	Keran	Keran	6	1282	0	**349**
04	Machil	Machil	7	2304	44	**245**
05	Lalpora	Wavoora	15	8041	107	**11169**
06	Kupwara	Kalaroose	2	5852	53	**12605**
07	Kupwara	Hyhama	4	5002	137	**5950**
08	Kupwara	Kupwara	21	5469	32	**961**
09	Drugmulla	Drugmulla	8	3736	8	**817**
10	Sogam	Sogam	20	9409	239	**2339**
11	Trehgam	Qaderabad Hirri	11	5439	0	**2504**
12	Kralpora	Kralpora	10	4657	0	**3245**
13	Kralpora	Meelyal	6	2834	8	**2838**
14	Kralpora	Reddi chowkibal	6	3117	35	**3144**
15	Tarathpora	Tarathpora	17	3362	0	**3578**
16	Ramhall	Villgam	14	3123	5	**504**
17	Handwara	Magam	17	3275	0	**1299**
18	Handwara	Handwara	22	4099	0	**1011**
19	Langate	Mawar	38	6251	32	**2999**
20	Handwara	Nutnussa	8	3254	128	**597**
21	Trehgam	Trehgam	10	3420	4	**381**
22	Langate	Langate	14	2414	5	**1**
23	Kralgund	Qaziabad (Kralgund)	44	6185	0	**1272**
24	Zachaldara	Rajwar	22	4684	0	**4000**
Total			**364**	**108631**	**948**	**69531**
	Urban/MC's	**MC's**	**Wards**			
01	Kupwara	Kupwara	13	1934	25	**803**
02	Handwara	Handwara	13	2011	59	**16**
03	Langate	Langate	13	1094	16	**2**
Total			**39**	**5039**	**100**	**821**
Total Rural+Urban			**364 Village /39 wards**	**113670**	**1048**	**70352**

District Administration

5. Health Care Infrastructure

Year	Distt. Hospitals	S.D. Hospitals	P.H. Centers	Dispensaries		F.W. Center Sub-Centers	Other	Total
				Allop.	Ayud (U).			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2017-18	01	07	54	06	27	236	03	334
2018-19	01	07	54	06	27	236	03	334
2019-20	01	07	55	06	27	235	03	334

District Administration © Kupwara, Jammu and Kashmir.

5.1 Beds Availability

Beds Available in Number

Year	Hospitals	HealthSub-Centers	Dispensaries	Others PHC and NTPHC's	Total
(1)	(2)	(3)	(4)	(5)	(6)
2016-17	315	196	44	325	880
2017-18	320	196	44	325	885
2018-19	320	202	44	325	891
2019-20	390	202	33	325	950

District Administration © Kupwara, Jammu and Kashmir.

5.2 Private Nursing Homes Operating in District Kupwara 2019-20

S.No.	Name-wise Private Nursing Homes	Bed Strength.
01	Waseem Memorial Nursing Home Handwara	10
02	M/S North Kashmir Nursing Home Bypass Handwara	10
03	Doctors INN Maternity Home Chogal Handwara	06
04	Dr. Wani's Quality Health Care Hospital Bramri Kupwara	25
05	ESS BEE Medical Centre Regipora Kupwara	15

District Administration © Kupwara, Jammu and Kashmir.

SPECIFIC PRIORITIES OF THE DISTRICT

1. Institutional Delivery

2. **Demand Generation, IEC/BCC** Nutrition, Health & RCH Education to Adolescents and behaviour Change in the difficult Populations.

3. **Human Resources:** There is a need for more staff in the Kupwara district. Vacant positions need to be filled as well as much more new staff needs to be recruited. To facilitate higher retention of medical staff, staff residences must be constructed, and incentives given to attract medical practitioners.

4. **Capacity Building:** Besides all new staff requiring training, current staff needs regular training to both to maintain and upgrade their skills. Capacity building of the staff is another grey area where much needs to be done. The current and future staff need proper training to ensure that maternal and child health improves in the rural areas. An assessment of training needs is to be carried out for all staff categories against their job descriptions. Appropriate training programmes have to be developed and implemented in the near future. This training must include education to be given to adolescents and children to help shape healthier living patterns (i.e., about alcohol, drugs, sexual practices, nutrition etc). Newer skills need to develop in the staff to face up to the newer needs that are coming up in the district.

5. HMIS Monitoring & Evaluation: Data validation and computerized data availability up to PHCs with district linkages.

6. Procurement and Logistics: Construction of a scientific Warehouse for Drugs

7. Adolescent Health: The focus is on the provision of Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, harmful effects of Alcoholism,

8. Anaemia.

9. Family Planning: Improving the coverage for Spacing methods and NSV.

Report 3

Report on Health Infrastructure and Health Care Delivery Systems in Reasi District.

Submitted by
Dr. Annie Jamwal (Fellow TRI)

Hashmat Habib (Assistant Fellow)

General Characteristics of the District

Reasi is one of the oldest towns of the Jammu and Kashmir State. It was the seat of the erstwhile Bhimgarh State, said to have been established by Raja Bhim Dev somewhere in the 8th century. Bhimgarh state now called Reasi was established by Bhim Dev in the eighth century. On records, the successive rulers are known from 1652, when Hari Dev was the king of Jammu. In 1810, under the rule of Diwan Singh, Jammu was under chaos when palace intrigues and mutinies shook the administration. It was at this time that Maharaja Ranjit Singh sent Gulab Singh to take control and Gulab Singh came down heavily against rebels and established the rule of law and order. After having control on the Reasi area he handed over the administration to his trusted commander, General Zorawar Singh who became the King of Jammu in 1822. It remained an independent principality till 1822, when Maharaja Gulab Singh the then King of Jammu consolidated the small states. Up until 1948 Reasi was a part of Jammu ,but in the first administrative reorganization of the State undertaken in 1948 the major part of the then district Reasi was merged with district Udhampur, while some areas became part of District Poonch (now Rajouri). Later in year 2006 Reasi was carved out as new district out of District Udhampur.

Location & Geographical Area.

Reasi is located at a distance of 64km from Jammu and is bounded by Tehsil Gool-Gulabgarh in the north, Tehsil Sunderbani and Kalakote of District Rajouri in the west, Tehsil Udhampur in the east, Tehsils Jammu and Akhnoor of District Jammu on the south. Reasi sub division has a population of 1,20,380 as per 2001 census with 25.57% Muslims and Hindu majority. Climatically a major part of this Sub-Division falls in sub-tropical zone and the rest in temperate zone. Summers are generally warm and winters cold with snowfall on the high ridges. One of the most beautiful thing about Reasi is that in summer the temperature of Reasi

will be less than most of the districts in Jammu and in winter its temperature will be higher than other districts in Jammu. so this makes Reasi favourable for all kinds of people visiting there.

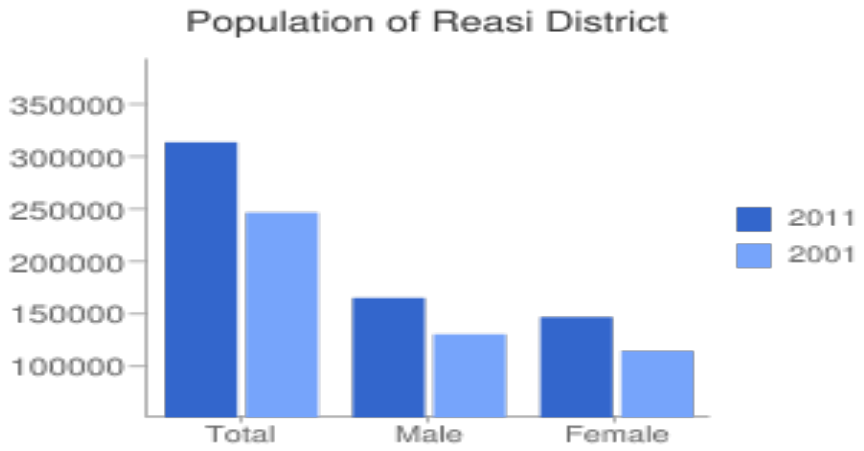
Topography

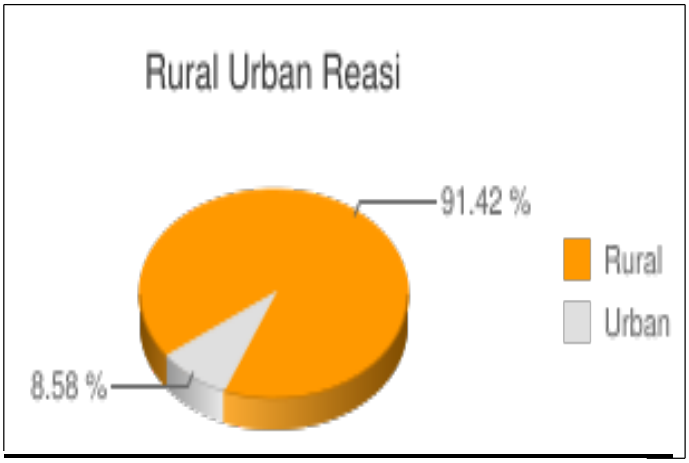
Indian Railways has undertaken the mega-project of construction of anew railway line in the state of Jammu and Kashmir, from Udhampur to Baramulla, which has been declared a national project . The alignment crosses a de ep gorge of the Chenab River, near Salal Hydro Power Dam, which necessitates construction of a long span bridge. After many deliberations, the configurations of steel arches were found most suitable, on account of aesthetics, economy, and availability of local expertise and construction materials. The Chenab Bridge, 359 m (1,178 ft) above river bed, will be the highest arch bridge in the world, and longest span for a BG rail line with arch span of 480 m (1,570 ft).This bridge is in the most difficult part of the project which has been assigned to the Konkan Railway Corporation Ltd. Many experts throughout the globe, based on their versatile and relevant experience, have been involved, in order to make this project a success.

