

**IMPACT OF JANANI SURAKSHA YOJANA ON
UTILIZATION OF REPRODUCTIVE AND CHILD
HEALTH SERVICES IN JAMMU AND KASHMIR-A
CASE STUDY OF DISTRICT PULWAMA**

DISSERTATION

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The Dissertation entitled, "Impact of Janani Suraksha Yojana on Utilization of Reproductive and Child Health Services in Jammu and Kashmir- A Case Study of District Pulwama" submitted by **Irfan Ahmad Thoker** for the partial fulfillment of the requirement for the degree of **Master of Philosophy in Economics (M.Phil)** is a research work done under my supervision and guidance. The candidate has fulfilled all the statutory requirements for the submission of the dissertation.

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DECLARATION

This dissertation is the result of an independent investigation. Wherever, the work is indebted to the work of others it has been acknowledged and cited.

I declare that this dissertation has not been accepted in substance for any other degree or diploma nor is it concurrently being submitted in candidature or achievement of any other degree at any other university.

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Research Scholar

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DEDICATED

TO

MY

BELLOVED

PARENTS

&

OTHER FAMILY

MEMBERS

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List of Abbreviations

AMG	Annual Maintenance Grant
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWC	Angan Wadi Centre
AWW	Angan Wadi Worker
AYUSH	Ayurvedic Yoga Naturopathy Unani Sidha Homeopathy
BMEO	Block Monitoring and Evaluation Officer
BPL	Below Poverty Line
BPMU	Block Program Management Unit
CBR	Crude Birth Rate
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CMO	Chief Medical Officer
CSSM	Child Survival and Safe Motherhood
DH	District Hospital
DPMU	District Program Management Unit
DPT	Diphtheria Pertusis and Tuberculosis
FRU	First Referral Unit
FWS	Family Welfare Services
GDP	Gross Domestic Production
GOI	Government of India
HFS	High Focus States
HME	Health and Medical Education

HMIS	Health Management Information System
HPS	High Performing States
ICDS	Integrated Child Development Service
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
J & K	Jammu and Kashmir
JSY	Janani Suraksha Yojana
LFS	Low Focus States
LPS	Low Performing States
MCH	Maternal and Child Health
MD	Mission Director
MLA	Member of Legislative Assembly
MLC	Member of Legislative Council
MOHFW	Ministry of Health and Family Welfare
MPHW	Multi Purpose Health Worker
NFHS	National Family Health Survey
NGO	Non Government Organization
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post Natal Care
PRC	Population Research Centre
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
SC	Sub Centre

SPMU	State Program Management Unit
SRS	Sample Registration System
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UEED	Urban Environmental Engineering Department
UIP	Universal Immunization Programme
UIP	Universal Immunization Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
VHND	Village Health and Nutrition Day
VHSD	Village Health and Sanitation Day
WB	World Bank
WHO	World Health Organization

Chapter - 1



Introduction

Human capital as characterised by good education and good health is an important determinant of economic growth. Health is now considered to be the most important social service sector having direct correlation with the welfare of the whole society. Health as a tool for economic growth has been a novel concept in the field of development. According to World Health Organization's (WHO's) commission on macroeconomic and health status, "Extending the coverage of crucial health services to the world's poor could save millions of lives each year, reduce poverty, spur economic development and promote global security". Most of the developing countries are facing health as a big hindrance in the process of economic development. Improvement in overall health status of the people is an important step towards economic development which includes everything from general hygiene, providing medicine and basic infrastructure and better coverage to all sections of the society in general and poor masses in particular. The state has to play a greater role particularly in setting up infrastructure in initial periods as it is not beneficial for private sector to enter and cover all the broader dimensions of health. Therefore, state has to spend more on health in order to ensure better health and well being of the people. But public spending is not the only way to ensure better health, there are other factors on which health of a nation is dependent such as better public policies, well performing institutions, broader coverage to all sections of the society particularly rural

people and better legislations to check the mishandlings correctly in a proper time bound manner.

Developing nation like India faces many institutional constraints in upgrading health infrastructure and most of the bottlenecks are linked to each other such that improvement of one is hampered by the other. Public spending on health is a small percentage of the total government expenditure and a huge portion of the expenditure is inefficient due to certain institutional factors such as health service access, health service delivery, lack of physical infrastructure, equipments, human resource, weak link between programmes and incompetent management of cash flow, drugs supply, quality of care, monitoring mechanism, referral and other communication act as a barrier to the success of public spending. Modern health care is a relatively newer concept in the rural masses most of which are unaware of its advantages and are dependent on traditional system of health care. In order to produce better health outcomes health policies and programmes should be framed to generate demand for modern health care and institutionalization of traditional health practices and efficiency of health care supply by providers should be checked at regular intervals and policies should be framed accordingly.

Each year more than half a million women die from causes related to pregnancy and child birth (UNICEF-2008). Further, for every woman who dies from pregnancy related complications, around 20 more incur injuries, infections and disabilities. India alone accounts for 22% of the global total. Most of these maternal deaths can be readily addressed if skilled health personnel on the one hand and key drugs, equipment, manpower, referral facilities on the other hand are simultaneously available. The picture is not too different for neo natal mortality. The WHO's figures in 2004 suggest that 40% of under five deaths occur in the first 28 days of life and 98% of neonatal deaths occur in low and middle income countries. Thus, delivering a baby in a medical facility under the supervision of a skilled medical professional can

surely make a significant dent in the instances of maternal and neonatal mortality.

According to United Nations Population Fund (UNFPA-2006) estimates, out of an annual increase of 76 million in world population, India alone accounts for as much as 16 million people, making a sizeable 21% contribution and a major chunk of population still lives on less than \$2 a day. Annually 22 lac infants and children die from preventable illness, 1 lac mothers die during child births, 5 lac people die of tuberculosis, diarrhoea and malaria while 5 million people are suffering from Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)¹. Despite these figures, India fares good in certain major health related indicators and its performance reflects significant progress over the years particularly after Independence. The crude birth rate declined from 40.8 per 1000 live births in 1951 to 22.1 in 2010. The crude death rate declined more rapidly from 25.1 in 1951 to 7.2 in 2010. The infant mortality also showed a significant decline from 110 in 1981 to 47 in 2010. The expectation of life at birth showed an increase from 55.5 years in 1981 to 62.3 years in 2008. However, despite this progress India fares poorly in most of the indicators in comparison with a number of developing countries like China and Sri Lanka. India is the 7th largest country in the world in terms of geographical area constituting 2.42% area and 2nd most populous country after China constituting 16.7% of world population. In order to meet the needs of this vast growing population various health related policies and programmes were formulated both at central and state level to meet the growing demand for healthcare. Over the years the expenditure on health as a percentage of Gross Domestic Product (GDP) has also been increased. Before independence India's health sector was very limited and access to healthcare was confined to certain sections of the society and most of the masses were deprived of the healthcare services particularly in rural areas where health care delivery system was

¹ Review of Health Care in India, 2006

invisible. After independence India has built a huge health infrastructure in the form of primary, secondary and tertiary health care institutions like Primary Health Centres (PHCs), Community Health Centres (CHCs), Hospitals in public, private and voluntary sectors. In 1951, India was the first country in the world to launch family planning programme whose overall objective was to stabilise population growth. The goal of population stabilisation is achieved only when child survival issues, maternal health issues and contraception issues are addressed simultaneously and effectively. This has led to change in approach from family planning method to family welfare. Till 1977, the major health activity was family planning which was changed into family welfare programme with maternal and child health becoming an integral part of family planning programme with the vision that reduction in the birth rate has a direct relationship with a reduction in infant and child mortality.

The family welfare programme focussed on the health needs of the women in the reproductive age group of 15-49 years and of children below the age of 5 years and provision of contraceptives and spacing services to the desired ones. The programme passed through various phases of expansion or modification. Universal Immunization Programme (UIP) against six preventable diseases, namely diphtheria, pertussis, childhood tuberculosis, poliomyelitis, measles and neonatal tetanus was introduced in the country in a phased manner in 1985, which covered the whole of India by 1990. Significant progress was made under the programme in the initial period when more than 90 per cent coverage for all the six antigens was achieved. UIP became a part of the Child Survival and Safe Motherhood (CSSM) programme in 1992 and Reproductive and Child Health (RCH) Programme in 1997. The CSSM Jointly funded by World Bank and UNICEF were started in 1992-93 and covered all districts of the country by 1996-97. The main objective of the CSSM programme was to improve the health status of infants, child and maternal morbidity and mortality. In order to effectively improve the health status of

women and children and fulfil the unmet need for Family Welfare Services (FWS) in the country, Government of India, during 1997-98 launched the Reproductive and Child Health (RCH) programme for implementation during the 9th plan period by integrating the CSSM Programme with other Reproductive and Child Health Services.

Accordingly Government of India introduced various other health related programmes and recently launched National Rural Health Mission (NRHM) which envisages as an umbrella programme by integrating all the related and interlinked stand-alone schemes into a single composite programme. National Rural Health Mission was launched by Prime Minister Dr. Manmohan Singh on April 12, 2005 over a period of seven years and has been operational throughout the whole country. The main features of NHRM are provision of accessible, affordable, effective and reliable primarily health care services, especially to the poor and vulnerable sections of the rural population, bridging the gap in rural health care services through the creation of cadre of Accredited Social Health Activists (ASHAs), improved health care, decentralized planning, intersectoral conversions and maintaining gender balance. NRHM envisages the second phase of Reproductive and Child Health Programme (RCH-II). It intends to improve the performance of Family Welfare Programmes in reducing Maternal and Infant Mortality and Morbidity and unwanted pregnancy leading to population stabilization.

An important component of NRHM is Janani Suraksha Yojana (JSY) launched in India on April 12, 2005. JSY was proposed by way of modifying the existing National Maternity Benefit Scheme (NMBS) which was linked to provision of diet for pregnant women of BPL families. JSY is a conditional cash transfer scheme to promote institutional delivery and reduce maternal mortality. The main objective of the scheme is to reduce the number of maternal and neonatal deaths and increase the institutional delivery. Besides it seeks to promote antenatal care during the pregnancy period, neonatal care

during delivery period and immediate post-partum period by establishing a system of coordinated care through field level health worker-Accredited Social Health Activists (ASHAs).

According to JSY guidelines, after delivery in a govt or accredited private health facility, eligible women (aged 19 years and above and up to two live births) would receive ₹600 in urban areas and ₹700 in rural areas in Low Focus States (LFS) with high in facility birth coverage i.e. High Performing States (HPS). In High Focus States (HFS) with low in facility birth coverage i.e. Low Performing States (LPS), all women irrespective of socio economic status and parity are eligible for cash benefit of ₹1000 in urban areas and ₹1400 in rural areas. JSY also continues to provide a small amount of financial assistance of ₹500 for births at home for pregnant women (aged 19 years and above) living below the poverty line and for the first two live births.

1.1. Jammu and Kashmir Scenario

The State of Jammu and Kashmir (J&K) comprising a population of 12 million, accounts roughly for 1% of the total population of the country. The State government has realized the importance of health in the overall development and due to this realization health in general and health of women and children in particular has been given top priority by the government in its planning and budgeting from time to time.

Various health and family welfare programmes were launched at par with national level from time to time in Jammu and Kashmir also. In J&K, family planning programme was introduced to control the high birth rates in 1956-57 and Family welfare Programme was launched in 1977-78 to promote contraception with emphasis on health of women. This was followed by Child Survival and Safe Motherhood Programme (CSSM) in 1980 to improve the health of mother and child. However, these programmes achieved only limited success as far as reduction in birth rate and infant mortality rate was concerned. Though, a substantial proportion of couples accepted family planning but the

demographic impact was limited. However, with the implementation of Reproductive and Child Health (RCH) programme heavy emphasis was given on promoting reproductive health of women. RCH not only promoted contraception but also promoted maternal and child health, quality of health services etc. With the implementation of RCH programme more and more women started utilizing antenatal, natal and postnatal care services. As per National Family Health Survey-3 (NFHS), 85% who gave birth before the five years preceding the NFHS-3 surveys had received antenatal care from a health professional. Similarly, more and more women are now utilizing institutional services for delivery as about half of the births in the five years prior to the survey in J&K took place in a health facility and more than 90% of children have been immunized against various vaccine preventable diseases. Despite that about 20% of the women were not utilizing antenatal care, 50% still deliver at home and there was not much improvement in maternal mortality and morbidity. Besides, immunization stagnated and there was no improvement in reducing dropout rates, therefore, under RCH Programme government attempted to rectify the problems in the implementation of RCH and introduced NRHM in the State like other parts of the country in Dec. 2005. NRHM is not only focusing on the health care but is also focusing on its attention towards important determinants of good health like nutrition, sanitation, hygiene, safe drinking water etc. The perspective plan for the NRHM aims to transform the public health system so as to make it more responsive, efficient and effective through a multi- prolonged approach. The state seeks to provide accessible, affordable and quality health care to the rural population especially to the vulnerable sections. NRHM in the State expects to reduce Maternal Mortality Rate to 100 per 100000 live births, Infant Mortality Rate to 30 per 1000 births and the Total Fertility Rate to 2.1 by the year 2011-12. It also aims at considerable reduction in communicable and non-communicable diseases especially Tuberculosis (T.B), water born diseases etc. Another focus of

NRHM in J&K is to improve Adolescence Sexual Reproductive Health through integrated Adolescent's Friendly Health Services.