Demographic status:

Description	2011
Population	3.15 Lakhs
Actual Population	314,667
Male	166,461
Female	148,206
Population Growth	27.04%
Area Sq. Km	1,719

Description	2011
Density/km2	183
Proportion to Jammu and Kashmir Population	2.51%
Sex Ratio (Per 1000)	890
Child Sex Ratio (0-6 Age)	919
Average Literacy	58.15
Male Literacy	68.38
Female Literacy	46.59
Total Child Population (0-6 Age)	55,799
Male Population (0-6 Age)	29,079
Female Population (0-6 Age)	26,720
Literates	150,542
Male Literates	93,937
Female Literates	56,605
Child Proportion (0-6 Age)	17.73%
Boys Proportion (0-6 Age)	17.47%
Girls Proportion (0-6 Age)	18.03%





Distinguishing features

- There are certain features in respect of J and K State in general, and Reasi district in particular, which have affected the availability and reliability of data. Some of the useful features of the district are as under:
- Parts of the district are hilly. In certain CD Blocks most of the portion is inaccessible and hilly. Further, forest covers good proportion of the area of the districts. Consequently, depending upon topography, district Reasi consist of difficult and inaccessible areas. While it is difficult for the people to access services, on one hand, on the other, it is also difficult for health services to extend, upgrade and improve services. It is difficult to organise outreach activities and maintain regular supplies, especially in the context of essential medicines, vaccines, etc.
- Due to the lack of amenities, it is very difficult to attract and retain human resources. There are significant number of vacancies in respect of various professional (specialists, surgeons, GDMOs), nursing, technical and support staff. This necessitates development of human resources policies and strategies appropriate to the region. In this connection modes like PPP and contracting may be used but after proper elaboration of the terms and conditions and payment system
- There seems to be different administrative units prevalent in respect of different agencies (Census, Revenue Department, Medical and Health, etc.). The Medical and

Health department has Medical Blocks. There are Tehsils, Community Development Blocks, Medical Blocks, Panchayats, Patwar Halqas, Gram Sabha and Villages. The units, which are conventional and are adopted by Agencies like Census and Rural Development Department may be taken as popular units than inventing or adopting different administrative units (for example Medical Blocks). It is some time difficult to reconcile geographical areas covered by them, which renders it impossible to compare data emanating from different units.

- Even at the lowest level, the concept of village is a bit misleading. Excepting some, most of the villages do comprise a number of settlements with different names than the overall village; commonly known as 'Modas'. Usually it takes considerable time to travel from one settlement to another, especially in hilly areas. This aspect is particularly important, inter alia, when we chose Anganwadi Worker or ASHA or conduct immunisation sessions.
- As motorable roads do not connect all settlements, travelling on foot and local modes of transport becomes necessary. At some hilly and inaccessible places, mules are resorted to for transportation of supplies as well as ill or incapacitated persons. Consequently while tackling about the issues of accessibility (from the side of community) as well outreach and ensuring timely supplies (on the part of Health Department and other agencies), these factors need to be taken into account and provided for in the future plans.

The district is comprised of a large number of unserved and underserved areas. This is due to the fact that there are straight and dangerous mountains, no health facilities, no transport, no social development, spread out population and migratory tribes.

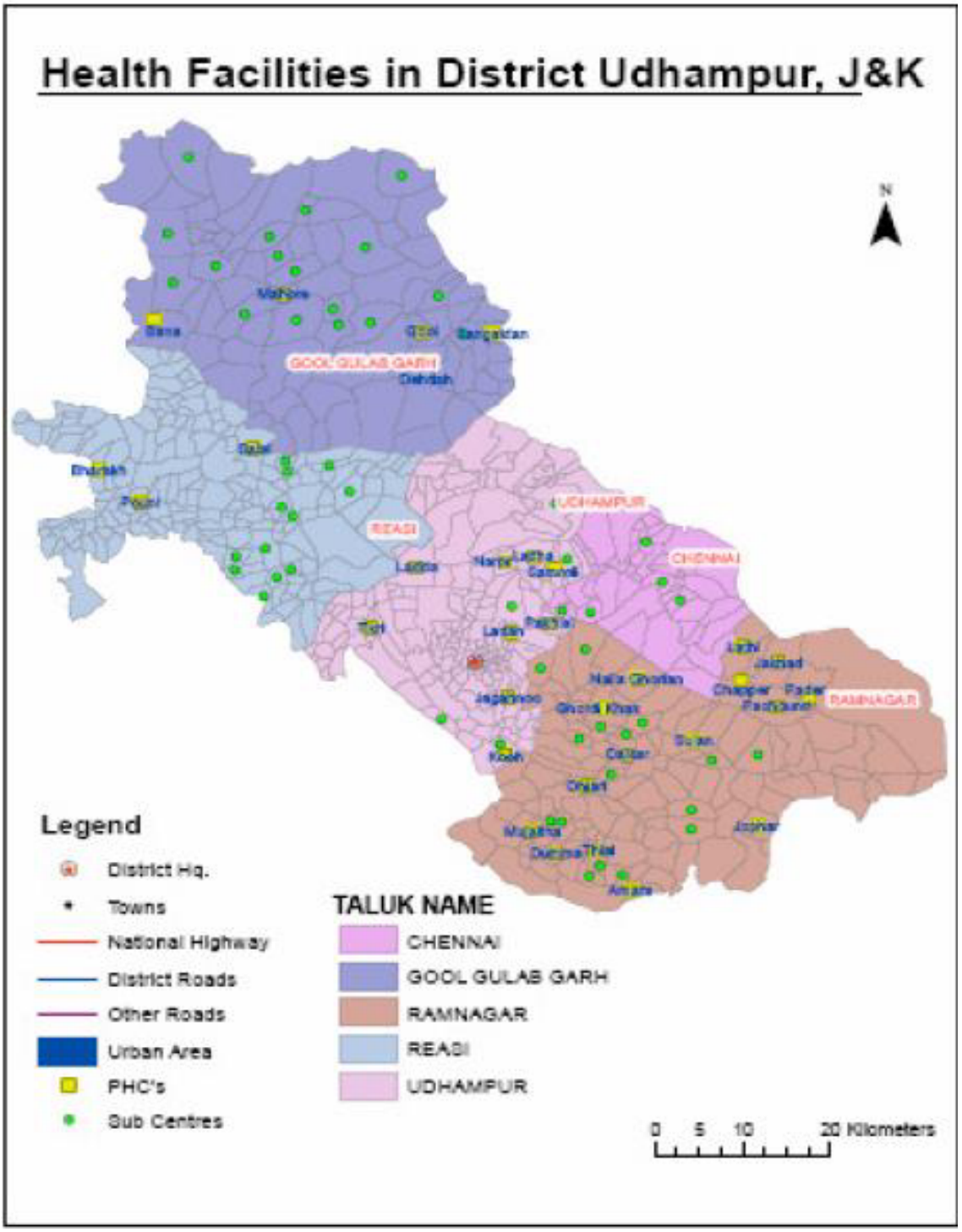
Specific Priorities of the District:

1. **Availability of Primary health care services:** Providing services of ANC, Safe delivery, PNC, Immunization, DOTS, Anaemia prevention, prevention of Malaria at the village level.
2. **Programme Management:** Efficient functioning of the District Health Society, a strengthened CMO's office with efficient district and Block programme managers and management units.
3. **Demand Generation, IEC/BCC:** Behaviour Change for utilization of services.

4. **Human Resources:** Filling of the vacancies as per the population based norms, increased mobility, increased incentives for retaining the personnel in difficult areas, motivational issues, provision of residential facilities, Availability of well-trained ASHAs.
5. **Capacity Building:** Focussed capacity building in Emergency Obstetric Care, Management, Continuous skill building of all personnel as per needs expressed and also the new job responsibilities under NRHM, opening a Staff Nurse Training College and Paramedical Staff training centre.
6. **Maternal Health:** Well managed system of deliveries by skilled birth attendants, promotion of institutional deliveries (labour rooms in all sub centres with residential facilities for ANMs), Emergency Obstetric Care services, JSY extended to all the pregnant women, Blood Storage Units in all CHCs. All CHCs to be developed as FRUs, PHC to be developed as 24x7 facilities with good referral mechanisms.
7. **Neonatal and Child Health:** Provision of Neonatal services at CHC, PHC, with trained personnel on IMNCI and IMCI and addressing Anaemia and Malnutrition
8. **Immunization:** Total coverage for immunization of children, pregnant women and adolescents
9. **Family Planning:** Improving the coverage for Spacing methods, NSV and Tubectomy.
10. **Adolescent Health:** Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, marriage at right age.
11. **National Disease Control Programmes:** Prevention and treatment of Malaria, Tuberculosis, Anaemia and malnutrition
12. **Infrastructure**: Increase in the number of Subcentres, PHC, CHC and General hospitals catering to the entire population and developing all the facilities as per IPHS norms.
13. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs**.**
14. **Monitoring and Evaluation:** Data validation and computerized data availability upto PHC with district linkages.
15. **Public-Private Partnership:** Involvement of the private facilities for providing services and NGOs.
16. **Intersectoral Convergence:** Involving the related departments as members in the District Health Society, Fixing Responsibilities of each sector for their accountability and Intersectoral Coordination .

Health infrastructure of Reasi district:

Name of District	DHs	CHCs	PHCs	NTPHC	MAC	SC	New SCs	Total
Reasi	1	2	12	10	9	64	39	137



Source: Government of Jammu and Kashmir

Family Planning Status:

Block	Sterlization		IUD		Condoms		Oral Pills	
	Dec-06	Dec-07	Dec-06	Dec-07	Dec-06	Dec-07	Dec-06	Dec-07
Katra	23	10	41	50	19000	9000	410	431
Reasi	40	97	60	40	10750	14050	394	418
Pouni	152	69	71	62	20000	22800	593	582
Mahore	20	65	308	436	14500	34030	1319	1863
Total	235	241	480	588	64250	79880	2716	3294

Source: CMO Office

Community Health Centre (CHC) District Reasi

(BPHC)/CHC Status	CHC Mahore	CHC Gool	CHC Pouni	CHC Reasi
Total no. of beds	Nil	5	10	12
Total no of OPD cases	150	60	110	200
Bed occupancy rate	Nil	40-60%	40-60%	40%
Up gradation of RKS	Nil	Yes	Yes	Yes
Vehicle/Ambulance	Yes	Yes	Yes	Yes
Ambulance with NGO partner	DNA	DNA	DNA	DNA
Rogi Kalyan Samiti	Yes	Yes	Yes	Yes

Source: CMO Office

Number of Institutions Requiring New Buildings

#	Category of Institution	Numbers
1	SC	45
2	PHC	15
3	CHC	0

Source: CMO office

Percentage Availability of Infrastructure

District: Reasi					
	Indicators	**SC (68)**	**PHC (22)**	**CHC (3)**	**DH**
1	Building (Govnt. + Donated)	47	63	100	
2	Building (Rented)	53	37	0	
3	Condition of Building (Good + Fair)	47	55	90	
4	Water Supply (Tap, borewell/ handpump/tubewell, well)	19	50	30	
4.1	Tap water supply	18	25	70	
5	Electricity	45	80	100	
5.1	In all parts of hospital	0	50	100	
	Electric supply (power generation stablization)	0	0	0	
6	Separate Toilet	0	0	80	
6.1	Sep.Toilet with running water	0	0	80	
7	Examination Table	77	71	100	
8	Labor Room	0	0	90	
8.1	Aseptic labor room	0	0	90	
9	Avail. of Quater for staff	0	22	0	
10	Number of beds available (Average)		2	12	
11	Laboratory		30	100	
12	Operation Theatare		0	100	
13	Waste Disposal (Burnt+Dump)		76	100	
14	Availability of incenator		0	0	
15	Telephone		0	80	
16	Computer		0	80	

Source: NRHM Jammu Division

Access to services:

1. Reaching the unreached population throughout reach services and mobile health units

2. Ensuring availability of service providers like Specialists, Doctors, and Staff Nurses and retaining the staff in the difficult areas.

3. Increasing overall access to RCH services, especially FP services through public private partnerships

Quality of services:

4. Improving quality of services at all levels through the use of standard protocols and systems

5. Improving the condition of the facilities as per the IPHS norms including provision of

quarters for the personnel

6. Building capacity of functionaries at all levels for improving quality of services

Programme management:

7. Strengthening programme management and CMO office with good Infrastructure and additional human resources through DPMUs.

8. Strengthening the HMIS through the development of GIS based MIS.

9. Building capacity of programme managers at the district and block levels for improving quality of management.

10. Improving supervision and monitoring of services and resource utilisations for achieving intended health results.

Report 4

Report on Health Infrastructure and Health Care Delivery Systems in District Baramulla.

Submitted by
Dr. Annie Jamwal (Fellow TRI)
Hashmat Habib (Assistant Fellow)

General Characteristics of the District

The city of Baramulla, founded by Raja Bhimsina held the position of a gate-way to the valley as it was located on the route to the Valley from Muzaffarabad, now in POK, and Rawalpindi, now in Pakistan. As such, a number of prominent visitors have been to Baramulla. These include the famous Chinese visitor Hiuen Tsang and Moorcraft, the British historian. Mughal Emperors has special fascination for Baramulla. Being the gate way of the valley it was a halting station for them during their visits to the Valley. In 1508 A.D. Emperor Akbar who entered the Valley via Pakhil spent a few days at Baramulla and according to "Tarikh-e-Hassan" the city during Akbar's stay, had been decorated like a bride, Jehangir also stayed at Baramulla during his visit to Kashmir in 1620 A.D. From the very beginning, Baramulla has enjoyed religious importance. The construction of Hindu Teeratha and Buddhist Viharas made the city scared to Hindus as well as Buddhists. In the 15th Century, the place became important to muslims also, as the famous muslim saint, Syed Janbaz Wali, who visited the valley alongwith his companions in 1421 A.D.chose Baramulla as the centre of his mission and after death, was buried there. His shrine attracts Pilgrims from all over the Valley. In 1894 the sixth Sikh Guru Shri Hargobind Ji visited the city and Gurdawara "Chatti Padshahi" was constructed in his memory, Baramulla thus became an abode of Hindus, Muslims, Buddhists and Sikhs living in harmony and contributing to a rich composite culture.

Location and Geographical area:

Baramulla district is largest in the entire valley both with reference to the population and area. Baramulla district is bounded by Kupwara district in the north, Budgam and Poonch in the south, parts of Srinagar and Ladakh in the east. Baramulla district has severe cold in winter and pleasant weather in summer. Annual rain fall in the district is usually registered 1270 mm. Soil in hilly areas is poor but in the plain areas it is fertile about 83.05% of the population lives in

villages and 16.94% in urban areas. Crops like paddy maize pulses grow in abundance. In addition to this the district is also rich in fruit growing, The district is spread from Srinagar district and Ganderbal district in the east to the line of control in the west and from Kupwara district in the north and Bandipore district in the northwest to Poonch district in the south and Badgam district in the southwest. Baramulla city is located on the banks of Jhelum river at the highest point of the river. The old town lies on the north (right) bank of the river and the new town lies on the south (left) bank. They are connected by five bridges including a suspension bridge connecting Gulnar park with Dewan Bagh. The district is located between 33 degree to - 44 North latitude & 75 degree to 96 E Longitude.

Demographic profile:

Baramulla District is the largest District in entire valley both with reference to the population and area. The District has a total population 8, 44,141(Census-2001 projection) out of which 4, 34,694 are male and 4, 09,447 are female which lives in 526 villages. The projected population of 2008 ranks the district 2nd in Kashmir valley with population of 10.25 lakhs. The district is predominantly rural in character as 86 percent population is rural. As per census 2001 the district has recorded a sex ratio of 909, which is higher as compared to the state sex ratio of 892 females per 1000 males. The sex ratio of 0-6 year's population as per the census 2001 is 818 for the district which is less than the state ratio of 937 for the same group. The overall literacy rate of the district as per census 2001 was 49 percent, which is less than that of the state average of 55 percent. The male literacy rate was higher (67 percent) in the district as compared to that of the females (48 percent). The district is way behind in terms of literacy rate both for males and females as compared to that of the state average. The district has Below Poverty Line (BPL) population of 27 percent (237068 persons) as on 1st October, 2007. Overall Scheduled Tribes (STs) account for six percent of the total population of the district as against 11 percent for the state. Total Scheduled Caste population in the district is only-92 persons. The migrant labourers are also working not only in urban areas but in rural areas predominantly. The dominated pockets of the district are Uri & peripheral villages of the block Tangmarg, Kreeri & Sheeri because of severe impact of 8th October 2005 earthquake.

Health Infrastructure Facilities

The Primary Health Care infrastructure has been developed as a three tier system with sub-centre, primary health centre and community health centre. Besides, one district hospital at the district headquarter, there are other different types of health institutions both public and private in the district to cater the health needs of the people. There are 134 SCs, 43 PHCs including 15 PHCs which have been designated as 24x7; six CHCs, seven first referral units (FRUs), 31 ISM (AYUSH) dispensaries, 21 Allopathic Dispensaries (ADs) and 11 private health institutions in the district. Overall more than half of the private health intuitions have a bed capacity of 30 or more. The information collected from the CMO office shows that all the six CHCs and 15 PHCs are operational on 24x7 bases but during our visit to the selected CHCs/PHCs we could find as none of selected 24x7 PHC was operational after 4.00 p.m. and out of selected two CHCs, one of the CHC was also running the same way. It was reported by the CMO that in all the CHCs and first referral units' facility survey as per Indian Public Health Standard have been completed but this statement was negated by the officials when we visited the selected intuitions during the survey.

Particulars	District Hospital	Community health centre	Public health centre	Sub-centre
Requirement of health centres as per norms	1	13	52	254
Existing health centres ending 3/2011	1	6	33	128
Shortage	-	7	19	126

(Source: Departmental figures)

Delivery Facilities

Regarding the health institutions which were providing all types of maternity facilities in the district, the data shows that there are 26 health institutions that provide delivery services to the pregnant women. Besides the district hospital, all the CHCs in the district provide this service to the women while as 15 PHCs are also providing normal delivery facilities to the women. Facility for both normal and caesarean section deliveries is available at the district hospital and some CHCs. Complete BeMOC is available in the district hospital and some designated CHCs and old type PHCs. Besides the district hospital, atleast two CHCs provide complete CeMOC facilities to the needy women. Two private health institutions of the district have also been

recommended for Public Private Partnership (PPP) and brought under the scheme of JSY. The district hospital, three CHCs, five PHCs, and two public maternity homes have the facility of New Born Care Units.

Human Resource

Both medical and Para-medical staff is the backbone of any health facility. No health programme can run smoothly without the availability of trained and technical human resource. As per the data collected regarding the staffing pattern in the district, it shows that all the 28 positions of Medical Officers are filled-in while as out of 7 sanctioned positions of Gynaecologists only 3 are regular in position. Further, out of the six sanctioned posts, only one post of Paediatrician in the district is presently in position. Overall actual shortfall of the manpower of different positions in the district was 29 percent. The shortfall was 57 percent in case of gynaecologists, 17 percent for Anaesthetists, 83 percent for paediatricians, 24 percent for staff nurses, 11 percent for ANMs and 57 percent in case of other specialists. During the survey it was observed that this shortfall of the human resource has severely affected the functioning of various health institutions in the district. One of the CHC (Chandoosa) was without any specialist and permanent Medical Officer. The SCs at certain places are run by a nursing orderly. The information collected shows that three staff nurses and 32 ANMs have been engaged on contractual basis in the district.

Rogi Kalyan Samitis (RKS)

The concept of community ownership in the NRHM has a direct reference to RKS and as per the guidelines CHCs/PHCs are to be brought under the community ownership through the system of RKSs. It would be a committee which would have members from the PRI, the civil society, health professionals, and NGOs. The RKSs are registered societies. The RKSs are envisaged at all levels such as district/CHC/PHC. Under NRHM it is envisaged that the hospital care system would move towards a fully funded universal social health insurance scheme. This system would obviously work only when the personnel working in the CHCs are not part of a State cadre but are recruited locally at the district level by the District Health Mission on contract basis. Since evolving such a system is likely to take some time at the first instance, it is proposed to give control of the budget of the PHCs/CHCs, and district hospitals to the Rogi Kalyan Samitis. Since all the RKSs at CHC and PHC levels get a grant of Rs. One lakh and are authorized to retain the user fee for its day to day expenses. They are also supposed to generate

funds for the use in various activities related to the development of the institution. The information provided by the DPMU Baramulla shows that RKSs have been constituted and registered for the DH, all the CHCs and PHCs. It was also observed during the field survey that RKSs are functional and meet regularly.

Janani Suraksha Yojna (JSY)

The National Rural Health Mission is a statement of hope and conviction. The government is committed to achieve the goals laid down in National Population Policy and National Health Policy. For the underserved poor at the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit. In many parts of the country, the public health system has not been in a satisfactory State; therefore, NRHM is to strengthen the public health institutions like as SCs/PHCs/CHCs and District hospitals so that all the health programmes may run smoothly and effectively. Such integration within the health department would make available more human resources with the same financial allocations and would also promote more effective interventions for health care. The Mission had to undertake suitable public- private partnerships to meet the deficiencies in the public health delivery system. Under the Mission, Janani Suraksha Yojna (JSY) is an innovative scheme to universalize the utilization of maternal health services. Under the scheme, cash assistance is given to the women who receive ANC during pregnancy period, institutional care during delivery and immediate post-partum period in a health facility. The basic aim of the scheme is to reduce the IMR to less than 30, MMR to 100 and increase institutional deliveries to 80 percent.