An important component of NRHM is JSY launched in J&K in 2006-07. With the implementation of JSY, the number of women coming for institutional deliveries has started picking up. During 2006-07, 13 thousand women have been covered under JSY. However, the number JSY beneficiaries declined from 13 thousand in 2006-07 to 8 thousand in 2008-09 because JSY was stopped in the year 2007-08 due to poor implementation and mismanagement of the scheme. However, the scheme was restarted in the year 2009 and the number of institutional deliveries started increasing considerably. About 4.25 lac women have received cash incentives till Oct. 2012². As per information available from Health Management Information System (HMIS) website, the percentage of women utilizing antenatal care services is about 96%, the proportion of institutional deliveries has gone up to 85% with child Immunization at 100%. However, it is not known to what extent these figures are correct and if correct whether such an improvement (increase in Institutional deliveries) can be attributed to JSY or some other factors has contributed for such an increase. Keeping in view the above facts and figures, the present study was taken up. The objective of the study is to evaluate the performance of JSY during the period 2009-2011.

1.2. Study Area

District Pulwama came into existence in July-1979 which was carved out from district Anantnag and is located at an altitude of 4500 to 6000 feet from the sea level. Recently one more district was carved out from district Pulwama in the year 2007 and exists in the shape of a new district called Shopian. The district headquarter Pulwama is about 32 Kms away from Srinagar city. The boundary districts of Pulwama are Anantnag, Kulgam, Shopian, Budgam and Srinagar. The district consists of three medical blocks

²Economic Survey 2012-13, Govt. of Jammu and Kashmir

i.e. Pulwama, Pampore and Tral. The total population of the district according to official data of District Programme Management Unit (DPMU) Pulwama in 2010-11 was 464125 and according to census 2011 population of the district is 5.70 lacs (570050 persons), out of which male population is 2,97,988(52.3%) and female population of 2,72,072(47.7%). The child population between 0-6 years of age are 97,642(17.12%) out of which males are 53176(54.5%) and females are 44466 (45.5%). This means highest consumers of health services are women and children as they together constitute 69% of the population. The density of population in the district is 598 persons per square kilometre and the population growth rate over the decade 2001-2011 was 29.18% and the district has the sex ratio of 913 females per 1000 population, slightly lower than the national average of 940. The 91% of the population lives in rural areas distributed in 332 villages with five towns and about 95% of population earns its livelihood directly or indirectly from agriculture and allied activities. The survey conducted by District Level Household Survey-3 (DLHS-3) in district Pulwama recorded 77.7% institutional deliveries, however, it is shrouded in mystery whether this increase in institutional deliveries is outcome of JSY incentives or not. In addition, district constitutes 69% women and child population and JSY is an incentive based programme for the well being of both mother and child, so it would be imperative to evaluate the JSY scheme for assessment and impact in district Pulwama. Keeping in view the above facts and figures about district Pulwama, the afore-said district was selected for field study and as such NRHM is exclusively for rural population with JSY as its core component so it will be worthwhile to conduct research in this district. Besides, being a native of the area I am well acquainted about the cooperation of the people so that data collection would not be a cumbersome process.

1.3. Objectives of the study

The present study would try to evaluate the JSY scheme for assessment and its impact on utilization of reproductive and child health services and

would be the first of its kind in Jammu and Kashmir. Though some studies have been conducted to assess the implementation of JSY in India which mostly are of evaluative nature but no such study has been conducted in Jammu and Kashmir. Besides, the studies conducted so far mostly deal with implementation process and no such research work which assesses the impact of JSY on utilization of antenatal, neonatal, postnatal care services and utilization of institutional deliveries and immunization services has been undertaken in Jammu and Kashmir. In this respect, the present study would be unique which will try to focus on the above said parameters. For in depth study, the specific objectives of the study are;

1. To review the process of implementation of JSY in Jammu and Kashmir.
2. To examine the level of awareness among women about the scheme.
3. To assess whether the receipt of JSY assistance is associated with increase in antenatal care, institutional deliveries and immunization services.
4. To analyze the problems in the implementation of the scheme.

In consonance with the above objectives the following hypothesis has been laid down for empirical studies.

1.4. Hypothesis

JSY incentives have not made any impact on utilization of antenatal care services, institutional delivery services and immunization of children in Jammu and Kashmir.

1.5. A Plan of the Study

Chapter-II: - It is based on review of literature, various concepts and methodology used in the study.

Chapter-III: - It is designed to know the performance of NRHM in Jammu and Kashmir. This chapter gives the detailed information regarding the appraisal of NRHM in terms of financial and physical performance.

Chapter-IV: - is designed to know the financial and physical performance of JSY in Jammu and Kashmir.

Chapter-V: - is based on analysis of the data gathered from the field survey, done in different villages of district Pulwama. This chapter titled as “Impact of JSY on utilization of RCH in J & K: A case Study of District Pulwama” is an attempt to study the impact of JSY on utilization of antenatal care, institutional delivery services and immunization of children in Pulwama.

Chapter-VI: - In this chapter, we conclude with findings, problems and suggestions for enhancing and strengthening the health care delivery system at gross root level.

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Chapter - 2



Literature Review, Concepts and Methodology

The present chapter is divided into three sections that is i) review of literature; ii) concepts and iii) methodology. In section first a brief review of related literature has been stated in order to gain background knowledge about the problem and to identify appropriate methodology, research design, techniques of analysis. In section second some of the concepts related to the problem have been defined and in section third the methodology of the study has been outlined. From the economic point of view, this is the first attempt from any scholar so far as Jammu and Kashmir is concerned. Some of the writers have made efforts to pure scientific nature. There are only few studies which have tried to evaluate and analyze the performance of JSY.

2.1. Review of Literature

Ashish Bose (2007) reflected that JSY should focus more on the creation of health infrastructure and ensure road connectivity in the rural areas rather than merely doling out money to poor families.

Hindustan Times (June 2, 2007) published a report issued by Madhya Pradesh Government which reveals that significant increase has been registered in institutional deliveries due to JSY incentives.

Dr. Ramakant Sharma (2008) found that in selected districts of Rajasthan sub centre and home deliveries decreased while CHC/PHC (institutional) deliveries increased due to the implementation of JSY in the state.

Shobha Malini et al. (2008) in their study revealed that ASHA provides major role in motivation for institutional deliveries. They also found that majority of beneficiaries faced problems of transport, communication, non availability of 24×7 facilities and lack of staff. These problems were also major deterrents for prospective mothers in accessing JSY services.

Chandrakant Lahariya (2009) indicated that cash incentives for institutional deliveries may increase quantum of care in India. Further the report reveals that JSY made significant impact on the rate of institutional deliveries even in low performing states as is reflected by high rate of participation by the families in the scheme.

Monica Munjial et al. (2009) found that institutional deliveries increased due to incentives among high income families and mostly in urban areas than low income families of rural population.

Bashir Ahmad et al. (2009) in their study, found that 55 percent deliveries in District Rajouri of Jammu and Kashmir took place in a health facility while as 45 percent took place at home. The report further revealed that JSY is poorly implemented in the district due to its low awareness among people.

Khursheed Ahmad et al. (2009) found that in district Baramullah of Jammu and Kashmir institutional deliveries increased to 81 percent due to JSY incentives and level of knowledge was the main factor for higher rate of institutional deliveries.

Saabira Chaudhaire (Nov. 20, 2009) in her research article on state of world's children report highlighted that maternal deaths in India are severe. The report emphasised that education of girls and strengthening of health care services are the most powerful ways to combat this phenomenon. Through initiatives like JSY, India is attempting to expand the health care access of women.

Sharad D Iyenger et al. (2009) in their study found that maternal health remains very unsatisfactorily in Rajasthan despite availability of various national programmes such as family planning, Child Survival and Safe

Motherhood and Reproductive and Child Health (Phase I and II) particularly due to non-availability of human resources especially mid wives and clinical specialists and their non residence in rural areas. However, the scheme of JSY provides an opportunity to improve maternal and neonatal health provided the quality issues can be adequately addressed.

M E Khan et al. (2010) in their research mention out that monetary incentives increased coordination between health providers and beneficiaries resulting into increased utilization of maternal and child health services and concluded that there is essential need for improved quality services.

Hindustan Times (June 4, 2010) published an article on India-US study in the International Journal Lancet reported that JSY scheme has lowered newborn deaths and still births in the country's poorest states.

Stephen S. Lim. et al. (June 5, 2010) revealed that incentives under JSY increased institutional deliveries significantly but poor and least educated women have not the highest odds of receiving the JSY incentives.

J Thomus (Sep. 2010) in his research revealed that JSY increased use of hospital deliveries and services rendered by skilled attendants and also reduced prenatal and neonatal mortality.

Sushma Das et al. (2010) highlighted the role of community based health workers who could help women to plan their deliveries and make sure that they get help in time and put on efforts to improve the client experience at public sector institutions instead of incentive for institutional delivery.

Anrudh K Jain (2010) found that JSY has only increased institutional deliveries but decrease in maternal mortality still remains a challenge.

Ambrish Dongre (2010) in his research found that through monetary incentives institutional deliveries increased marginally but initially it has widened the disparities between targeted and non-targeted states and after few years of implementation it resulted into a dramatic decline.

The Hindu, (sep. 08, 2010) published an article written by K. M Dayashankar which reflects that JSY has failed to achieve its desired goals of increasing institutional deliveries among poor women due to its poor publicity or awareness programme about the scheme in rural areas.

Parul Sharma et al. (2010) in one of the districts of Uttarakhand found that JSY incentive utilization was low in rural areas as compared to urban areas. They suggested that greater focus should be on Maternal and Child Health through increased efforts of ASHA's support with proper monitoring mechanism.

Sanjeev K Gupta et al. (2011) observed that majority of respondents knew about the scheme regarding monetary benefit for institutional delivery but the name of the scheme was known to a very small proportion and concluded that focus should be on advertising in order to make people fully aware about the scheme and stress should be towards other components of the scheme.

Sheetal Vyas et al. (2011) in their study conducted in Ahamadabad city of Gujrat found that there is no significant difference between total costs of normal delivery at home and at govt. hospital, therefore, people should be motivated for institutional deliveries instead of home deliveries.

Geeta S Pardeshi et al. (2011) in their study found that there is significant increase in institutional deliveries and deliveries assisted by health personnel in the NRHM period, however, less proportion of deliveries in the home is conducted by health personnel and focus should be on increasing institutional deliveries especially in the rural areas.

Zakir Hussain (2011) in his research paper highlighted the role of the NRHM in order to improve the health care delivery system at all levels especially in rural areas. It also highlighted the need for more investments which would have a positive impact on several health indicators like immunization, institutional deliveries and antenatal care delivery services.

Vikar Dagur et al. (2012) in their ‘pay for performance approach’ of JSY found that cash incentives are the major drivers for utilization of institutional deliveries, ANC and PNC visits and has markedly increased access to quantum of maternal and child health services.

Parul Sarma et al. (2012) found that earlier registration of beneficiaries with some health personnel was higher among educated women which had a positive impact on the number of ANC visits.

2.2. Concepts

The concepts used in this study are as follows:-

2.2.1. Antenatal care (ANC): Antenatal care refers to pregnancy related health care check up which is usually provided by a Doctor, ANM or any other health personnel.

2.2.2. Beneficiary: Any institutional and home delivery that has availed the JSY benefits or received cash incentives is considered as a beneficiary.

2.2.3. Child Mortality: The probability of dying for a newborn between the first and fifth birthday of life i.e. 0-5years of age is known as child mortality.

2.2.4. Crude Birth Rate: The number of births per thousand people in a given year is called crude birth rate.

2.2.5. Crude Death Rate: The crude death rate is the number of deaths per thousand people in a year.

2.2.6. Delivery care: Delivery care is the care which a pregnant woman usually gets at the time of actual delivery.

2.2.7. Fertility Rate: The number of children born per year per thousand females in the age group of 15-49 years is called the fertility rate.

2.2.8. Immunization: Immunization is the process by which a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body’s own immune system to protect the person against subsequent infection or disease.

2.2.9. Infant Mortality: The probability of dying for a newborn before the first birthday of life in the age group of 0-1 years is known as infant mortality.

2.2.10. Maternal Health: Maternal health refers to the health of women during pregnancy, child birth and the postpartum period.

2.2.11. Neonatal Mortality: The probability of dying for a newborn in the first month of life is known as neonatal mortality.

2.2.12. Post Neo Natal Mortality: The probability of dying for a newborn after the first month of life but before the first birthday is known as post neonatal mortality.