Financial Mechanism

There are a large number of schemes running in the health sector interventions. Many of these programmes pertaining to disease specific control programme. Many other related to family welfare. Special programmes have been initiated as per need for diseases like TB, Malaria, Filaria, HIV/AIDS etc, The NRHM has to strengthen the public health institutions for all health programmes and to bring all of them within the umbrella of a health plan so that preventive, promotive and curative aspects are well integrated at all levels.

District Hospital

District Hospital is the apex health facility in the health care system in a district and provides almost all the specialized health care services to people on subsidized cost. The District Hospital Baramulla is one of oldest district hospital in the state and perhaps among the first ones'. Major units of the hospital are still in the old building and few units have been shifted to the new hospital building which is still under construction. District Hospital Baramulla not only caters to the health care needs of its own population but also a large population from adjoining districts of Kupwara and Bandipora also get the specialized services from this hospital. The hospital is located in the heart of the town on the banks of river Jhelum and is hardly half a kilometre away from the general bus stand. The nearest CHC is at a distance of 20 Kms from the DH and it takes about 45 minutes to reach the destination by public transport. The farthest CHC is 50 Kms away from DH and it takes 2 hours to reach the CHC by public transport. The Medical Superintendent of the DH reported that the facility survey was carried out in the district as per Indian Public Health Standard.

Hospital Services

Under NRHM, the district hospitals are to be strengthened so as to provide quality health services. In addition Rogi Kalyan Samitis have been established at the district hospitals so as to utilize the untied fund for the development of the hospital to make them more effective in terms of better delivery of services to the people. This part of the information deals with the general amenities and facilities available at the district hospital. The information collected shows that surprisingly the kitchen facilities are not available in the hospital. Most of the facilities like the Central Sterile and Supply Department (CSSD), hospital laundry, medical and general stores, ventilation in the wards both natural or exhaust, water coolers/refrigerators, round the clock water supply, and overhead water storage tank with pumping and boosting arrangements were available in the hospital. The facilities like the engineering and provision for firefighting in case of any emergency were not available in the hospital.

The State Pollution Control Board (SPCB) and the State Directorate of Health Services have issued strict orders to all the Government and Private Hospitals/ Nursing Homes to strictly comply with the norms laid down for the disposal of the bio medical waste and in this background such directions were followed in the district hospital and mostly the bio medical waste is either outsourced to the agency or buried. It was observed by the survey team that Bio

Medical Waste was segregated in three different bins placed outside the rooms in the hospital. The proper drainage and sanitation system for waste water, surface water, sub soil water and sewerage was found in place in the District Hospital.

Community health centre (CHC)

The CHCs are currently provided on the population norm of 1 per 1, 20,000 population in general areas and 1 per 80,000 population in tribal/desert areas. Under the Mission, the CHCs are conceived as the first major curative health service providers addressing 80 percent of all ailments requiring out-patient services or hospitalization. Since the credibility of any health institution is generally determined by the standard of curative services it provides as benchmarked to the best institutions, the Mission attaches utmost importance to strengthen the existing CHCs and build up new ones to bring the number of CHCs broadly in conformity to the ratio of one per one lakh population. Lack of accountability in the CHCs has been the main reason for patients preferring private facilities over them. To bring in quality accountability in the health services, Indian Public Health Standards (IPHS) have been set up for the CHCs. IPHS is a novel concept to fix benchmarks of infrastructure including building, manpower, equipment, drugs, quality assurance through introduction of treatment protocols.

CRITICAL ISSUES AND PRIORITY ACTIONS

Themes	Critical Issues	Specific Priorities
District Health Management:	Training Monitoring and evaluation.	Capacity building of the members of the District Health Mission and District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews and also on GoI / GoJ&K guidelines for running the District. Health & FW Society Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. Formation of a monitoring Committee from all departments.
District & Block Programme Management	Strengthening monitoring and reporting	Development of total clarity amongst officials and Consultants about NRHM activities. Training of district officials and Block SMOs Streamlining Financial management and systems

		Capacity building of the DPMU personnel for monitoring
Reducing maternal and child deaths	Increasing Institutional deliveries	Construction/repair of S/Cs and PHCs where ever required Operationalisation of 24X7 PHCs. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHC, CHC and ANMs at the sub centres Plan IEC/BCC activities Timely incentive to JSY beneficiaries & ASHAs Strengthen FRUs for Emergency Obstetric Care services along with minimum basic infrastructure, drugs, blood storage facility and equipments.
Family Planning	Low level of FP acceptance. Lack of motivation for adoption of FP methods Low level of male participation	Increased awareness for Emergency Contraception and 10 yr Copper T. Partner with private doctors for FP and RCH services Plan IEC/BCC for family planning methods

	Adolescent Health	Adolescent boys are exposed to smoking, drug addictions, and alcoholism. Lack of knowledge amongst adolescent boys and girls about RH and life skills	Implement life skills programme through schools and NGOs to increase the knowledge levels of Adolescents on RH and Life skills Operationalise Adolescent Friendly Health services at the health facilities.
	Mobile Medical Units (MMUs)	Remote population is not covered Sufficient staff and logistics.	Provide MMUs services. Contract MOs and staff nurses for MMUs
	Upgrading CHCs to IPHS	No CHC is as per IPH standard.	Upgrade Boniyar, Kunzer, Rohama and Dangiwacha Block PHC as CHC Upgrade all functional 6 CHCs and Boniyar Block PHC to IPHS. Additional 7 CHCs to be built as per population
	Upgrading PHCs for 24 hr Services and IPHS standards	There are 49 PHCs but only 2 are functioning 24 hrs No PHCs are as per IPHS	20% PHCs to be upgraded every year to IPHS 14 PHCs in rented building require constructions* Construction of staff quarters in all 49 PHCs Placement of doctors, paramedics & other staff

			Equipments and drugs for making it functional for 24 hrs Additional 19 PHCs to be built as per population.
	Upgrading Sub Centres to IPHS standards	Out of 155 sub centres, 135 sub centres are in rented buildings and only 26 sub centres are in government buildings. There are no staff quarter in any of the sub centres There is no fencing in sub centres	Need to construct 135 Subcentres building.* Construction of delivery rooms in SCs for institutional deliveries Drugs, equipments and human resources as per IPHS Construction of staff quarters for all SCs. Construction of fencing in all SCs Additional 255 SCs to be built as per population.
10	Immunisation	Lack of awareness amongst parents Alternate vaccine delivery Lack of Cold storage Efficient monitoring and supervision Frequent power breakdown	Strengthening the District Family Welfare Office Enhancing the coverage of Immunization Alternative Vaccine delivery mechanisms in place Effective Cold Chain Maintenance upto sub centre level Power back up

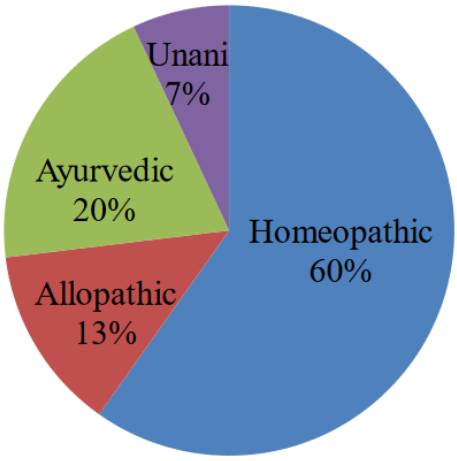
Inter Sectoral Convergence	Lack of coordination between ICDS and health department	Linkages to be developed between ICDS workers and health workers - by joint planning and monitoring of activities
	Lack of coordination between RDD and health department	Linkages to be developed between the Health Department and the Rural Development department Awareness on sanitation/ Hygiene Covering of school/ Anganwari for hygiene and sanitation education Promote & encourage cost effective construction of household latrine & their proper use and eliminate open defection
	Lack of coordination between PHE and health department	Provision of Bleaching powder and chlorine tablets Joint communication strategy. Sharing quality monitoring with the Health Department at block, district and state levels Community based organisations will be engaged by a team of frontline workers – health, ICDS and PHE departments.
Human Resource	Lack of manpower at all levels starting from Sub	All staff to be in place as IPHS norms by 2010 Increased salaries for contractual doctors and

	centres to PHCs to CHCs to DH	Specialists Special allowances for Regular staff.
Capacity Building	Lack of skills at all level from VHWSC to MO	Fully skilled personnel at all levels in the Health sector, ICDS, PRIs, NGOs and private sector for provision of services. Allowing Specialists and MOs for developing special skills as per their needs by attending special courses anywhere in India.

Particulars	*Sub-centres*	*PHC's*	*CHC's*
Number of the health centres checked	**20**	**11**	**4**
Centres housed in private buildings	17	2	-
Buildings in bad condition	18	3	1
Poor cleanliness	18	1	1
Citizens charter not displayed	20	7	1
Complaint box not maintained	20	8	2
Separate utility for men and women	17	3	3
Operation theatre not existing	-	4	1
Labour room not present	19	5	-
Separate male and female wards not present	-	4	1
No waiting rooms	-	10	2
No provision for water supply	19	1	-
No provision for water storage	20	1	-
No sewerage facilities	-	6	3
No bio-waste disposal facility	20	10	4
No electricity	20	1	-
No stand- by power	20	5	-

Departmental Figures

Fig. 2: System of treatment of Gujjar and Bakerwals Uri Tehsil of Baramulla District



Credit: Anzar Nabi *et al*.

Report 5

Report on Health Infrastructure and Health Care Delivery Systems in Anantnag District.