2.2.13. Post Natal Care (PNC): The health of a mother and her newborn child depends not only on the health care she receives during her pregnancy and delivery, but also on the care she and the infant receive during the first few weeks after delivery. Postnatal checkups soon after the delivery are particularly important for births that take place in non institutional settings. Recognizing the importance of post natal checkups, the RCH programme recommends three post natal checkups (Ministry of Health and Family Welfare).

2.3. Methodology and Data Base

To analyse the “Impact of Janani Suraksha Yojana on utilization of reproductive and child health services in Jammu and Kashmir -A case study of district Pulwama”, the data was obtained from both primary and secondary sources. Since the data from secondary sources was not adequate, the same was supplemented by primary data which was collected by means of well designed and well structured pre tested open end questionnaire, framed strictly in accordance with the objectives and hypothesis of the study.

Selection of the sample was based on the information collected from the District Programme Management Unit (DPMU), Pulwama. The data collected from DPMU revealed that there were three medical blocks viz Pampore, Pulwama, and Tral, constituting 332 villages with population of 5.70 lacs (Census 2011). To conduct the field survey a random sample of 300

respondents at the rate of 100 from each block who have availed benefits of JSY in the district were taken as sample beneficiaries. Therefore, the analysis of the data for empirical estimation has been done on the basis of the above three medical blocks. The selection of villages from each block was done on the basis of population which was grouped into three categories viz. i) Villages with population greater than 5000, ii) Villages with population between 5000-2000 and iii) villages with population less than 2000. From each group two villages were selected forming total of six villages from each block and therefore, 18 villages from whole district. From each selected village a maximum number of 17 beneficiaries were selected with the help of local Accredited Social Health Activist (ASHA) and Angan Wadi Worker (AWW) and thereby completing a sample of 300 beneficiaries.

The reference period for the present study has been taken from 2009 to 2011. Information was collected through various methods such as administering the questionnaire and interviews. The survey of the sample was conducted to get information regarding socioeconomic background, awareness about JSY, registration process, cash incentives, utilization of ANC, delivery care, PNC services and use of immunization services and problems faced by the sample beneficiaries (see the Questionnaire in Appendix).

The secondary data has been obtained from the following sources;

- i. Official records of District Programme Management Unit Pulwama.
- ii. Official records of Department of Health, Government of Jammu and Kashmir.
- iii. Digest of Statistics (2008-2009), Directorate of Economics and Statistics, Planning and Development Department, Government of Jammu and Kashmir.
- iv. Economic Survey (2010-2011), Directorate of Economics and Statistics, Planning and Development Department, Government of Jammu and Kashmir.

- v. Performance Review of J&K Economy (2008-2009), Directorate of Economics and Statistics, Planning and Development Department Government of Jammu and Kashmir.
- vi. Directorate of Health Services, Government of Jammu and Kashmir.
- vii. Official publications of Department of Health and Family Welfare, Govt. of Jammu and Kashmir.
- viii. District Level Household and Facility Survey (2007-08), Ministry of Health and Family Welfare, Govt. of India.

After collecting primary data from JSY beneficiaries and secondary data from various published and unpublished official sources, the data has been classified and tabulated for making the further analysis and interpretation. The study is a descriptive and analytical in nature. For impact analysis binary logistic regression model was used to the data collected from the field survey through SPSS-18.0 version software. To show the impact of JSY three indices viz. 'ANC' (Anti-natal Care), 'IS' (Immunisation Services) and 'INSTDELVRY' (Institutional Delivery) have been used in a binary logistic regression. Since all the dependent variables were qualitative variables with a binary choice (Yes or No type answers), we used logit model because of its simplicity.

In a first binary logistic regression equation 'ANC' is considered as dependent variable, which is a combination of three characteristics i) Ante natal Care checkups, ii) IFA tablets and iii) doses of TT injections and was assigned two values of binary choice, either value 1 or 0 (1 means all types of ANC received and 0 means ANC not received).

In a second binary logistic regression 'IS' is a dependent variable which is combination of five main characteristics i.e. BCG, DPT, 2PV, 3PV, MIG and was assigned two values of binary choice, either value 1 or 0 (1 means all types of IS received and 0 means IS not received).

Similarly, in a third binary logistic regression ‘INSTDELVRVY’ is a dependent variable which is a combination of two values, either value 1 or 0 (1 means the place of birth of a child in Govt/Pvt. Health institutions and 0 means the place of birth in home). All the three dependent variables (ANC, IS and INSTDELVRVY) have been explained by various independent variables, i.e. Age, Educational level, Family size, BPL/APL, Rural/Urban and Cash Received with the help of following expressions:

- i) $ANC=f(\text{Age}, \text{Edu}(E1+E2+E3+E4), \text{Fsize}(F1+F2+F3), \text{BPL/APL}, \text{Rural/Urban}, \text{Cash Received})$
- ii) $IS=f(\text{Age}, \text{Edu}(E1+E2+E3+E4), \text{Fsize}(F1+F2+F3), \text{BPL/APL}, \text{Rural/Urban}, \text{Cash Received})$.
- iii) $INSTDELVRVY=f(\text{Age}, \text{Edu}(E1+E2+E3+E4), \text{Fsize}(F1+F2+F3), \text{BPL/APL}, \text{Rural/Urban}, \text{Cash Received})$

According to binary logit model, the Probability (P_i) that one received ANC, Probability (P_i) that one received IS and the Probability (P_i) that one’s Childs place of birth is at govt/pvt health institution is given by the following expression (Hanemann-1984):

$$P_i = F_{\eta}(\Delta V) = 1 / \{1 + \exp(-\Delta V)\}$$

$$= 1 / \{1 + \exp(-(\alpha + \beta_1 \text{Age}, \beta_2 \text{Edu.}, \beta_3 \text{Fsize}, \beta_4 \text{BPL/APL}, \beta_5 \text{Rural/Urban}, \beta_6 \text{Cash Received}, e))\}$$

Where, P_i = Probability of answer ‘yes’ from a respondent

$F_{\eta}(\Delta V)$ = Cumulative distribution function (CDF) of a standard logistic variate

ΔV = Represents all explanatory variables explained.

e = Error term and

$\alpha, \beta_1, \beta_2, \beta_3, \beta_4, \beta_5$ and β_6 = Unknown Parameters to be Estimated

The parameters of the Logit Model are estimated, by ‘Maximum Likelihood Method’, using SPSS-18.0 version. Moreover, in the present study various statistical tests like chi-square; p-value, -2loglikelihood and other

mathematical tools like growth rate, percentages and arithmetic mean have been used to arrive on certain conclusions.

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Chapter - 3



Appraisal of National Rural Health Mission In Jammu and Kashmir

The present chapter is based on secondary data which was collected from various sources and an attempt was made to analyse the overall performance of NRHM in Jammu and Kashmir in terms of coverage, implementation, physical and financial performance. The chapter is divided into two sections, the section I deals with the definition and main features of NRHM and section II deals with the analysis of secondary data regarding performance of NRHM in Jammu and Kashmir.

3.1. Health scenario in Jammu and Kashmir

The Jammu and Kashmir state comprises 22 districts divided into three administrative divisions. The Kashmir region comprises the ten districts namely Anantnag, Kulgam, Pulwama, Shopian, Srinagar, Budgam, Ganderbal, Baramullah, Bandipora and Kupwara. The Jammu region also comprises ten districts viz Doda, Ramban, Kishtwar, Udhampur, Reasi, Jammu, Samba, Kathua, Rajouri and Poonch. The Ladakh region consists of two districts- Kargil and Leh. In terms of health care coverage, the state is divided into two divisions i.e. Kashmir division and Jammu division, Kashmir division comprises twelve districts i.e. ten districts of Kashmir region and two districts of Ladakh region while as Jammu division comprises ten districts of Jammu region. Every region has distinct social, economic, linguistic and cultural characteristics.

The State of Jammu and Kashmir has a population of 1, 25, 48,926 persons comprising of 66, 65,561 males (53.11%) and 58, 83,365 females (46.89%),

with a child population of 20, 08,642 (16.01%) in the age group of 0-6 years (census-2011). The population in the age group of 7 years and above is 1, 05, 40,284 persons (83.99%), out of which males are 55, 84,899 (44.50%) and females are 49, 55,385 (39.46%). The decadal growth rate of population (census 2011 v/s 2001) of the State is 23.71% as against 17.64% at all India level. The population of the State is roughly 1.04% to the total population of the country. The sex ratio per 1000 of population is 883 as against 940 at all India level and child sex ratio as 859/1000 against the 914/1000 of population at all India level. Similarly, the total literacy rate in the State is 68.74% as against the national average of 74.04%. The male literacy stands at 78.64% and 82.14% while as female literacy is 58.01% and 65.46% at the national and the State level. The rural population in the State is 91, 34,820 (72.79%) as against 68.84% at all India level and urban population is 34, 14,106 (27.21%) as against 31.16% at the national level.

Health is the most important social service sector and is placed on the top priority by both state and central governments of the country. The state of Jammu and Kashmir is giving priority to the health sector by way of strengthening health institutions to meet the growing health care needs of the people especially those living in rural areas. The department of health has made remarkable progress in the last few years but still, there is a lot to be done to improve the health care delivery system. The State is committed to make every effort to safe guard and promote health of the people and ensure wide spread and efficient medical services to whole of the state especially the rural areas. The State has been focussing on infrastructural up gradation facilities, availability of man power resources, medical equipments and better access and coverage to all sections of the society. The number of health institutions has increased considerably from 124 in 1950 to 4801 in 2009-10. Health care facilities in the State got heavy emphasis right from the independence. The beginning was made with the opening of two hospitals one each at Jammu

Tawi and Srinagar by the Maharajas. Later on, some more hospitals were opened both at district and state level in order to cater to the needs of the special groups such as women and children who are the largest consumers of health services in terms of demand.

After India became a signatory to the Alma Ata declaration of 1978 by committing itself to attain the goal “Health for All” by 2000 A.D., the government started to concentrate on the development of rural health infrastructure. This was done to provide health care services to the rural population which by and large had remained neglected. Till 2005, health was sole state subject after that there was a shift from state to central level.

In Jammu and Kashmir various efforts are now being made by state govt. to increase the health care delivery system to the remotest corners of the state. At present i.e. 2011-12³, there are 114 District Hospitals/Sub District Hospitals, 648 Ayurvedic/Allopathic/Unani dispensaries, 380 Primary Health Centers (PHCs), 338 Medical Aid centers, 10 Tuberculosis (TB) centers, 8 Sexually Transmitted Disease/ Venereal Disease (STD/V.D) clinics, 2036 Family Planning centers and sub centers and 52 Leprosy sub centers and leprosy control units in the State providing essential health and family welfare services to the people of the State. The health indicators in the State are comparatively better than the national average. As per the figures indicated in the SRS Bulletin-2012, some of the vital health indicators are performing far better than the national average as shown in table 3.1.1.

³ Directorate of Economics and Statistics, Govt. of J & K, Srinagar

Table3.1.1. Health indicators of J&K in comparison with All India level

S. No	Health indicators	All India average	J&K
1	Birth rate	22.8	17.8
2	Death rate	7.1	5.5
3	Infant Mortality rate	44	41
4	Total fertility rate	2.4	2.1
5	Mothers who had at least received 3 or more ANC (%)	68.7	87.0
7	Institutional delivery	72.9	80.9
8	Children having vaccinated with DPT-3 doses (%)	76.2	82.9
9	Full immunization (%)	61.0	66.6

Source: Sample Registration System SRS-Bulletin 2012 and Coverage Evaluation Surveys 2009 by UNICEF

From the above table it is evident that the birth rate of population is 17.8 at State level against 22.8 at national level while as death rate is 5.5 against 7.1 at national level. The infant mortality rate has declined to 41 at State level against 44 at national level and fertility rate also declined to 2.1 against 2.4 at national level. The percentage of mothers who had at least received 3 or more ante natal checkups has risen to 73.3% as against 51.1% of national average. The institutional deliveries and immunization in the State also show better performance when comparing with the national average i.e. institutional delivery rate of 80.9% as against 72.9% and immunization rate of 66.6% as against 61% respectively. Therefore, health indicators of J&K state are performing far better than the national average.

3.2. Section I:

3.2.1 National Rural Health Mission (NRHM)

The National Rural Health Mission was launched by Prime Minister Manmohan Singh on April 12, 2005 with the goal to improve the availability of and access to quality health care to the rural masses, especially the poor women and children. It aims to provide effective healthcare to people living in rural areas across the country, with special focus on the rural population in 18 states with poor health achievements and Jammu and Kashmir (J&K) is among one

such focus states. In J&K, NRHM was started in December 2005, in order to strengthen the public health care delivery system by community ownership of health facilities. J&K state has been identified as one of the high focus states under NRHM, focussing not only on health care but also on important determinants of good health like nutrition, sanitation, hygiene, safe drinking water etc. The NHRM aims to transform the public health system so as to make it responsive, efficient and effective through a multi prolonged approach. The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections of the society.

3.2.2 Objectives of the Mission

- Reduction in maternal and infant mortality rate.
- Reduction in total fertility rate.
- Universal access to public health care services with emphasis on services addressing women and children's health.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilisation, gender and demographic balance.
- Revitalize local health traditions and mainstream Ayurvedic Yoga Naturopathy Unani Sidha and Homeopathy (AYUSH).
- Promotion of healthy life style.