Submitted by

Dr. Annie Jamwal (Fellow TRI)

Hashmat Habib (Assistant Fellow)

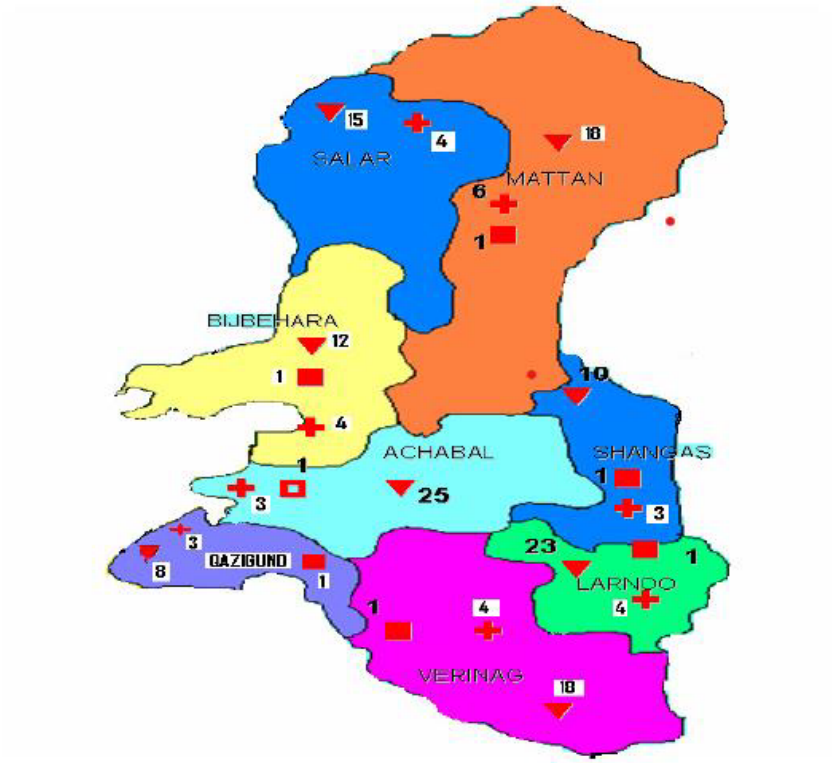
General Characteristics of the District

Anantnag is one of the districts of the Kashmir Valley situated in its South and Southwestern direction at a distance of 52 Kms of Srinagar. Anantnag is spread over an area of 2092 sq. Kms. with a population of 7.32 lacs and sex ratio is 922 females per 1000 males as per Census 2001. There are 406 villages, 158 Gram Panchayats and 7 CD blocks in the District. And about 85% of the population lives in rural areas. The population density of the district is 350 as per 2001 census. The literacy rate of the district is 44% as compared to 54% at state level. The male literacy rate is 56% and for females it is 32%. The district is famous for its countless springs and streams and is the gateway to the Kashmir Valley. It is also called the granary of the Kashmir Valley as it is very fertile agriculturally. The district is predominantly rural and situated at an average height of 1700 meters above sea level.

The district is significant for its being an important halt for the 'Amarnath Yatra' that takes place in the summer. Despite the unstable conditions in the region the yatra has been going on successfully every year due to the devout fervour of the pilgrims and the bravery of the local people who contribute towards the safe and well-looked after pilgrimage area. The local population is economically dependent on farming practices and the tourist trade that comes in during the summer months as also during the pilgrimage season.

Anantnag has recently had the district Kulgam carved from it and till date the efforts are on to significantly bifurcate one block viz, Quazigund in a manner that is suitable to both the districts. Divided into 8 blocks Anantnag houses the breathtakingly beautiful valley of Pahalgam and has hosted lakhs of pilgrims on their way to the formidable Amarnath yatra every year.

DISTRICT: ANANTNAG



Source: GOI

Health Sector in district:

The role of Health Sector has assumed greater Significance in District Anantnag in view of its topography and presence of tourists almost in all seasons of the year in general and Amarnath ji yatra in particular. It is worthwhile to mention here that the cave is situated in that part of the Himalayan Mountains which lies in the Pahalgam area of the District. The District has seven Medical Blocks namely Achabal, Bijbehara, Larnoo, Mattan, Sallar, Shangus and Verinag. There are 03 District Hospitals located at the District Headquarter which include Mirza Mohammad Afzal Beigh Memorial Hospital, Maternity & Child Care Hospital and District Tuberculosis Centre. Besides, there are 05 Sub District Hospitals located at Bijbehara, Dooru, Seer Hamadan, Shangus and Kokernag. Moreover, the District has 27 primary Health Centres (PHC's), 36 New Type Primary Health centres (NTPHC's) , and as many as 137 Sub Centres

(SC's) spread in nook and Corner of the District for providing easy and efficient health care facilities to general public. The main activities performed by these health institutions are general health care, (RNTCP) Revised National Tuberculosis Program, (NLEP) National Leprosy Eradication Program, (COB) Control of Blindness, School Health check-ups. Under the flagship programme of National Health Mission (NHM), institutional deliveries have increased tremendously in rural areas and the maternity as well as the infant death rates have also decreased.

Govt. has already considered establishment of a Medical College in the District, for which land has been identified at Dialgam Anantnag. Proposal for setting up a Nursing Training College is underway .Besides sanctioning of AIIMS at Awantipora which is also nearer and appropriate location to facilitate superficiality health care to people of this district as well.

The district has made considerable progress in providing of medical facilities to the public the details reflecting structure of Health and Medical facilities available in the district are given on the succeeding pages including both rural & urban areas.

NO	District	Population	Growth Rate	Sex Ratio	Literacy	Density
1	Anantnag	1070000	38.58%	927	64.32	302

Infrastructure

Number of Health Institutions in District Anantnag

Category	Total
District Hospital	1
Sub District Hospital SDH/CHC	5
Maternity & Childcare Hospital	1
District TB Hospital	1
Primary Health Centre PHC	26
New Type PHC	36
Mobile Medical AID Centre	1
Sub Centres	137
General Nursing and Midwifery School	1
Auxiliary Nursing and Midwifery School	1

Human Resources

Category	Sanctioned	In position	Vacant
Gazetted			
Sr. Consultant	4	3	1
Consultant	59	48	11
Medical Officer	161	133	28
Dental surgeon	40	38	2
Administrative posts	58	49	9
TOTAL	322	271	51
Non Gazetted			
Para Medical Staff	439	416	23
Class IV	316	316	0

Source: dhskashmir.org

Priorities as per background and planning process

National Rural Health Mission encompasses a wide range of health concerns including the determinants of the good health. Though there is a significant increase in resource allocation for the NRHM, there can never be adequate resources for all the health needs and all that needs to be done for ensuring good health of all the people. It is therefore necessary to prioritize the areas where appropriate emphasis needs to be given. Based on the background and the planning process following are the overall priorities of this District:

1. Low Institutional Delivery: Due to the undulating terrain there has been a marked lacuna in this area of health care delivery to the district. The dependence of the population on the government practitioners is almost total as there is very little private practitioner presence.
2. Demand Generation, IEC/BCC Nutrition, Health & RCH Education to Adolescents and Behaviour Change Communication for difficult to reach populations like the sheep rearing communities or Bakarwals and the tribals.

3. Human Resources: There is a need for more staff in Anantnag district. Vacant positions need to be filled as well as more staff needs to be recruited. To facilitate a higher retention of medical staff, staff residences must be constructed, and special, attractive incentives given to attract medical practitioners.
4. Capacity Building: All new staff would require training while the current staff also needs regular training to both maintain and upgrade their skills. Thus, capacity building of the staff is a grey area requiring attention. It is therefore essential to work out a strategy for capacity building suited to the district to ensure that maternal and child health improves effectively in the rural areas. An assessment of training needs is to be carried out for all staff categories against their job descriptions. Appropriate training programmes have to be developed and implemented in the near future. This training must include education to be given to adolescents and children to help shape healthier living patterns (i.e., awareness and information about alcohol, drugs, safe sexual practices, nutrition etc). Newer skills need to be developed in the staff to face up to the newer needs that are emerging in the health scenario of the district.
5. HMIS Monitoring & Evaluation: Data validation and networked, centralized computerized data availability up to PHCs with district linkages.
6. Procurement and Logistics: Construction of adequate, standardized warehousing facilities for the storage of Drugs.
7. Adolescent Health: The focus is on provision of Adolescent Reproductive and Sexual Health [ARSH] education to school children at the tender stages where they can obtain the maximum information and be aware besides awareness building on good health practices, responsible family life, and harmful effects of alcoholism. There is a tendency among the young males to succumb to depression which needs to be addressed immediately.
8. Anaemia. A rampant occurrence among the poorer sections of the district and especially in the rural and tribal populations. There is need to take care of this condition immediately.
9. Family Planning: Improving the coverage for Spacing methods and NSV. As this a Muslim majority area there is a mindset against family limitation practices which is prevalent widely. However, the population and especially the women are agreeable to adopting spacing methods to improve the quality of life of themselves and their children. This aspect needs to be highlighted and addressed accordingly.

Name of Block											Total for District
Name of Health Blocks		Achabal	Bijbehara	Mattan	Shangus	Sallar	Verinag	Qazigund	Larnoo	DH / MCCH	
Health Institutions											
No. of Gen. Physicians	Govt.	-	1	-	-	-	-	-	-	02	03
	Pvt.	-		-	-	-	-	-	-	-	-
No. of Radiographers	Govt.	-	01	-	-	-	-	-	-	01	2
	Pvt.	-		-	-	-	-	-	-	-	-
No. of Public Health Nurses		-	-		-		-		-	01	01
No. of Staff Nurses		2	11	10	2	2	4	8	2	18+6	65
No. of LHVs		1	2	02	1	02	00	01	2	1+0	12
No. of Pharmacists		26	16	22	12	15	18	12	27	10+2	160
No. of Lab. Technicians		2	1	6	3	4	4	04	06	4+2	36
No. X Ray Technicians		1	1	4	2	4	2	4	00	2+1	21
No of Ophthalmic Assts.		1	1	2	1	1	2	3	2	1+0	14
No. Dental Mechanics/Hygienists		-	-	-	1	1	1	-	-	1+0	4
No. of MPHWs		5	4	4	5	2	7	2	8	0+0	37
No. of ANMs		21	19	25	12	15	18	10	21	4+0	145
No. of AW Workers		195	127	232	76	82	198	286	196	0+0	1392
No. of UDCs		3	0	6	0	0	3	4	4	4+0	24
No. of LDCs		2	0	4	0	0	0	0	2	1+1	10
No. of Computer/Statistical Assts.		-	-	-	-	-	-	-	-	1	01
No. of Drivers		4	7	7	2	6	5	6	4	2+2	45
No. of ASHAs selected		105	75	111	79	64	98	213	135		880
No. of Trained Dais		45	20	46	35	20	34	30	30		260
No. of Asst. surgeons		12	16	19	10	12	19	09	18	27+7	149

Source: Government of Jammu and Kashmir (2007)

Summarized Recommendations gathered from the Village Action Plans of District Anantnag:

1. RCH/Maternal Health: Complete awareness of ANC, Provision of Iron folic tablets, Calcium, Vit. A, at the sub-centres in adequate quantities. Facilities for institutional delivery at sub-centres and transportation for the pregnant ladies has also been suggested.
2. Child Health & Immunizations: Improvement in Child Health component under NRHM by having required supply of vaccines at sub-centres, complete awareness about immunizations among the public. Provisions for cold chain maintenance and proper delivery system have also been strongly recommended.
3. Family welfare: Stress on availability of preventive measures like contraceptives at the sub centres and there should be emphasis on increasing awareness and encouraging use of contraceptives among the people by all health personnel.
4. Adolescent health: Vigorous awareness campaign has been suggested in the village plans and has been urged to be taken up seriously under the NRHM purview. Guidance, counselling facilities at sub centres, proper scrutiny of RTI/STI cases and awareness regarding RTIs and STDs has also been recommended.
5. National Disease Control Programme: As T.B is prevalent throughout the district recommendations for complete eradication of the disease by taking proper measures like wide-spread awareness generation, anti-tobacco campaign, personal hygiene, anti-pollution drives, highly organized DOTS programme, random checking of sputum and blood samples among the vulnerable group are also some of the suggestions made in the village plans.
6. Leprosy control: Proper guidance and awareness regarding symptoms and treatment of leprosy cases has been suggested repeatedly.
7. Blindness Control: Increasing the frequency of cataract and eye check-up camps which normally happen once in a year or two. This aspect has been strongly recommended in the village plans. Availability of Vit. A at sub centres, availability of eye specialist once a week at sub-centre level for vision testing of children has also been recommended.
8. NRHM Additionalities :(ASHA) Definition of job role of the ASHAS, proper training, and provision of medicine kit and timely honorarium for their services has also been suggested.