In order to achieve the above objectives the following strategies have been adopted in the State.

- Strengthening of the health institutions and providing primary health care through Community Health Centers (CHCs), Primary Health Centers (PHCs) and sub centres so as to provide all the basic and emergency obstetric care.
- Improving the immunization services for the vaccine preventable diseases.

- Improving the health care services and the services determining the health of the society viz. sanitation and potable drinking water.
- Decentralizing the health planning and management of the health institutions by constituting District Health Missions and District Health Societies for planning and implementing the health initiatives in the respective districts through formation of Rogi Kalyan Samities (RKS) and Village Health Sanitation and Nutrition Committees (VHSNC).
- Bringing all the centrally sponsored schemes under the umbrella of NRHM.

3.3. Section II:

3.3.1. Physical performance of National Rural Health Mission (NRHM)

Under the NRHM, several new interventions were made over the years. These include establishment of First Referral Units (FRUs)/Primary Health Centers (PHCs) on 24×7 basis, baby care corners, provision of additional human resources, training of medical and paramedics in skilled births and management of neo-natal childhood illness, organisation of Reproductive Child Health (RCH) camps, strengthening referral transport, promoting institutional deliveries through involvement of ASHAs and conducting awareness camps. For the successful implementation of the scheme, efforts are made both at state and central level. In order to ensure increase in the number of safe institutional deliveries, the State govt. has ensured engagement of large number of trained medical personnel like doctors, para medical personnel, staff nurses and pharmacists along with adequate managerial personnel. For the success of NRHM, a lot of manpower was engaged in the State as shown in the table 3.3.1.

Table3.3.1. District wise engagement of Manpower under NRHM in J&K (up to Jan. 2012)

S.no	District	Specialists	Doctors	ISM Doctors	ISM Dawasaz	Staff Nurse	Lab. Tech.	OT Tech.	X-ray Tech.	Second ANM	MPHWs	Total	Percentage share
1	Kishtwar	0	13	13	07	13	09	02	03	39	0	99	02.30
2	Kathcua	1	6	28	24	29	23	10	10	124	0	255	05.94
3	Reasi	0	2	15	11	07	11	6	6	62	0	120	02.79
4	Doda	0	4	22	13	28	14	5	6	70	27	189	04.39
5	Samba	0	6	13	13	26	12	7	8	74	0	159	03.69
6	Jammu	8	30	29	25	57	36	16	16	244	0	461	10.72
7	Poonch	2	8	22	17	35	17	5	6	99	0	211	04.90
8	Rajouri	1	11	30	22	21	39	14	16	139	0	293	06.81
9	Ramban	0	6	12	7	8	11	7	8	39	8	106	02.46
10	Udhampur	3	5	25	20	11	11	2	3	92	0	172	04.00
11	Anantnag	2	21	25	26	47	22	10	10	114	0	277	06.44
12	Budgam	1	29	34	33	42	30	17	18	114	0	318	07.39
13	Bandipora	0	9	8	7	21	11	6	6	44	0	112	02.60
14	Baramullah	1	23	29	28	26	17	11	11	117	0	263	06.11
15	Ganderbal	1	6	15	15	12	8	1	0	6	0	64	01.48
16	Kargil	0	3	4	1	6	15	3	3	56	0	91	02.11
17	Kulgam	2	20	19	18	40	22	8	8	81	0	218	05.06
18	Kupwara	4	28	34	30	29	20	9	10	138	0	302	07.02
19	Leh	1	4	26	9	41	16	2	6	36	0	141	03.27
20	Pulwama	0	16	17	16	28	10	4	4	71	0	166	03.86
21	Shopian	1	14	9	9	19	9	8	8	44	0	121	02.81
22	Srinagar	9	1	9	7	13	2	0	2	119	0	162	03.76
Total		37 (00.86)	265 (06.16)	438 (10.18)	358 (08.32)	559 (13.00)	365 (08.48)	153 (03.55)	168 (03.90)	1922 (44.69)	35 (00.81)	4300 (100)	100

Source: -Compiled from official data of Department of Health and Family Welfare, NRHM, Govt. of Jammu and Kashmir

It is clear from the above table that under NRHM 4300 persons have been engaged all over the Jammu and Kashmir state till Jan. 2012, out of which 44.69% are engaged as ANM's, 13% staff nurses, 10% ISM doctors and 8% as lab technicians. Specialists, Doctors who are the largest health providers constitute insignificant proportion of less than 1% and 6% respectively.

So far as distribution of manpower is concerned, it is highly uneven in Jammu division because most of it is skewed towards Jammu district i.e. 10.72% when compared with other districts of the same division who constitute less than 3% of manpower. In Kashmir division there is better distribution when compared with Jammu division as most of the districts constitute uniform manpower of more than 3%. However, against 5370 posts sanctioned under NRHM, 20% posts are still vacant under NRHM which filled if would have made State far better than other states of the country. Thus, NRHM is partially implemented in the State and needs lot of attention both at state and central level for its success. Despite that NRHM in the state has helped a lot in increasing institutional deliveries. As a result of these measures, the position of maternal and child health indicators has shown lot of improvements. The major achievements under NRHM are:

3.3.2. Human Resource Management:

Under National Rural Health mission, the district hospitals, CHCs, PHCs and sub-centres are being revitalized through better human resource management including provision of additional human resources. In this regard 37 specialists, 703 doctors and 3560 paramedics have been engaged on contract basis in order to fill the critical gaps in the health institutions having the potential to be converted into First Referral Units and 24x7 PHCs. Similarly, 82 persons have been engaged as District Programme/Accounts Managers/Monitoring and Evaluation officers and 152 persons as block accountants/monitoring and evaluation officers.

3.3.3. Operationalisation of First Referral Units and 24×7 Primary Health Centers

With a view to reduce the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), focus has been given to improve the services for mother and child healthcare in existing health institutions. The health facilities have been strengthened to provide facilities for conducting deliveries. Community Health Centers (CHCs) are being upgraded as First Referral Units (FRUs) to provide emergency obstetric care including caesarean section. 74 CHCs have been operationalised as FRUs in the State with provision of additional doctors/paramedical personnel. Similarly, Primary Health Centers (PHCs) are upgraded as 24×7 facilities to provide round the clock basic obstetric services. 170 PHCs have been strengthened as 24×7 facilities in the state so far.

3.3.4. Link Worker

In order to provide services for delivering mothers a cadre of link workers known as Accredited Social Health Activists (ASHAs) were created for the successful implementation and better coverage of NRHM among rural masses. Till Jan. 2012, 9575 ASHAs have been engaged so far against the target of 10000 during the same year, out of which 9500 have been trained and have also been provided with drug kits.

3.3.5. Referral Transport System

For strengthening referral transport facilities in order to meet the emergency needs of the delivering mothers, 125 ambulances have been procured till March 2011, 50 basic life support units for meeting accidental cases after every 30 kms and 25 critical care ambulances were also established during 2011-12.

3.3.6. Janani Suraksha Yojana (JSY)

The Janani Suraksha Yojana was launched in the state in Dec. 2005 with the aim to promote safe institutional deliveries. Due to some complaints regarding its smooth implementation in April 2007, JSY was stopped. However, in Nov. 2008, it was restarted resulting into rapid growth in terms of number of beneficiaries i.e. in 2008-

09, there were only 7771 beneficiaries who increased to 112210 in 2010-11. About 4.25 lac mothers have benefitted so far under JSY ending Oct. 2012.

3.3.7. Neonatal care services

For the provision of neonatal care services to the newly born children, 259 baby care corners, 66 stabilisation units and 5 sick neonatal care units in District Hospitals have been established.

3.4. Infrastructural Development

Improvement in the health status of the population has been one of the major thrust areas for the social development programmes, which will be achieved through improving the access to and utilisation of health services with special focus on rural population. In this regard NRHM is a welcome step that has made a steady progress in terms of development of health infrastructure and provision of necessary inputs. Despite the disturbance in Jammu and Kashmir the state has made remarkable progress for improving infrastructural development particularly in terms of providing Primary Health Centres (PHCs), Community Health Centres (CHCs), Dispensaries and sub centres.

In the first phase of NRHM (2005-12), the focus was on bridging infrastructure gaps and expansion of man power to improve the delivery of health care services. Thus, infrastructural development viz. construction and up gradation of hospitals is considered to be an important component for the success of NRHM in Jammu and Kashmir. As per the data provided by Department of Health and Family Welfare ₹267 crore has been provided for the construction of Community Health Centres, Primary Health Centres and Sub centres under NRHM, out of which ₹224.95 crore i.e. about 84% have been spend upto Jan. 2012.

Physical development in terms of health societies, sanitation committees, up gradation of CHCs/PHCs, selection and training of ASHAs, engagement of Doctors, increase in the number of ambulances etc are among the major achievements of

NRHM. Following table shows the main physical achievements of NRHM up to Jan. 2012.

Table3.4.1. Physical achievements under NRHM (2011-2012)

No. of District Health Societies constituted	22
No. of Rogi Kalyan Samitis registered	567
No. of Village Health and Sanitation Committees constituted	6788
No. of CHC upgraded	74
No. of PHC made operationalized as 24×7	170
No. of Baby care corners established	260
No. of Specialists/Doctors/Paramedics engaged	4300
No. of Ambulances provided	175
No. of ASHA's selected	9575

Source: - Directorate of Health Services Kashmir, NRHM, Srinagar

It is evident from the above table that 22 district health societies have been created till Jan. 2012 over the period of seven years from the inception of the NRHM in the State. For involvement of community in the programme, 6788 Village Health and Sanitation Committees and 567 Rogi Kalyan Samitis (RKS) have been created so far. In order to meet the shortage of manpower, 4300 Specialists/Doctors/Paramedics were engaged till 2012 and 9575 Accredited Social Health Activists have also been engaged under NRHM against the target of 10000.

3.5. Maternal Health, JSY and Child Immunization

Maternal and child health has remained an integral part of the Family Welfare Programme of India since the time of first five year plan (1951-56), when the Government of India took steps to strengthen maternal and child health services. In order to improve the availability of and access to quality health care, especially those living in rural areas, the poor, women and the children, the government introduced NRHM in all the states of the country with a view to reduce maternal mortality, improve maternal and child health and increase institutional delivery. In order to

provide access to and improve maternal health, the state has made remarkable progress in maternal health, JSY and child immunization as shown in table 3.5.1 and 3.5.2.

Table 3.5.1: Maternal Health and Child Immunization (year-wise)

Maternal Health	2008-09	2009-10	2010-11	2011-12 (Nov.2012)	Total	Average
No. of cases of referral transport for pregnant women and sick newborns	3250 (16.05%)	5882 (29.05%)	5992 (29.60%)	5120 (25.30%)	20244 (100)	5061
No. of integrated RCH Camps organized	NA	390 (37.79%)	411 (39.83%)	231 (22.38%)	1032 (100)	258
Immunization						
No. of Children whom BCG Dose given	198540 (24.16%)	225829 (27.48%)	248499 (30.23%)	149081 (18.13%)	821949 (100)	205487
No. of Children DPT/Polio III Dose given	NA	NA	238400 (62.50%)	143000 (37.50%)	381400 (100)	95350
No. of Children to whom Measles Injection given	169700 (22.30%)	209787 (27.56%)	232022 (30.49%)	149541 (19.65%)	761050 (100)	190263

Source: - Compiled from NRHM Performance Review-2012, NRHM Newsletter, SHS, Govt. of J&K

Figures in parenthesis indicate percentage from total

From the above table it is evident that referral transport services have been provided to 20244 women from 2008-09 to 2011-12. On an average 5061 women were provided with referral transport services in the State. In terms of percentage, the referral transport increased from 16% in 2008-09 to 30% in 2010-11.

For strengthening maternal health about 1032 Reproductive and child health camps were organised since 2008-09 to 2011-12. On an average 258 RCH camps are organised annually in the state for making people aware about the different components of the programme. The RCH camps have increased from 37% in 2008-09 to 40% in 2010-11. Therefore, maternal health services in terms of referral transport and RCH camps have increased over the period of time.

The above table also shows that the number of children whom BCG Dose was given increased from 24% i.e. 198540 in 2008-09 to 30% i.e. 244899 in 2010-11. The number of children who received Measles Injection increased from 22% in 2008-09 to

30% in 2010-11 and on an average 190263 children got Measles Injection annually in the state. Thus, immunisation of children is also showing positive sign.

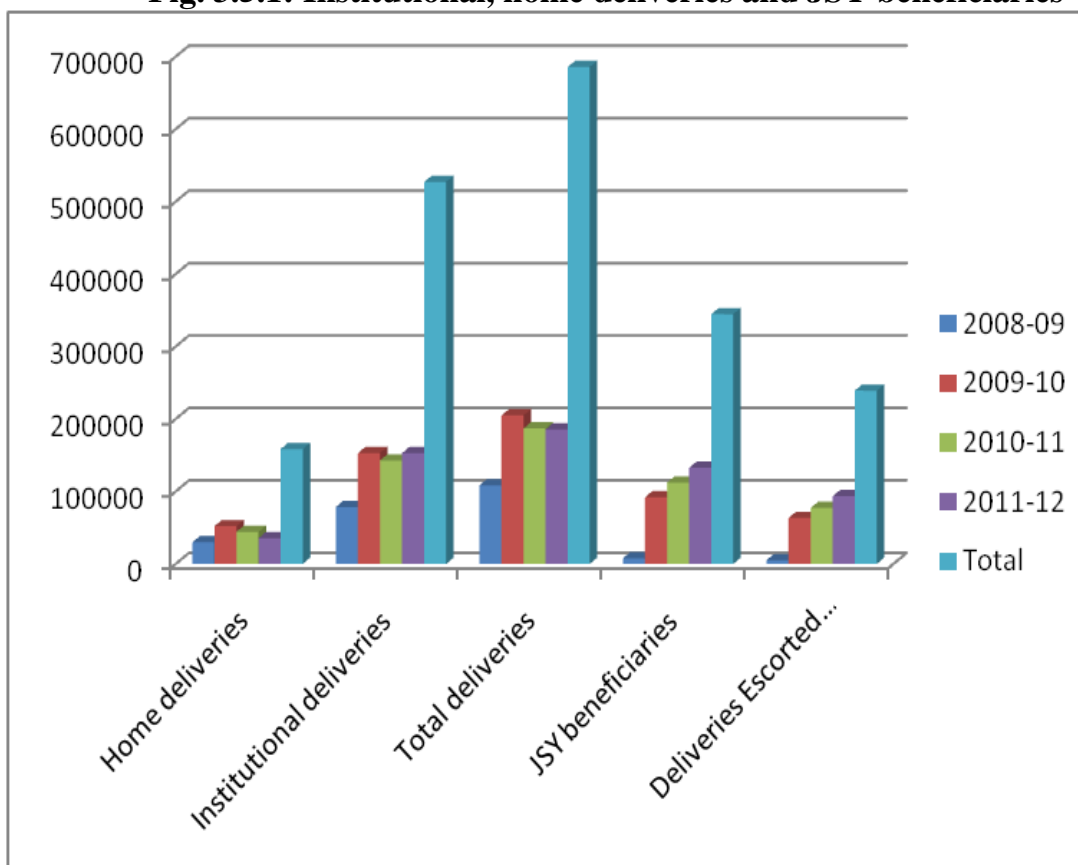
Table 3.5.2: Institutional, home deliveries and JSY beneficiaries

Year	Home delivery	Institutional Delivery	Total deliveries	JSY beneficiaries	Deliveries Escorted by ASHAs
1	2	3	4=2+3	5	6
2008-09	29771	78557	108328	7771	5087
2009-10	51980	152866	204846	91887	63427
2010-11	44237	142669	186906	112210	77113
2011-12	35530	152998	185528	132645	93386
Total	158518 (23.13%)	527090 (76.87%)	685608 (100)	344513 (50.24%)	239013 (34.86%)

Source: - Compiled from NRHM Performance Review-2012, NRHM Newsletter, SHS, Govt. of J&K.

Figures in parenthesis indicate percentage from total

Fig. 3.5.1: Institutional, home deliveries and JSY beneficiaries



The above table shows that total deliveries increased from 108328 in 2008-09 to 185528 in 2011-12, out of total number of deliveries i.e. 685608, 77% were institutional deliveries and 23% were home deliveries. The above table also depicts that 50% women were given cash incentives under JSY and 34% women were escorted by ASHAs.

3.6. Financial performance of National Rural Health Mission

At the apex level, there is State Health Mission headed by the Chief Minister and co-chaired by the Health Minister with principle secretary, Health and Medical Education (H&ME) as convener and ministers of the Planning, Finance, Social welfare and Rural Public Health Engineering and Urban Environmental Engineering Department (UEED) as members.

The State Health Mission acts as an insight to the Health system for provision of consideration of policy matters, review of progress and providing adequate measures to promote NHRM visibility.

At the State level there is the State Health Society (SHS), which is governed by chief secretary with principle secretary Health and Medical Education as vice chairman and Director General Health and Family Welfare, RCH and NRHM as convenor and the principal secretaries of related departments as official members. The governing body of the State Health Society is supposed to meet once every six months. The main functions of the governing body are:

1. Approval of annual state action plan for the NRHM.
2. Consideration of proposals for institutional reforms in the Health and Family Welfare sector.
3. Status of follow up action on decisions of the State Health Mission.

Executive Committee of the SHS is headed by the Principal Secretary Health and Medical Education with Director General, Health and Family Welfare, Reproductive Child Health NRHM as vice chairman and Directors of the related departments as

members, it is supposed to meet once in every month. The main functions of executive committee are:

1. To review the details regarding expenditure and implementation.
2. Approval of proposal for districts and release of funds for different programmes as per Annual action plan to the District Health Society.
3. To follow the decision of governing Body and provide support to the State Health Mission/State Health Society through State Programme Management Support Unit (SPMSU) which is headed by Mission Director.

At the district level there is District Health Mission headed by District Development Board with District Development Commissioner as Vice Chairman and CMO as convenor, MLAs, MLCs and District officers of all other related Departments/NGOs as members. The District Health Society, headed by District Development Commissioner, CMO, as convenor and District officers of other related departments as members, act as the nodal forum for implementing various schemes and activities of NRHM at the District level. There are District Programme Management Units comprising of District Programme Manger, District Accounts Manager, and District Monitoring and Evaluation Officer providing technical support to the District Health Societies.

At the Block level there are Block Monitoring and Evaluation Officers and Block Accounts Manager who provide technical support to the BMOs. Besides this, there are Rogi Kalyan Samitis (RKS)/Patient welfare committees constituted at the District Hospitals, CHCs and PHCs headed by MLA of constituency to manage the affairs of hospitals in such a way so as to meet the expectation of the people especially for quality curative services. CMO/Deputy CMO is the vice chairman of RKS for District Hospital/CHCs and PHCs. RKS has been constituted with a view to utilize the funds received from Government of India (GOI) under NRHM for the strengthening and maintenance of the Hospital.

3.7. Fund position of National Rural Health Mission (NRHM)

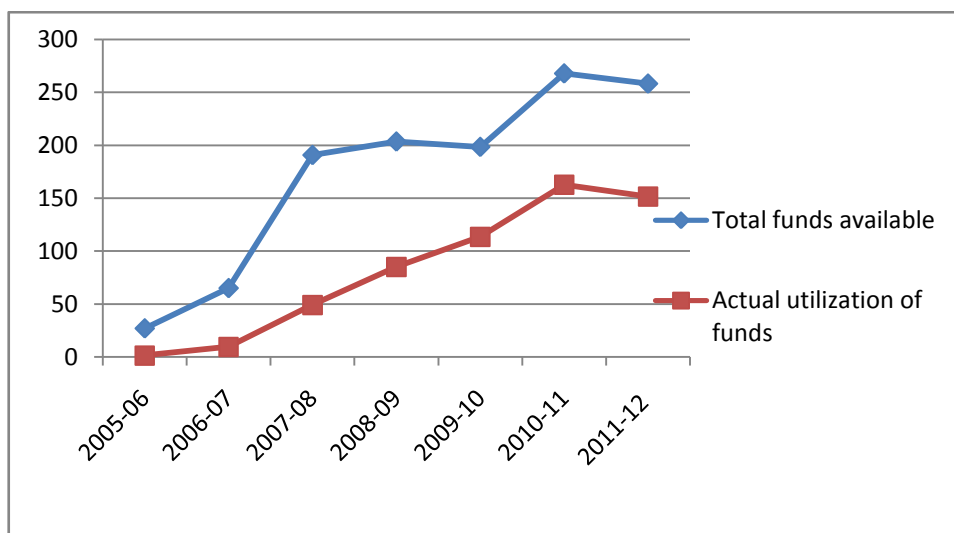
Under the NRHM the grants are provided to the states by the Ministry of Health and Family Welfare (MOH&FW), Govt. of India (GOI) with the state contribution of 15 per cent. However, State's contribution from 2012-13 would be only 10 percent and 90 percent of funds would be given by the centre provided utilisation certificates are properly maintained and satisfactorily utilised up to the mark. MOH&FW, GOI has released ₹592.61 crores and an amount of ₹87.12 crores have been provided as State share to the State Health Society ending Jan., 2012. Out of total availability of ₹679.73 crores, ₹573.02 crores (84%) stands utilised ending Jan., 2012. The year wise release of funds and expenditure made is given in table 3.7.1.

Table 3.7.1. Availability of funds and expenditure under NRHM (₹ in crores)

Year	Total funds available	Actual utilization of funds	Percentage utilization of funds
2005-06	27.00	1.44	9.59
2006-07	65.03	9.54	14.67
2007-08	190.74	49.11	25.74
2008-09	203.51	85.17	41.85
2009-10	198.44	113.55	57.22
2010-11	267.84	162.71	60.74
2011-12	258.21	151.50	58.67
Total	679.73	573.02	84.30

Source: Department of Health and Family Welfare, NRHM, Govt. of J&K.

Fig 3.7.1. Availability of funds and expenditure under NRHM



The table and fig.3.7.1, shows that in 2011-12, total funds released by the govt. accounts for ₹258.21 crores, out of which 58% funds has been utilised. On the whole, from the inception of the scheme (Dec.-2005) up to ending Jan. 2012, total funds released both by central and state government amounts to ₹679.73 crores, out of which ₹573.02 crores (84.30%) has been utilised for the success of NRHM as well as for the betterment of rural masses. Moreover, the figure 3.7.1 depicts that funds utilization shows a modest increase over the years but the gap between availability of funds and actual expenditure is widening particularly after 2010-11 which is a matter of concern as it will not be able to meet the growing demand of healthcare of growing population in a near future.

3.8. Utilisation of Untied funds, Annual maintenance grant and Corpus grant

Untied funds, Annual maintenance grant and Corpus grant are important components of NRHM. The Untied funds are provided to each PHC for undertaking centre specific activities, Annual maintenance and corpus grants for development of physical infrastructure. As per requirement the expenditure of these funds are to be undertaken with local consent of PRIs and RKS members. Necessity of Untied fund has been felt mainly due to unavailability of funds for undertaking any innovative Centre specific need-based activity, as the allotment of funds to the States has traditionally been of the nature of tied fund for implementing a particular

activity/scheme and this hardly left any funds for specific public health facilities. This centralized management and schematic in-flexibility for local action at block and periphery level was often a barrier for development of good health centres. Further it has been observed that most of the Primary Health Centres have not been maintained properly due to lack of steady fund available locally for repair of infrastructure and basic facilities. Therefore, health sector reforms under the National Rural Health Mission (NRHM) aims to increase functional, administrative and financial resources and autonomy to the field units. In order to strengthen the sub-centres, GOI provides ₹10, 000 per annum for each sub-centre and are being deposited in a joint bank account of the ANM and Sarpanch. It is operated by the ANM in consultation with “Village Health and Sanitation Committee”. Clear guidelines have been issued to the Sub-centres from the State as to how to utilize the fund. However, the main thrust of these funds are to meet the minor repair of Sub-centres, payment for cleaning services after child birth and other associated activities, emergency transport services to the specified referral centres, transportation of samples/drugs during epidemics, labour wages for environmental cleanliness/sanitation.

3.8.1. Regional Distribution of Expenditure under NRHM

State level data on fund availability and corresponding expenditure provides only a macro view of the achievements under NRHM. In order to have a better understanding regarding the expenditure, it is necessary to look at in aggregate data at the district level, block level and most preferably at the village level. Here we restrict ourselves to the analysis of data at the district level for each of the two divisions of the state viz. Jammu Division and Kashmir Division including Ladakh region.