9. JSY: Timely remuneration to mothers at delivery was highlighted and it was repeatedly suggested that there should be proper monitoring of JSY funds at all levels. Other aspects like gender equity, IEC, Capacity building, inter-Sectoral convergences, untied funds to VWHSC were also taken up in the discussions for speedy and accurate implementation.

Report 6

Report on Health Infrastructure and Health care delivery systems in Kathua district.

Submitted by
Dr. Annie Jamwal (Fellow)

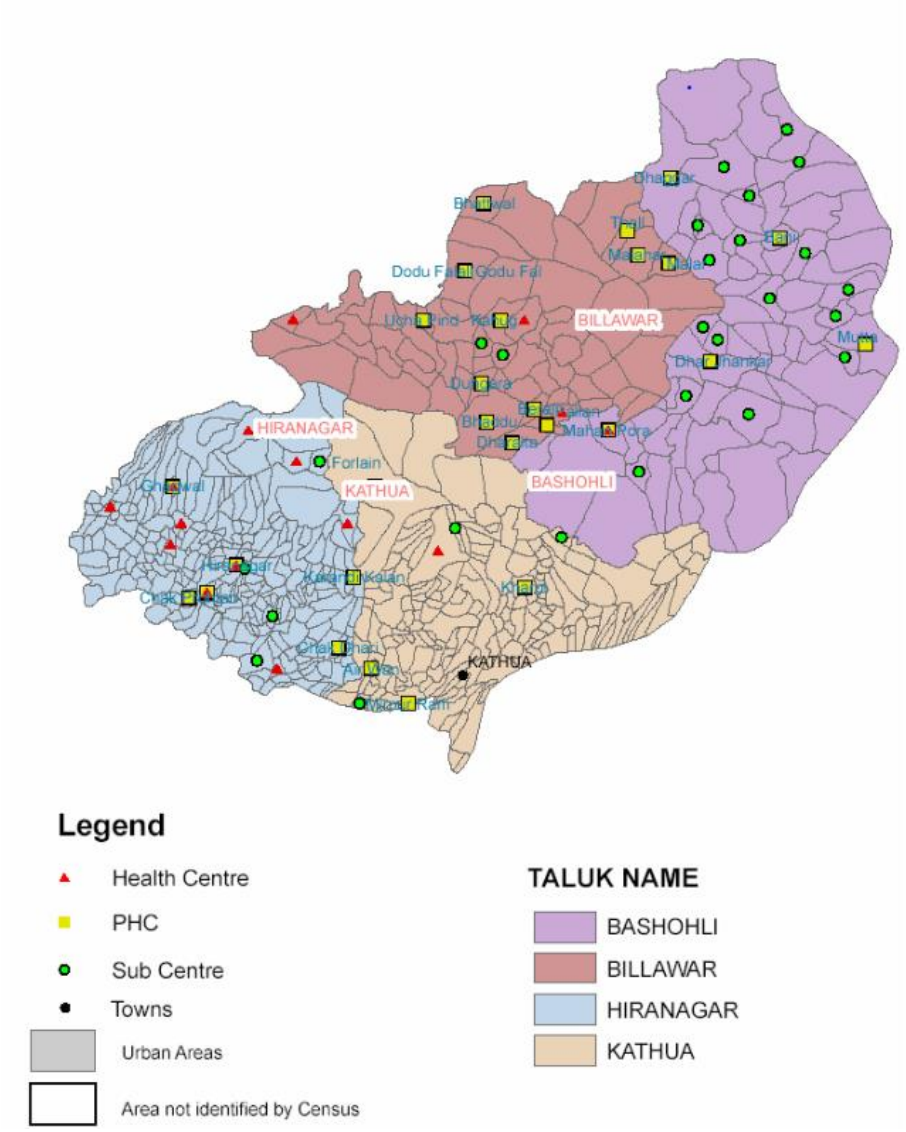
Hashmat Habib (Assistant Fellow)

General characteristics of the district:

Kathua District is situated at 32°17' to 32°55’ North Latitude and 75°70' to 76°16’ East longitude. The District is surrounded by Punjab in the South-East, Himachal Pradesh in North-East, District Doda and Udhampur in North and North-West, Jammu in the West and Pakistan in the South-West. It has an area of 2651 sq kms. The district can be conveniently divided into three distinct agro-climatic regions. The area falling South of Pathankot-Jammu-Srinagar National Highway consists of deep alluvial soils. The area is mostly irrigated and quite productive. This area touches Pakistan and Punjab border and it is also popularly called Border Area. The second zone falling north of the National Highway extends upto foothills of Himalayas and falling mostly in Shivalik ranges is called Kandi area. It is characterized by shallow soils full of boulders with negligible natural water resources. The area faces acute shortage of water and the productivity of the land is very marginal. Part of Kathua, Barnoti, Hiranagar, Ghagwal, Basohli and Billawar block falls in this category. The third area falls beyond Shivalik ranges and extends upto to Peer Panjal ranges. This area is mountainous in nature with little potential for agriculture.

The district comprises of 5 Assembly Constituencies & 11 Tehsils; Kathua, Bani, Basohli, Billawar, Hiranagar, Nagri, Marheen, Dinga Amb, Lohai-Malhar, Mahanpur, Ramkote.
It is also divided into 19 blocks: Bani, Basohli, Baggan, Kathua, Billawar, Hiranagar, Nagri, Barnoti, Marheen, Dinga Amb, Duggain, Duggan, Lohai-Malhar Mahanpur, Mandli, Nagrota Gujroo, Bhoond, Dhar Mahanpur, Keerian Kandyal, & has approximately 512 villages.
The district has a reporting area of 2.65 lakhs Hectare as per revenue records out of which 0.45 lakhs Hectare is agricultural use, 0.36 lakhs Hectare constitutes barren and uncultivable land excluding follow land, 0.12 lakhs Hectare accounts for culturable waste, 0.13 lakhs Hectare is under misc. trees, 0.10 lakhs Hectare forms permanent pastures, 0.01 lakhs Hectare is fallow

land other than current fallows, 0.14 lakhs is the area under current fallows and 0.61 Hectare is net area sown. According to the agricultural census of 1991-92, the district had 69508 number of lands holding of different sizes. Out of these 60.15% were of below one Hectare and only 39.85% were of the sizes of one Hectare and above which indicates that large number of land holding are very small.



Source: Government of Jammu and Kashmir

History of the district:

Though there is no detailed and fully documented history of Kathua district. It is believed that Jodh Singh a famous Rajput of Andotra clan migrated from HASTINAPUR to KATHUA nearly 2000 years ago and settled here. The three Hamlets of Taraf Tajwal, Taraf Manjali and Taraf Bhajwal were established by his three sons Viz. Teju, Kindal and Bhaju. Their

descendent are now called as Tajwalia, Bhajwalia and Khanwalia Rajputs of Andotra sub-caste. The conglomeration of these three hamlets was loosely called "KATHAI" in earlier times which with the passage of time came to be called as KATHUA.

NAME	REF.YEAR	MAGNITUDE
Total Population	2001 Census	5,44,206
Male Population	2001 Census	2,85,308
Female Population	2001 Census	2,58,898
Rural Population	2001 Census	4,66,870
Urban Population	2001 Census	77,336
SC Population	1981 Census	0.84
Sex Ratio	2001 Census	907 Females per 1000 Males
Literacy	2001 Census	65.29 %
Male Literacy	2001 Census	75.73 %
Female Literacy	2001 Census	53.92 %
No. of House Holds	1981 Census	0.61
Occupied Residential	1981 Census	0.58

Source: District Website

Language and culture:

Dogri is the main language spoken by the people of the district. Though the Dogri spoken in some parts of the district has the influence of Punjabi tone also but the rural areas specially the Hilly areas are free from Punjabi. Their other main language is Pahari. However a very small section of the Population residing in Lohai-Malhar and BANI Blocks also speaks Kashmiri. GOJRI is also spoken by the Gujjar Community settled here and there. Hindi, English and Urdu are the main medium of education. Official language is Urdu.

The district is culturally an integrated part of Jammu region and all important religious fairs like Lohri, Maha Shivratri, Id-ul-Fitr, Holi, Ramnavmi, Baisakhi, Basantpanchami, Martyr's day of Guru Arjun Dev, Raksha Bandhan, Janam Ashtami, Mahanavami, Dussehra, Diwali, id-ul-zuha, Guru Ravi Dass's b'day, Mahatma Gandhi's b'day Guru Govind Singh's b'day, Chacha Nehru's birthday. Above all, the Independence Day and Republic Day are celebrated with great enthusiasm. Holy Navratras also provide special occasion for worship and pilgrimage to holy places culminating into small to big fairs. Ram Lilas are organized in every town as well as in every village of the district. The most famous Ram Lila is performed in BASOHLI.