3.8.1a: Jammu Division

Table 3.8.1. District wise expenditure for the year 2009, 2010 and 2011-Jammu Division (₹ in crores)

District	Activity	Total funds available	Actual utilization of funds	Actual utilization of funds as a percentage of total funds available
Jammu	Untied funds	1.88	0.51	27.12
	Annual Maintenance Grant	1.72	0.55	31.97
	Corpus Grant	2.86	1.10	38.46
	Total	6.47	2.17	33.53
Kishtwar	Untied funds	0.38	0.20	52.63
	Annual Maintenance Grant	0.29	0.12	41.37
	Corpus Grant	0.60	0.38	63.33
	Total	1.27	0.71	55.90
Kathua	Untied funds	1.34	0.55	41.04
	Annual Maintenance Grant	1.48	0.52	35.13
	Corpus Grant	2.66	1.29	48.49
	Total	5.49	2.37	43.16
Reasi	Untied Grant	0.87	0.22	25.28
	Annual Maintenance Grant	0.76	0.18	23.68
	Corpus Grant	1.50	0.45	30.00
	Total	3.13	0.86	27.47
Rajouri	Untied funds	1.10	0.54	49.09
	Annual Maintenance Grant	1.37	0.67	48.90
	Corpus Grant	2.14	1.17	54.67
	Total	4.62	2.39	51.73
Doda	Untied funds	1.01	0.44	43.56
	Annual Maintenance Grant	0.78	0.32	41.02
	Corpus Grant	1.51	0.78	51.65
	Total	3.31	1.55	46.82
Ramban	Untied funds	0.31	0.19	61.29
	Annual Maintenance Grant	0.40	0.15	37.50
	Corpus Grant	1.07	0.42	39.25
	Total	1.80	0.78	43.33
Poonch	Untied funds	0.81	0.54	66.67
	Annual Maintenance Grant	1.95	0.45	23.07
	Corpus Grant	1.14	0.85	74.56
	Total	3.91	1.84	47.05
Udhampur	Untied Grant	0.84	0.60	71.42
	Annual Maintenance Grant	0.68	0.42	61.76
	Corpus Grant	1.79	0.96	53.63
	Total	3.32	1.98	59.63
Samba	Untied funds	0.61	0.29	48.54
	Annual Maintenance Grant	0.70	0.36	51.42
	Corpus Grant	1.06	0.58	54.71
	Total	2.38	1.24	52.10

Source: - Department of Health and Family Welfare, NRHM, Govt. of J&K

It is observed from the above table that in Jammu division most of the funds were available to district Jammu i.e. ₹6.47 crores, out of which only 33% got utilised over the three years period (2009 to 2011) and the lowest number of funds were available to district Kishtwar i.e. ₹1.27 crores, out of which 56 % were utilised.

The highest Untied funds were available to district Jammu i.e. ₹1.88 crores, out of which 27 % of funds were utilised and lowest funds were available to district Ramban i.e. ₹0.31 crores, out of which 61% were utilised.

In terms of Annual maintenance grant, the highest Annual maintenance grant were available to district Poonch i.e. ₹1.95 crores, out of which only 23% were utilised and lowest in district Kishtwar i.e. ₹0.29 crores, out of which 41% were utilised. In terms of corpus grant, Jammu district got the highest funds i.e. ₹2.86 crores, out of which 38% funds were utilised and lowest funds were available to district Kishtwar i.e. ₹0.60 crores, out of which 63% were utilised from 2009 to 2011.

3.8.1 b: Kashmir Division

Table 3.8.2: District wise expenditure for the year 2009, 2010 and 2011-Kashmir Division (₹ in crores)

District	Activity	Total funds available	Actual utilization of funds	Actual utilization of funds as a percentage of total funds available
Anantnag	Untied funds	1.26	0.68	53.96
	Annual Maintenance Grant	0.86	0.50	58.13
	Corpus Grant	1.82	1.20	65.93
	Total	3.95	2.40	60.75
Pulwama	Untied funds	0.88	0.21	23.86
	Annual Maintenance Grant	0.64	0.19	29.68
	Corpus Grant	1.70	0.48	28.23
	Total	3.22	0.89	27.63
Kulgam	Untied funds	0.67	0.43	64.17
	Annual Maintenance Grant	0.60	0.37	61.66
	Corpus Grant	1.12	0.68	60.71
	Total	2.40	1.49	62.08
Shopian	Untied funds	0.72	0.38	52.77
	Annual Maintenance Grant	0.33	0.19	57.57
	Corpus Grant	0.87	0.46	52.87
	Total	1.93	1.03	53.36
Srinagar	Untied funds	0.44	0.27	61.36
	Annual Maintenance Grant	0.30	0.20	66.67
	Corpus Grant	1.39	0.65	46.76
	Total	2.13	1.14	53.52
Budgam	Untied funds	1.31	0.82	62.59
	Annual Maintenance Grant	1.11	0.75	67.56
	Corpus Grant	2.99	2.03	67.89
	Total	5.42	3.60	66.42
Ganderbal	Untied funds	0.54	0.23	44.59
	Annual Maintenance Grant	0.59	0.33	55.93
	Corpus Grant	0.82	0.43	52.43
	Total	1.96	1.00	51.02
Baramullah	Untied Funds	1.37	0.75	54.74
	Annual Maintenance Grant	1.25	0.72	57.60
	Corpus Grant	2.26	1.42	62.83
	Total	4.89	2.91	59.50
Kupwara	Untied funds	1.02	0.50	49.01
	Annual Maintenance Grant	1.64	0.69	42.07
	Corpus Grant	1.89	0.75	39.68
	Total	4.57	1.95	42.66
Bandipora	Untied funds	0.34	0.23	67.64
	Annual Maintenance Grant	0.23	0.18	78.26
	Corpus Grant	0.46	0.35	76.08
	Total	1.04	0.76	73.07

Kargil	Untied funds	0.57	0.24	42.10
	Annual Maintenance Grant	0.54	0.20	37.03
	Corpus Grant	0.49	0.33	67.34
	Total	1.61	0.78	48.44
Leh	Untied funds	0.49	0.33	67.34
	Annual Maintenance Grant	0.63	0.42	66.67
	Corpus Grant	0.68	0.49	72.05
	Total	1.81	1.26	69.61

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

It is observed from the table 3.8.2. that in Kashmir division most of the funds were available to district Budgam i.e. ₹5.42 crores, out of which 67% got utilised over the three years period (2009 to 2011) and the lowest funds were available to district Bandipora i.e. ₹1.04 crores, out of which 73% were utilised.

In terms of Untied funds, the highest funds were available to district Baramullah i.e. ₹1.37 crores, out of which 55% of funds were utilised and lowest funds were available to district Bandipora i.e. ₹0.34 crores, out of which 68% untied funds were utilised.

Highest Annual maintenance grant were available to district Kupwara i.e. ₹1.64 crores, out of which only 42% were utilised and lowest in district Bandipora i.e. ₹0.23 crores, out of which 75% were utilised.

In terms of Corpus grant, Budgam district comprised the highest funds i.e. ₹2.99 crores, out of which 68% funds were utilised and lowest funds were available to district Bandipora i.e. ₹0.46 crores, out of which 76% were utilised from 2009 to 2011.

From the analysis of table 3.8.1 and 3.8.2, it is observed that an Untied fund of ₹18.86 crores, Annual maintenance grant of ₹18.87 crores and Corpus grant of ₹32.90 crores was available for J&K state during 2009 to 2011. Out of which Jammu division has an availability of ₹9.20 crores (48%) in terms of Untied Fund, ₹10.07 crores (53%) in terms of Annual maintenance grant and ₹16.36 crores (49%) in terms of Corpus grant during 2009 to 2011. In Kashmir division including Leh and Kargil districts, the availability of ₹9.65 crores (51%) in terms of Untied fund, ₹8.80 crores (46%) in terms of Annual maintenance grant and ₹16.53 crores (50%) in terms of Corpus grant during

the same period. Therefore, we can conclude that proportion of funds is more or less uniformly distributed among both the regions of the State.

So far as utilization of funds is concerned, Jammu division utilized about 45% of Untied Funds as compared to 53% of Kashmir division during 2009 to 2011. Similarly, 37% Annual maintenance grant and 45% Corpus grant were utilised by Jammu division while as Kashmir division utilised about 54% and 55% respectively during 2009 to 2011. Again in Jammu division, districts Udhampur (59.63%), Kishtwar (53.90%) and Samba (52.10%) are among high performing districts whose overall fund utilisation is greater than 50%. Similarly, in Kashmir division, districts Bandipora (73.07%), Leh (69.61%), Kulgam (62.08%) and Anantnag (60.75%) were among the districts whose overall fund utilisation is greater than 60%. Again, in Jammu division, districts Jammu (33.53%) and Reasi (27.45%) are among the low performing districts who have utilized less than 35% of available funds. Similarly, Pulwama (27.63%) and Kupwara (42.66%) are among the low performing districts in the Kashmir division.

Therefore, we conclude that about 49% untied funds, 46% Annual maintenance grant, 51% Corpus grant were utilised at the State level during the year 2009 to 2011. This means about 50% of funds under NRHM remain unutilised during the year 2009 to 2011 which is a matter of great concern as if these funds have been utilised rather could have made the health sector far better than that of current position. Thus, we can conclude that unavailability of funds is not responsible for lower health outcomes but under utilization of existing funds mars the proper functioning of the NRHM in the state. This non utilisation of funds also breeds corruption as most often the officers in-charge fall prey of greed which result into big Scandals like in case of Uttar Pradesh in 2012. Therefore, state government should take positive steps in order to make proper use of existing available resources through proper management and provide sound infrastructural base for meeting the growing needs of growing population in a time bound manner.

The health of a nation can be better understood from the efficiency of the delivery system in meeting the problems at gross root level. If the foundation is firm, there is no reason why the structure can't be sound. There are various factors responsible for low utilization of NRHM funds but the factors which came to the forefront from our study are as under:

1. Shortage of staff is the main reason for low utilization of NRHM funds, as 20% of the posts sanctioned under NRHM are still vacant in Jammu and Kashmir.
2. Lack of Managerial staff also adds up the problem as most of the health officials are unskilled and working on contract basis.
3. Under NRHM funds are transferred from Centre to State, implementation is being taken care of by the State government. Low utilization of funds emerges because there is duplication in efforts, sluggishness in implementation and confusion over accountability.
4. Timely provision of incentives to health officials is also a big hindrance for NRHM success.

Despite low utilization of funds at state level, there is much regional variation across the two regions of the state, with Kashmir division showing better performance due to better distribution of health personnel among all the districts of the Kashmir division.

3.9. Conclusion

Over the years, with the introduction of NRHM, several new interventions were made including establishment of First Referral Units (FRUs), Community Health Centres (CHCs), Primary Health Centres (PHCs) on 24×7 basis, baby care corners, management of neo-natal childhood illness, organisation of RCH camps, strengthening referral transport, promoting institutional deliveries through involvement of ASHAs and conducting awareness camps. For strengthening maternal health about 1032 Reproductive and child health camps were organised since 2008-09 to 2011-12. On an

average 258 RCH camps are organised annually in the state for making people aware about the different components of the programme. The RCH camps have increased from 37% in 2008-09 to 40% in 2010-11. Therefore, maternal health services in terms of referral transport and RCH camps have increased over the period of time. As a result of these measures, the position of maternal and child health indicators has shown a lot of improvement. For the successful implementation of the scheme, efforts were being made both at state and central level in order to ensure increase in the number of safe institutional deliveries. The number of total deliveries increased from 108328 in 2008-09 to 185528 in 2011-12, out of total number of deliveries from 2008-09 to 2011-12 (i.e. 685608), 77% were institutional deliveries and 23% were home deliveries, 50% women were given cash incentives under JSY and 34% women were escorted by ASHAs. Therefore, NRHM has helped a lot in increasing institutional deliveries. Despite, this NRHM in J&K faces certain limitations which are as under:

- Persistent gaps in man power and infrastructure in government sector especially at the primary health care level in remote rural areas where health care needs are greatest.
- Poor financial allocation to delivery of health care and improper utilisation of existing resources.
- Lack of administrative capability and competence.
- Lack of adequate health education.
- Lack of close monitoring of implemented health programmes.
- Partial implementation of NRHM at gross root level.
- Lack of proper infrastructure in Community Health Centres, Primary Health Centres, Sub Centres/Dispensaries.
- Lack of accountability.
- Lack of community participation or minimum role of Panchayati Raj Institutions (PRIs) and local bodies.

- Lack of proper training facilities to ASHA workers and their insensitiveness towards lower sections of society.
- Non utilisation of allotted funds, as 50% of allotted funds remains unutilised.
- Lack of skilled health personnel like doctors, specialists, paramedical in CHCs, PHCs, SCs/ Dispensaries mostly in far flung areas of the state.

In order to tackle all these problems government should take positive initiatives particularly in framing health policies and frame clear cut objectives with proper planning. Government should take result oriented initiatives and should provide more health programmes on the pattern of NRHM. There should be proper interlinkage between various social development schemes and NRHM programme in order to have a holistic approach to the welfare of society. The government should channelize the adequate funds in proper pipeline with adequate care and handle them in a resonance manner so that its benefits reach to the poorest of the poor.

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Chapter - 4



Financial and Physical Performance of JSY in J & K

The present chapter is based on secondary data which was collected from various sources and an attempt was made to evaluate the overall performance of Janani Suraksha Yojana (JSY) in Jammu and Kashmir in terms of coverage, implementation of JSY, physical and financial performance of JSY. The present chapter is divided into two sections. The section I deal with the definition and main features of JSY and section II deals with the analysis of secondary data regarding physical and financial performance of JSY in Jammu and Kashmir.

4.1. Section I

4.1.1. Janani Suraksha Yojana

Janani Suraksha Yojana, an integral component for safe motherhood under National Rural Health Mission (NRHM), was launched on April 12, 2005 with the dual objective of improving maternal and neonatal health through the promotion of institutional deliveries. It is a 100 percent centrally sponsored scheme which provides a cash incentive to a delivering woman who gives birth to a child in a health facility both public as well as in an accredited private health institution. The scheme aims to promote institutional deliveries amongst poor pregnant women in all the states and union territories of the country with special focus on Low Performing States (LPS). Specifically, women in Low Performing States (LPS) are offered ₹1400 in rural areas

and ₹1000 in urban areas irrespective of socioeconomic status and parity aged 19 years and above and up to two live births. JSY also continues to provide a small amount of financial assistance of ₹500 for births at home for pregnant women aged 19 years and above living below the poverty line and for the first two live births. In High Performing States (HPS), women aged 19 years and above and up to two live births would receive ₹600 in urban areas and ₹700 in rural areas living in households below the poverty line.

Table4.1.1.Cash incentives under JSY

S. No	Place of Delivery	Rural	Urban
1	High Performing States (HPS)	₹700	₹600
2	Low Performing States (LPS)	₹1400	₹1000
3	Home delivery	₹500	₹500

Source: - Operational Guidelines (2005-06) - NRHM, J&K.

The policy stipulates that cash incentives should be disbursed to the mother immediately at the institution itself. The Janani Suraksha Yojana is an incentive based programme for the promotion of institutional deliveries with the aim to reduce maternal and neonatal mortality and ensure the well being of both the mother and new born. In order to promote safe institutional deliveries, Govt. of India implemented the JSY throughout the country including Jammu and Kashmir. The State has been identified as one of the Low Performing States (LPS).

With the introduction of JSY the number of institutional deliveries started picking up. To ensure better community participation in health initiatives, various committees and organisations have been formed at the village, block and district levels of each state. The Village Health and Sanitation Committees, the Panchayat Raj institutions, the Rogi Kalyan Samitis (Patient Welfare Committees) at the Primary Health Centres and the Community Health Centres and the scheme of ASHA (Accredited Social Health Activists) are at the forefront of community participation.

Under the ASHA scheme, local women are educated to promote healthy lifestyles in rural communities.

To ensure availability of sufficient manpower at the Primary Health Centres and the Community Health Centres, additional staff, including nurses and medical officers, is being provided. Local residents in remote areas are being trained for providing basic health services. There is also stress on development of multiple skills of health functionaries, especially doctors and paramedics, so that they can single-handedly carry out a number of tasks.

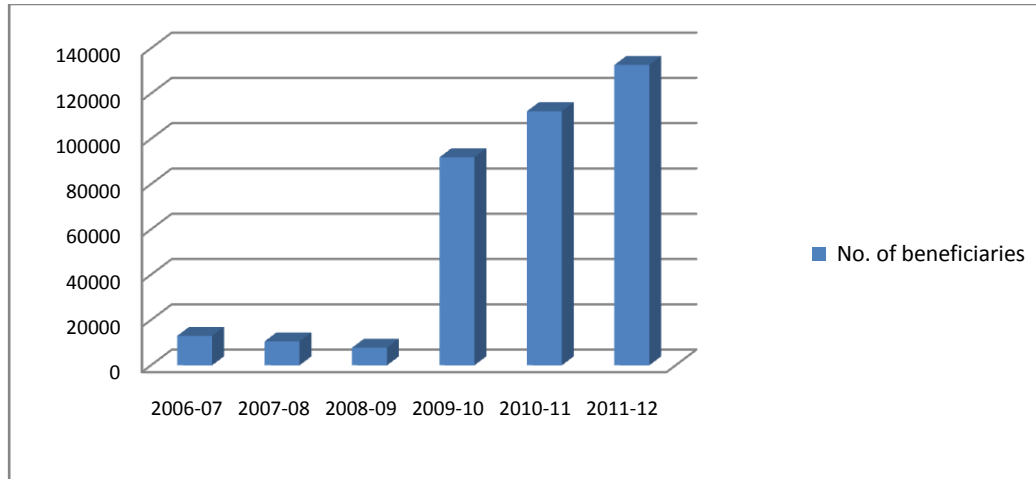
In order to improve maternal health in the state of Jammu and Kashmir, 5992 women have been provided referral transport services and 411 Reproductive Child Health awareness camps were organised in 2010-11 for making people aware about the different components of the programme. Out of 186906 total deliveries, 76.33% were institutional deliveries, 60% women were given incentives under Janani Suraksha Yojana, 41.25% women were escorted by ASHAs and 23.66% were home deliveries, the post natal care within 48 hours was provided to 65848 (35.23%). The total number of immunized children in the year 2011-12 was 248499, out of which 95% children were given DPT/Polio III Dose and 93.36% got Measles Injection. Thus, State has made tremendous progress since its inception i.e. 4.25 lac women have received JSY incentive so far (Oct. 2012). The year wise number of JSY beneficiaries is shown in table 4.1.2.

Table 4.1.2. Year wise performance of JSY in J & K

S. No	Year	No. of JSY beneficiaries	Growth rate
1	2006-07	13000	-
2	2007-08	10568	-0.18
3	2008-09	7771	-0.26
4	2009-10	91887	10.82
5	2010-11	112210	0.22
6	2011-12	132645	0.18

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

Figure 4.1.2. Number of JSY beneficiaries (year wise)



It is revealed from the table and diagram 4.1.2, that number of beneficiaries has increased substantially over the years. However, in 2008-09 the number of beneficiaries has declined due to lack of funds and poor implementation of the scheme. In 2009-10, the number of beneficiaries has increased to 91887, showing 10.26% increase in the growth rate as compared to corresponding year in which there was a negative growth rate of -0.26%. Over the years, there is an increase in the number of beneficiaries.

4.1.2. Accredited Social Health Activist (ASHA)

ASHA is the first port of call for any health related demands of the rural masses especially women and children who are large consumers of health services but have least access to health services. ASHA is a trained female health activist who promotes health practices in the community, creates awareness on health and its social determinants and mobilizes the community towards local health planning. 9575 ASHAs have been engaged ending Jan. 2012, out of which 9500 have been trained in module I, 9184 in Module II to IV and 8630 in Module V and about 9500 have been provided with drug kits.

4.2. Administrative set up of JSY

The state of Jammu and Kashmir is among one of the low performing states. In the state, JSY was implemented in Dec. 2005 under the overall umbrella of NRHM. For the successful implementation of the scheme, efforts were being made both at State and central level. In order to ensure increase in the number of safe institutional deliveries, the State govt. has ensured engagement of large number of trained medical personnel like doctors, para medical personnel, staff nurse and pharmacists along with adequate managerial personnel.

For implementation of the scheme at State level, JSY nodal officer has been nominated from the State medical directorate to oversee JSY activities, headed by Mission Director NRHM. The nodal officer works full-time with the State Programme Management Unit providing for effective implementation of Reproductive and Child Health Programme and support for JSY.

At the district level, the Reproductive and Child Health Officer (RCHO) or an officer of a similar rank is made responsible for JSY intervention. The Programme Manager of DPMU supports JSY district officer. JSY is linked with the block medical officer-in charge responsible for both performance and financial monitoring.

At the peripheral or community level, ANM is held responsible and is supported by her supervisor. ANMs closely work with ASHAs and Anganwadi workers and interact with PRI members for promoting the scheme. Through circulars and discussions in the monthly meetings, the State informs the health care providers regarding JSY and districts/blocks are asked to follow a similar procedure. Health workers at the block, district and state levels are trained through various programmes on skill development and capacity expansion. These programmes are conducted by various NGOs and development partners. The orientation regarding the scheme is provided to Anganwadi workers during block-level monthly meetings and ANMs during their routine interactions. In addition, interpersonal and group communication are also given priority to publicize JSY activities and are reinforced through mass media activities such as hoardings at strategic locations, posters, wall paintings at health facilities and public places. ASHAs exclusively, on payment of cash assistance to the beneficiary are asked to publicize the scheme in their area of work. Even though efforts are made by the State to generate demand for services, there has not been any formal orientation of the scheme to Panchayat Raj Institutions (PRIs) Representatives, who are the source of information at the community level. This is a matter of concern. JSY guidelines propose that the money should be placed in the joint account of Sarpanch and ANM. Hence, it becomes imperative to equip them with the minute details of the scheme, revisions, how the funds would be drawn from the account etc. and above all for seeking their support in promotion of institutional deliveries.

During the collection of secondary data interaction was made with some State officers from where it emerged that the Ministry of Health and Family Welfare (MOH&FW) has revised JSY guidelines several times regarding the eligibility criteria, cash assistance and their disbursement. As per the present new guidelines for Low Performing States (LPS), age restriction that was 19 years or less, more than two births, women from Below Poverty Line (BPL) families have all been removed, for

home deliveries assistance of ₹500 has been sanctioned only for BPL women in both rural and urban areas. With reference to new guidelines, the issues related to time-frame of payment to the beneficiaries have also come up.

4.3. Section II

4.3.1. Financial and physical performance of Janani Suraksha Yojana

All schemes of health and family welfare have been incorporated under the overarching umbrella of NRHM. Through the NRHM budget, funds are allocated to districts on the basis of their needs for judicious implementation of health programmes and creation and up gradation of Sub Centres, Primary Health Centres and Community Health Centres. Untied funds are also available at various levels.

For smooth functioning of the Janani Suraksha Yojana (JSY), sound financial mechanism is an essential ingredient for improving the outcomes falling under its purview to improve the maternal and neonatal health of both mother and child. Under JSY all women delivering in a Government health centres like Sub-centre (specifically accredited for institutional delivery by State), or in Primary Health Centers (PHCs), Community Health Centers (CHCs), First Referral Units(FRUs), District and State Hospitals or a JSY accredited private hospitals are eligible for JSY incentive.

The JSY is a 100% centrally sponsored scheme which draws its funds from the Reproductive Child Health (RCH) programme. The State government estimates the funds required for JSY payments through setting up of targets for expected deliveries in the upcoming year. This target hypothetically comes from the consolidation of the targets set up by all the districts in the State. The targets set up by the district authorities, in turn calculate the expected deliveries or targets for JSY beneficiaries by generally adding 10% of the previous year's institutional deliveries for the current year. The annual requirement is approved as part of the approval of the annual State Project Implementation Plan (State PIP) approval. However, funds are released once utilisation certificates for previously released funds are submitted and there is a request for additional release. Instead of keeping track of the money being invested in health

schemes and its utilisation, there should be result-oriented evaluation of a certain scheme for follow-up action. This will help us improve health indices. The funds are transferred from Centre to State Health Society and from there to district health societies which release it directly to district hospital and to block offices where the payment is made available to the beneficiary.

The public healthcare system should have the capacity to provide treatment for all kinds of health problems, including rare/serious disorders and complicated cases that are hard to be diagnosed. Besides, the national health insurance scheme should be amended, taking into consideration the lack of affordability of the poor to undertake specialised and expensive treatments. The entitlements should give the rural poor enough insurance coverage as compared to the competitive private insurance schemes.

The performance of JSY varies across the regions and within the same region it varies across the districts. Within each district it is not uniform across all the blocks. The block wise performance among all the districts of the regions of Jammu and Kashmir is given in table 4.3.1 to 4.3.22. We first take up Jammu division and then Kashmir division.

i) Jammu Division

Table 4.3.1. Performance of JSY in Jammu and Kashmir-district Doda

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Doda	1918	89600	1924	2663400	1587	1587340	5429	1809
2	Block Ghat	138	68600	186	187600	223	881200	547	182
3	Block Baderwah	0 ⁴	663200	607	1027700	471	821000	1078	359
4	Block Assar	207	89600	48	240800	29	312800	284	94
5	Block Gandeh	281	268800	555	775600	386	742000	1222	407
6	Block Thatri	02	49000	104	107800	291	586200	397	131
Total		2546	1228800	3424	4762100	2987	4930540	8957	2985

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

It is obvious from the above table that in District Doda 8957 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 5429 were recorded in District Hospital Doda. On an average 2985 deliveries are recorded annually in district Doda. In 2009, 2546 deliveries were recorded, 3424 in 2010 and 2987 in 2011 who received financial incentives of about `0.12 crores, `0.47 crores and `0.49 crores respectively under JSY. At block level highest deliveries (1222) were recorded in block Gandeh and lowest (284) from block Assar.

⁴ It indicates that the pregnant women who belonged to the respected block were referred to District Hospital due to reasons of complications and financial incentives were born by their own parent block from which they were referred.

Table 4.3.2. Performance of JSY in Jammu and Kashmir-district Jammu

S. No	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Jammu	1352	NA	1924	1230200	1587	1575000	4863	1621
2	Block Akhnoor	699	446600	1321	2227988	1614	2884800	3634	1211
3	Block Bishnah	77	1094800	317	3926300	341	3896800	735	245
4	Block Dansal	25	455000	56	1195900	70	1191943	151	50
5	Block Sohanjana	70	905800	185	3111800	244	3099300	499	166
6	Block Kotbilwal	59	698600	105	2402250	62	1128850	226	75
7	Block ₹ Pora	554	1394400	1039	3041400	939	3686750	2532	844
8	Block Pallanwala	293	709800	359	2246750	403	2345400	1055	351
Total		3129	5705000	5306	19382588	5260	19808843	13695	4565

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is clear from the above table that in District Jammu 13695 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 4863 were recorded in District Hospital Jammu. On an average 4565 deliveries are recorded annually in district Jammu. In 2009, 3129 deliveries were recorded, 5306 in 2010 and 5260 in 2011 who received financial incentives of about ₹0.57 crores, ₹1.93 crores and ₹1.98 crores respectively under JSY. At block level highest deliveries (3634) were recorded in block Akhnoor and lowest (151) from block Dansal.