Un-served / underserved / vulnerable areas, population in the District

There are a large number of Underserved populations and areas in the district Kathua. The Total Population of Scheduled Caste is 127364 (23.2%) and is mainly in Blocks Kathua and Hiranagar. The total ST population is 34174 (6.2%) with predominance in the block of Basholi. The tribes are mainly Bakarwal and Dhodhi Gujjars. These are comprised of Nomadic tribes and are mainly involved in livestock. During winters they migrate to the low-lying areas for grazing of animals. The total no. of BPL families in district are 28064 and is distributed in all the blocks

Block-wise Data on SC & ST Population

		SC Population					ST Population				
Block		Total	Male	Female	Sex ratio	Percentage	Total	Male	Female	Sex ratio	Percentage
Billawar	**Total**	**24575**	**12681**	**11894**	**938**	**20.7**	**8978**	**4652**	**4326**	**930**	**7.6**
Billawar	Rural	23649	12193	11456	940	20.8	8868	4589	4279	932	7.8
Billawar	Urban	926	488	438	898	20	110	63	47	746	2.4
Basohli	**Total**	**14710**	**7653**	**7057**	**922**	**15.5**	**14098**	**7304**	**6794**	**930**	**14.9**
Basohli	Rural	13871	7200	6671	927	15.6	14097	7303	6794	930	15.8
Basohli	Urban	839	453	587	852	14.1	1	1	0	0	0
Kathua Block	**Total**	**51231**	**27214**	**24017**	**883**	**28.2**	**8526**	**4528**	**3998**	**883**	**4.7**
Kathua Block	Rural	36557	19453	17104	879	29.9	7812	4085	3727	912	6.4
Kathua Block	Urban	14674	7761	6913	891	24.6	714	443	271	612	1.2
Hiranagar	**Total**	**36848**	**19333**	**17515**	**906**	**23.8**	**2572**	**1285**	**1287**	**1002**	**1.7**
Hiranagar	Rural	35447	18589	16858	907	24.2	2537	1266	1271	1004	1.7
Hiranagar	Urban	1401	744	657	883	16.6	35	19	16	842	0.4
Kathua	**Total**	**127364**	**66881**	**60483**	**904**	**23.2**	**34174**	**17769**	**16405**	**923**	**6.2**
Kathua	Rural	109524	57435	52089	907	23.2	33314	17243	16071	932	7.1
Kathua	Urban	17840	9446	8394	889	22.7	860	526	334	635	1.1

Source: Census of India 2001

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Health Institutions, Population Coverage Ratios and Health Functionaries in the District

Name of Block → / Name of Health Blocks		Nagri Parole	Hiranagar	Billawar	Basoli	Bani	DH	Total for District
Health Institutions								
No. of Speciality Hospitals		0						0
No. Referral Hospitals		1						1
No. of CHC/BPHCs		0	1	1	1	1		4
No. of Blood Banks		0					1	1
No. of CHCs (IPHS Standards)		0	1					1
No. of Blood Storage Units		0					1	1
No. of PHCs in the Block		5	6	8	6	3	-	28
No. of MOs in Positions		9	8	10	5	0	4	
No. of 24 hrs. PHCs		1		1				2
No. of MTP Centres							1	1
No. of Sub Health Centres		33	45	38	19	17	-	152
No. of ANMs in Position in SCs		28	42	29	6	10	-	115
No. of AYUSH Dispensaries								45
No. of Beds in Govt. Institutions		23	56	55	32	8		174
No. of Anganwadi Centres		394	260	214	129	192	-	1,189
No. of Ultrasound Clinics	Govt.						1	1
	Pvt.							2
	Unregistered							
Population Coverage								
Population covered		1,78,802	1,74,904	1,28,504	64,444	44,300	-	6,23,388
No. of Sub-centres covering more than the current norm (5000)		2	0	1	0	0	-	3

Source: Government of India

Table:1	Percentage Availability of Infrastructure				
District: Kathua					
	Indicators	SC (152*)	PHC+ADs(39)	CHC(4)	DH
1	Building (Govt. + Donated)	40.15	67.62	100	100
2	Building (Rented)	57.18	32.38	0.00	0
3	Condition of Building (Good + Fair)	46.55	56.66	100	100
4	Water Supply (Tap, borewell/ handpump/tubewell, well)	16.05	47.85	100	100
4.1	Tap water supply	10.80	35.36	100	100
5	Electricity	28.65	72.54	100	100
5.1	In all parts of hospital	2.35	69.19	100	100
	Elertic supply (power generation stablization)	0	0	100	0
6	Separate Toilet	5.78	13.57	100	100
6.1	Sep.Toilet with running water	0.00	0.00	100	100
7	Furniture	54.88	85.00	90	100
8	Labor Room	0.61	9.60	100	100
8.1	Aseptic labor room	0.00	1.67	100	100
9	Avail. of Quater for staff	24.30	20.55	100	100
10	Number of beds available (Average)		1	15	80
11	Laboratory		18.41	100	100
12	Operation Theatare		2.22	100	100
13	Waste Disposal (Burnt+Dump)		30.08	100	100
14	Availability of incenator		0.00	100	0
15	Telephone		2.22	100	100
16	Computer		0.00	50	100
17	Generator/Invertor		2.22	100	100
18	Vehicle		9.52	100	100
19	Emergency Room / Casualty			100	100
20	Separate wards for males and females (Yes/No)			100	100

Source: CMO office and Facility survey as on July 2012

OVERALL PRIORITY AREAS OF THE DISTRICT:

1. Providing services for the Unreached population
2. Providing services during floods and at pilgrimage sites
3. Addressing the health of the migrant workers and SC population.
4. Quality services at all levels
5. Availability of Programme Officers, Specialists, Doctors and Staff Nurses and retaining the staff for efficient health care delivery.
6. Improving the condition of the facilities as per the IPHS norms including provision of quarters for the personnel on duty.
7. Strengthening CMO office with good Infrastructure and technical assistance
8. Strengthening the HMIS especially availability of correct data and its use
9. Capacity building of functionaries at all levels
10. Improved monitoring for improved services
11. Improving the image of the health services within the community.

SPECIFIC PRIORITIES OF THE DISTRICT

1. **Availability of Primary health care services:** Providing services of ANC, Safe delivery, PNC, Immunization, DOTS, Anaemia prevention, prevention of Malaria at the village level
2. **Programme Management:** Efficient functioning of the District Health Society, a strengthened CMO's office with efficient district and Block programme managers and the district technical support.
3. **Demand Generation, IEC/BCC:** Behaviour Change for utilization of services.
4. **Human Resources:** Filling of the vacancies as per the population based norms, increased mobility, Increased emoluments for retaining the personnel, motivational issues, provision of quarters at all facilities, Availability of well-trained ASHAs for each 1000 population
5. **Capacity Building:** Focussed capacity building in Emergency Obstetric Care, Management, Continuous skill building of all personnel as per needs expressed and also the new job responsibilities under NRHM, opening a Staff Nurse Training College and Paramedical Staff training.
6. **Maternal Health:** Well managed system of deliveries by Skilled birth attendants, promotion of institutional deliveries Emergency Obstetric Care services, JSY extended

to all the pregnant women, Blood Storage Units at all CHC , All CHC to be developed as FRUs, PHC to be developed as 24x7 facilities with good referral mechanisms.

7. **Neonatal and Child Health:** Provision of Neonatal services at CHC, PHC, with trained personnel on IMNCI and IMCI and addressing anaemia and malnutrition.
8. **Immunization:** Total coverage for immunization of children, pregnant women and adolescents.
9. **Family Planning:** Improving the coverage for Spacing methods, NSV and Tubectomy.
10. **Adolescent Health:** Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, marriage at right age.
11. **National Disease Control Programmes:** Prevention of Mosquito transmitted diseases especially malaria.
12. **Infrastructure**: Increase in the number of Subcentres, PHC, CHC and General hospitals catering to the entire population and developing all the facilities as per IPHS norms.
13. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs.
14. **Monitoring and Evaluation:** Data validation and computerized data availability up to PHC with district linkages.
15. **Public-Private Partnership:** Involvement of the private facilities for providing services and NGOs.
16. **Intersectoral Convergence:** Involving the related departments as members in the District Health Society, fixing responsibilities of each sector for their accountability and hence better intersectoral coordination can be achieved.

Conclusion and Policy Recommendations

Today the public infrastructure in India is becoming more and more inaccessible to the public at large, because of the inadequate government healthcare services and high cost of treatment at the private medical institutions. The Central Government should increase the share of healthcare expenditure from one percentage of GDP to around three percent of GDP; the state governments should also increase their share of funds allotted for healthcare. To provide equitable access to the healthcare services and to continuously raise the standards of healthcare services must be the twin goals of the government. It has to be remembered that education and healthcare are two sectors which must be given more and more importance by the government because of our dependence on service sector. The prospect of service sector would depend upon the human capital (professionals), and a better health among the general populace would definitely have a positive impact on the service sector. There are no ready-made solutions or exact steps which can guide us to improve the healthcare facilities and nutritional level of people, but rather there is need to act from different angles. Diversion of more monetary resources towards the healthcare is an extremely necessary but insufficient step, unless there is a motivation among the healthcare professionals towards serving the people even the diverted funds would not yield extraordinary results. The government must focus on the healthcare infrastructure both qualitatively as well as quantitatively. Many times, there have been outbreaks of different diseases in one country, and the same was actually not disclosed by it at international level. But in this globalised world there are chances that disease may be transmitted to other nations, hence it must be provided by WHO that the States should be obliged to share information about the outbreak of diseases. Moreover, an international surveillance network must also be created to take appropriate steps to take preventive measures to stop the transmission of disease. Although the step may involve cooperation among the countries yet, the Indian government must take an initiate in this regard and present such a plan before the international community. Many scholars have suggested Public Private Partnership as a solution to the problem to deal with budgetary constraints which the government faces frequently while implementing different healthcare plans and schemes. But it has to be remembered that with the advent of private players the cost of services is increased considerably, and in India where the majority of the population is poor it may lead to inaccessibility to healthcare services. The government must rather focus on the better utilization of the funds and the resources employed by it in the healthcare services. The government must

also review its health policy at regular intervals, possibly every two years to assess the impact of different schemes and programmes which are run by it. The government of Jammu and Kashmir must identify the areas which are lagging behind in healthcare services, and special focus must be provided for such areas. Special attention must also be given to the tribal areas which are hit by epidemics, floods, and other natural disasters, because the chances of the spread of disease are greater in such areas. Suitable preventive measures must also be taken by the government in the form of vaccination and creation of better sanitation facilities to stop the occurrences of diseases. The National Rural Health Mission is a wonderful programme which has brought many changes in the quality of healthcare services in the rural areas. But the mission must also include in its ambit the urban poor and specially the people who live in slums. The mission can be more effective if there would be a better utilization of resources; a better monitoring and auditing system would further expand the horizons of the mission. There is also need of better coordination among the different actors which are working directly or indirectly in the areas of healthcare namely Central Government, State Government, and the Civil Society. A more comprehensive, coordinated, and integrated approach would yield more fruitful results and bring radical changes in our healthcare system.

Social and economic organisation determines the pattern of health and illness, as well as the type of medical care available in societies. The present study is built on this premise and examines the nature and growth of health care development among tribal areas in Jammu and Kashmir with special reference to some particular districts. In differentiated societies where economic organisation is profit centred the development of health care assumes certain inevitable patterns. These societies, in the first place, encourage health care systems that perpetuate the existing social and economic relations with its concern for profit. This results in the growth of a medical practice that is heavily curative, thus undermining the importance of preventive and promotive functions. Individuals develop a health culture in such situations that makes them depend debilitatingly on medicine and other medical interventions. The specialisation and the sophistication which medical care acquires in this pattern of growth then pushes the cost upward restricting the benefits largely to the richer sections. The poorer sections inevitably become victims of this growth. The curative orientation of medical care, in the second place, in conjunction with its bias favouring the richer sections, results in an uneven growth of health care facilities discriminating backward rural regions against urban centres. These further distances the

poor who are concentrated in rural areas from the health care system. The health care system in India during the Post-Independence period conforms to this pattern. Health care development among tribal communities assumes significance in this context because it brings to sharp focus the nature and content of health care system. The tribal communities in Jammu and Kashmir constitute a significant portion of its total population. They are concentrated in the hilly and backward districts and are historically isolated from the mainstream populations. The tribal situation in the state is characterised by extreme poverty and exploitation by non-tribals. The tribal situation here is characterised by poverty, exploitation and deprivation. They are either landless or owners of little land. Many are unskilled agricultural labourers and earn poorly for their survival and are thus caught in a vicious circle of landlessness, low income, illiteracy and low health. The economic conditions and living environment of tribal households in our sample is miserable. They earn income that is barely adequate for their survival. They also lack opportunities, and this coupled with lack of skill pulls them down into a perpetual state of poverty. The added disadvantage of ignorance due to illiteracy, along with the unhygienic circumstances and personal habits, the contaminated water they drink, and the lack of other basic amenities make the tribals susceptible to a variety of health problems. The major health problems on the basis of the symptoms reported by the tribals are fever, diarrhoea, skin diseases and T.B. The relationship between poverty, living environment and diseases is obvious and the tribals, especially the women and children, are conspicuously undernourished and malnutritional. Illness has a definite role and meaning in their life. The tribals perceive illness as a state where he becomes dysfunctional, that is, he is unable to perform his routine work. They also associate continuous medication with illness. Tribals are mostly fatalistic and believe that illness is a punishment for their sins. This attitude to diseases results in a set of responses that are superstitious and bordering on faith healing. The belief also develops a sense of helplessness and indifference towards diseases. This coupled with the pressures of poverty and struggle for survival force the tribals to ignore their health problems unless it reaches an exploding level. They are also ignorant of diseases and consider their existence as normal in spite of intense suffering. The responses of tribals to the health problems combine both traditional and modern health care practices. The initial response in most cases is to fall back on the traditional system of giving homemade remedies or seeking the help of a medicine man who provides more specific treatment of folk medicines. If the illness persists the tribals seek the help of modern medical

institutions even if they are distantly located and involve expense. Traditional practices, considered as a deterrent in spreading the message of modern health care, coexist peacefully in their scheme of things. The intensity of their faith in traditional systems however is on the decline. This is inevitable in the present arrangement where the primary health centres are rated for their efficiency on the basis of their achievement in family planning. The primary health centres faced with the pressures to fulfil the targets on family planning, ignore other aspects of health care that are more immediate and relevant. An attitude has also developed among health staff to exclude from their focus communities or groups who are considered to be negative to family planning. Tribals are a victim of this attitude as they are believed to be indifferent to family planning. The attitude of health personnel in primary health centres and other medical institutions towards tribals is unsympathetic and negative. They are ignorant of tribal culture, its specificities and the historical reasons for their backwardness. They consider the tribals as irrational, superstitious and hence as a category who are apathetic to modern medical practices. This attitude again works against the tribals and distances them from the health care delivery system. The nature of interaction of tribals with the health care facilities, however, contradict many of the above accepted assumptions about them. They accept and utilise facilities if these are available within accessible distance and also if services are affordable to their income status. They are also influenced by the type of services and feel encouraged by the reassuring responses from institutions and staff. The presence of institutions in their midst and their various activities, even if centred around family planning, brought about changes in their health culture and traditional practices. Their willingness to accept modern medical facilities in deliveries is an indication of these changes. Tribals, contrary to the belief expressed by the health personnel, accept the concept of family planning. But the immediate reasons that forced those in our sample for accepting the methods are basically economic compulsions. To sum up, the health problems of tribals, their responses to those problems and the interaction with the health care delivery systems reflect clearly their unique backwardness and their relative position in society. The diseases are largely diseases of poverty, and they arise out of inadequate income and other social and economic disabilities such as lack of skill, lack of education and lack of political consciousness. These factors form a vicious relationship and pulls the tribals down to a state of perpetual backwardness of which ill-health is a natural outcome. These conditions also force them to treat ill-health as normal till it explodes as a medical catastrophe. They are crippled

further when they confront an indifferent if not a hostile health care delivery system. The modern health care system has several inherent tendencies such as its curative orientation undue concern on family planning and the urban bias of health personnel that force it to exclude the tribals from their focus. The tribals on the other hand, are evolving a health culture that make them depend increasingly on modern health care delivery system. These observations about the health problems of tribals and the health care delivery system in the study are suggestive of certain trends that explain the nature of health development among tribals in Jammu and Kashmir. The pattern of utilisation of health care facilities in a society is a function of two sets of factors: availability and accessibility. Each of these aspects represent a system that is internally coherent but shaped by a number of factors that interact with each other. Availability manifests itself in the provision of health care institutions and services. The nature and extent of availability of health care facilities at the national level is determined in accordance with the equations of various interests and their relative bargaining ability. Even at the micro level the magnitude and distribution of facilities to a group or a location is largely a function of their economic and political strength, the level of awareness, the ability to articulate and the quality of leadership. Accessibility which reflects the extent of utilisation of facilities is also decided by a set of variables that are economic, social and cultural. It varies between groups in a hierarchical society, such as ours, on the basis of income, caste, customs and practices. Availability and accessibility favours those at the top while those at the bottom are deprived in both respects. The tribal communities who rank the lowest in the social hierarchy are one of the worst affected in this regard. These communities in Jammu and Kashmir are socially, economically and politically weak. They lack awareness and above all lack a sensitive leadership to bring in facilities to their locations. The accessibility on the other hand is limited by the lack of availability, lack of income, cultural practices and the various expressions of dominance-dependence relationship which discourages then to use the health care system. These constraints expressed through availability and accessibility evolved a health care system over the years that was indifferent to the health needs of tribals. The inequalities in health status which reflects the social and economic inequalities is accentuated under the present system which emphasises after event interventions using expensive drugs and sophisticated equipments. The production of health care, primarily of drugs and equipments, and its inherent concern for maximising profits exerts pressure on the health care system to expand according to the logic of profit. Curative orientation

at the cost of preventive and promotive health is the inevitable outcome of this. It also promotes a differentiated social arrangement to have a constituency among the richer sections. The public health care system which was introduced to overcome the economic and social disabilities of poorer sections to enable them to have access to medical care was also a victim of this orientation. The health care institutions in this set up confine themselves largely to curative and family planning activities. This ignored the health problems of the poor and the social conditions of their origin. The inequalities in society and the inability of the poorer sections to bring facilities to their regions and to their advantage has resulted in a tendency that promoted uneven development of health care facilities benefiting the influential sections. In Jammu and Kashmir this tendency was conspicuous in that the health care facilities are concentrated in towns and developed regions without considering the intensity of the problems faced by tribals. The curative orientation of modern medicine reinforced this uneven development. The health care system has developed a health culture in society, irrespective of divisions within it, that made individuals depend exceedingly on modern medicine and medical facilities. In the case of tribals, the eventual growth of health care facilities around them visibly disturbed their traditional health culture. The use of tribal medicines though popular as first level interventions is gradually declining in importance. This destruction of indigenous systems is inevitable in the present system because of its orientation to profit.

- The achievement for most of the health indicators in Jammu and Kashmir achieve favourably with the national average. However, there is a need to address for improving quality in health care and easier access of health care facilities.

- Although Government introduces inclusive development for minimising the regional disparities but there still exists the skewed rural/urban availability of public health service, inequitable distribution of health personnel among the health centres and hospitals.

- The Study points out that the health infrastructure is not uniform throughout the state. Some districts are suffering from inadequate health infrastructure, whereas some districts are ahead.

- PHCs and Sub-centres in the arears are generally short of medicines and other supplies or simply lack other non-medical services in Jammu and Kashmir.

- It was observed that due to the bad connectivity and migration of the tribals of Jammu and Kashmir, they face tremendous health care issues and mostly prefer the traditional healing system.
- The tribal people have to visit hospitals located in the distant places for treatment, which results in additional financial burden on the poor households.
- One of the important findings of the study was that majority of the tribal people did not have access to efficient means of transport and communication facilities. Therefore, the expenditure on transportation was more among all the households.

In the present context, there has been a continuous increase in demand for healthcare facilities due to increasing population and increasing awareness about the health services. Consequently, the health expenditure of the households has been increasing considerably over the period. The following policy recommendations are suggested based on the findings of the study.

Accessibility to healthcare services is extremely limited in many areas of the state, and the districts are no exception. In addition, existing healthcare infrastructure is unplanned and irregularly distributed. it is essential to strengthen the public health services in the unreachable areas where the tribal folks are living.

Doctors, specialists, surgeons, laboratory technicians and other stuff is common to serve the needs of the rural population in the state. Due to the severe shortage of health personal, tribal people do not have easy access to better healthcare services.

Ensuring the availability of life saving drugs and medical test facilities free of cost in the PHCs and sub centres will not only provide health security to rural people but will directly contribute in reducing the ill-health conditions among the tribals.

expenditure on transportation and loss of earnings update tribal people is another great concern in the tribal areas. Frequent visits to hospitals not only increase the health expenditure, but also reduces the family earnings, which further pushes the family in deep trouble. Therefore, government should ensure 24 X 7 health services in PHCs, sub centres, mobile clinic facilities, arrangement of vehicles, etc.

Lack of private health facilities and inadequate public health facilities increases health expenditure in the tribal areas, so it is necessary to motivate practitioners to start their services in these tribal areas.