Table 4.3.3. Performance of JSY in Jammu and Kashmir-district Kathua

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Kathua	2174	155000	2202	314000	2296	243000	6672	2224
2	Block Parole	197	3560650	235	3010350	102	2489150	534	178
3	Block Hiranagar	215	1933900	395	2957600	471	2522413	1081	360
4	Block Billawar	364	881000	732	1759700	911	2273300	1096	365
5	Block Bani	115	157400	242	418800	282	507600	639	213
6	Block Basoli	134	229600	143	408700	138	445100	415	138
Total		3199	6917550	3949	8869150	4200	8480563	11348	3782

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is evident from the above table that in District Kathua 11348 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 6672 were recorded in District Hospital Kathua. On an average 3782 deliveries are recorded annually in district Kathua. In 2009, 3199 deliveries were recorded, 3949 in 2010 and 4200 in 2011 who received financial incentives of about ₹0.69 crores, ₹0.88 crores and ₹0.84 crores respectively under JSY. At block level highest deliveries (1096) were recorded in block Billawar and lowest (534) from block Parole.

Table 4.3.4. Performance of JSY in Jammu and Kashmir- district Kishtwar

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Kishtwar	1639	NA	1593	3295750	2149	2332450	5381	1793
2	Block Padder	138	2686050	234	211400	546	2471000	918	306
3	Block Dachan	0	16500	46	92000	144	286400	190	63
4	Block Assar	0	78800	95	101400	146	269600	241	80
Total		1777	2781350	1968	3700550	2985	5359450	6730	2243

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

The above table reveals that in District Kishtwar 6730 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 5381 were recorded in District Hospital Kishtwar. On an average 2243 deliveries are recorded annually in district Kishtwar. In 2009, 1777 deliveries were recorded, 1968 in 2010 and 2985 in 2011 who received financial incentives of about ₹0.27 crores, ₹0.37 crores and ₹0.53 crores respectively under JSY. At block level highest deliveries (918) were recorded in block Padder and lowest (190) from block Dachan.

Table 4.3.5. Performance of JSY in Jammu and Kashmir- district Poonch

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Poonch	1785	42000	1892	89000	2341	539400	6018	2006
2	Block Surankote	925	1400400	1492	3183000	1391	2721400	3808	1269
3	Block Mandi	553	1147000	707	1907900	1035	3104900	2295	765
4	Block Mendhar	1189	242900	1273	3037800	1723	3609100	4185	1395
Total		4452	2832300	5364	8217700	6490	9974800	16306	5435

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

The above table depicts that in District Poonch 16306 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 6018 were recorded in District Hospital Poonch. On an average 5435 deliveries are recorded annually in district Poonch. In 2009, 4452 deliveries were recorded, 5364 in 2010 and 6490 in 2011 who received financial incentives of about ₹0.28 crores, ₹0.82 crores and ₹0.99 crores respectively under JSY. At block level highest deliveries (4185) were recorded in block Mendhar and lowest (2295) from block Mandi.

Table 4.3.6. Performance of JSY in Jammu and Kashmir-district Rajouri

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Rajouri	2654	3668300	3551	4657000	3779	5554600	9984	3328
2	Block Sunderbani	1434	1724800	1460	2597000	2001	299300	4895	1631
3	Block Kalakote	287	386400	489	3442400	670	1167300	1446	482
4	Block Nowshera	920	1023250	1028	1419200	915	1559700	2863	954
5	Block Kandi	231	312200	300	NA	372	624800	903	301
6	Block Darhal	441	506400	361	517400	440	931900	1242	414
7	Block Manjakote	119	183400	236	323000	183	393800	538	179
Total		6086	7804850	7425	12956000	8360	10531400	21871	7290

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is obvious from the above table that in District Rajouri 21871 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 9984 were recorded in District Hospital Rajouri. On an average 7290 deliveries are recorded annually in district Rajouri. In 2009, 6086 deliveries were recorded, 7425 in 2010 and 8360 in 2011 who received financial incentives of about ₹0.78 crores, ₹1.29 crores and ₹1.05 crores respectively under JSY. At block level highest deliveries (4895) were recorded in block Sunderbani and lowest (538) from block Manjakote.

Table 4.3.7. Performance of JSY in Jammu and Kashmir-district Ramban

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1.	District Hospital Ramban	522	427000	668	814400	787	851800	1997	659
2.	Block Banihal	876	1115200	741	1269000	768	1566100	2385	795
3.	Block Batote	204	419600	476	631700	588	985300	1268	422
4.	Block Ukheral	333	924100	664	1031000	799	1954690	1796	598
5.	Block Gool	166	391600	360	438400	251	537600	777	259
Total		2101	3277500	2909	4184500	3193	5895490	8203	2734

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is clear from the above table that in District Ramban 8203 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 1997 were recorded in District Hospital Ramban. On an average 2734 deliveries are recorded annually in district Ramban. In 2009, 2101 deliveries were recorded, 2909 in 2010 and 3193 in 2011 who received financial incentives of about ₹0.32 crores, ₹0.41 crores and ₹0.58 crores respectively under JSY. At block level highest deliveries (2385) were recorded in block Banihal and lowest (777) from block Gool.

Table 4.3.8. Performance of JSY in Jammu and Kashmir-district Reasi

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1.	District Hospital Reasi	373	360800	616	575700	693	633800	1682	560
2.	Block Reasi	4	NA	62	18000	150	277300	216	72
3.	Block Katra	431	448200	467	857800	316	930200	1214	404
4.	Block Pouni	239	486400	257	926150	241	947600	737	245
5.	Block Mahora	352	492800	738	831600	842	1317800	1932	644
Total		1399	1788200	2140	3209250	2242	4106700	5781	1927

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is evident from the above table that in District Reasi 5781 deliveries were recorded from 2009 to 2011, out of which 1932 number of deliveries were recorded in District Hospital Reasi. On an average 1927 deliveries are recorded annually in district Reasi. In 2009, 1399 deliveries were recorded, 2140 in 2010 and 2242 in 2011 who received financial incentives of about ₹0.17 crores, ₹0.32 crores and ₹0.41 crores respectively under JSY. At block level highest deliveries (1932) were recorded in block Mahora and lowest (216) from block Reasi.

Table 4.3.9. Performance of JSY in Jammu and Kashmir- district Samba

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1.	District Hospital Samba	637	0	976	2000	983	49000	2596	865
2.	Block Ramgarh	618	1535950	763	1821250	726	2121000	2107	702
3.	Block Purmandal	10	759400	9	1044050	7	1067800	26	8
4.	Block Samba	59	2339700	86	3267400	54	3169400	199	66
Total		1324	4635050	1834	6134700	1770	6407200	4928	1642

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

The above table depicts that in District Samba 4928 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e.2596 were recorded in District Hospital Samba. On an average 1642 deliveries are recorded annually in district Samba. In 2009, 1324 deliveries were recorded, 1834 in 2010 and 1770 in 2011 who received financial incentives of about ₹0.46 crores, ₹0.61 crores and ₹0.64 crores respectively under JSY. At block level highest deliveries (2107) were recorded in block Ramgarh and lowest (26) from block Purmandal.

Table 4.3.10. Performance of JSY in Jammu and Kashmir-district Udhampur

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Udhampur	1720	NA	2437	160000	2643	560400	6800	2266
2	Block Basantgarh	60	139700	168	359200	365	763400	593	197
3	Block Chenani	230	1152900	478	1929100	1182	3100000	1890	630
4	Block Majalta	140	498750	309	1151231	397	1168150	846	282
5	Block Ramnagar	241	651900	456	1337100	688	1794300	1385	461
6	Block Tikri	53	1201850	219	1362400	230	2319950	502	167
Total		2444	3645100	4067	6299031	5465	9706200	12016	4005

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is obvious from the above table that in District Udhampur 12016 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 6800 were recorded in District Hospital Udhampur. On an average 4005 deliveries are recorded annually in district Udhampur. In 2009, 2444 deliveries were recorded, 4067 in 2010 and 5465 in 2011 who received financial incentives of about ₹0.36 crores, ₹0.62 crores and ₹0.97 crores respectively under JSY. At block level highest deliveries (1890) were recorded in block Chenani and lowest (502) from block Tikri.

Table 4.3.11. Performance of JSY in Jammu and Kashmir-district Anantnag

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Anantnag	8616	663087	8754	3140611	9854	11851600	27224	9074
2	Block Achabal	304	83852	430	1319105	417	700400	1151	383
3	Block Bijbehara	1815	185009	968	1699685	1054	2174100	3837	1279
4	Block Larnoo	1126	4849134	702	479391	731	1324400	2559	853
5	Block Mattan	2850	328391	613	1237975	658	1767900	4121	1373
6	Block Sallar	1150	52518600	305	637250	144	354000	1599	533
7	Block Shangus	1468	38450	607	1293930	614	1132600	2689	896
8	Block Verinag	964	557483	553	660015	496	844100	2013	671
Total		18293	59224006	12932	10467962	13968	20149100	45193	15064

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

The above table reveals that in District Anantnag 45193 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 27224 were recorded in District Hospital Anantnag. On an average 15064 deliveries are recorded annually in district Anantnag. In 2009, 18293 deliveries were recorded, 12932 in 2010 and 13968 in 2011 who received financial incentives of about ₹0.59 crores, ₹1.04 crores and ₹2.01 crores respectively under JSY. At block level highest deliveries (4121) were recorded in block Mattan and lowest (1151) from block Achabal.

Table 4.3.12. Performance of JSY in Jammu and Kashmir-district Bandipora

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital/Block Bandipora	432	1230000	1251	NA	1311	NA	2994	998
2	Block Hajin	406	1301600	669	NA	749	NA	1824	608
3	Block Gurez	330	62000	361	NA	299	NA	990	330
Total		1168	2593600	2281	NA	2359	NA	5508	1836

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is clear from the above table that in District Bandipora 5508 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 2994 were recorded in District Hospital Bandipora. On an average 1836 deliveries are recorded annually in district Bandipora. In 2009, 1168 deliveries were recorded who received ₹0.25 crores as JSY incentive. In the year 2010 and 2011, total numbers of deliveries were 2281 and 2359 respectively. However, the data regarding financial utilization was not available for the year 2010 and 2011. At block level highest deliveries (2994) were recorded in block Bandipora and lowest (990) from block Gurez.

Table 4.3.13. Performance of JSY in Jammu and Kashmir-district Baramulla

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Baramulla	2623	3116932	2313	4115200	2370	4524450	7306	2435
2	Block Boniyar	37	186300	253	869750	283	768100	573	191
3	Block Uri	516	509200	745	1360550	860	1539568	2121	707
4	Block Sheeri	68	213047	138	722350	158	757169	364	121
5	Block Dangi wacha	192	453900	400	895000	216	471300	808	269
6	Block Rohama	22	0	109	405650	89	412200	220	73
7	Block Sopore	1567	1760600	1761	4102283	2087	4439977	5415	1805
8	Block Kreeri	191	409400	293	923200	348	1302911	832	277
9	Block Pattan	453	440000	461	1184200	477	2206807	1391	463
10	Block Kunzar	27	45900	94	759300	68	818800	189	63
11	Block Tangmarg	402	847040	716	1788800	591	1545774	1709	569
Total		6098	7982319	7283	17126283	7547	18787056	20928	6976

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is evident from the above table that in District Baramullah 20928 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 7306 were recorded in District Hospital Baramullah. On an average 6976 deliveries are recorded annually in district Baramullah. In 2009, 6098 deliveries were recorded, 7283 in 2010 and 7547 in 2011 who received financial incentives of about ₹0.79 crores, ₹1.71 crores and ₹1.87 crores respectively under JSY. At block level highest deliveries (5415) were recorded in block Sopore and lowest (189) from block Kunzer.

Table 4.3.14. Performance of JSY in Jammu and Kashmir- district Budgam

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Budgam	353	439600	992	1645000	695	830200	2040	680
2	Block Beerwah	191	200000	294	731000	372	931000	857	286
3	Block Ompora	12	775000	35	44800	82	298200	129	43
4	Block Chadora	236	413400	608	1254400	451	1139600	1295	431
5	Block Chattergam	15	230000	126	823450	169	803600	310	103
6	Block Char-e-sharief	36	0	270	554400	267	805000	573	191
7	Block Khag	14	491000	300	1314600	278	688800	592	197
8	Block Khan Sahib	258	0	401	732400	428	1150800	1087	362
9	Block Magam	502	738670	613	843750	695	999600	1810	603
10	Block Nagam	40	129900	114	323950	163	418600	317	105
11	Block Soibugh	128	294350	123	575400	104	824600	355	118
Total		1785	3711920	3876	8843150	3704	8890000	9365	3122

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

The above table depicts that in District Badgam 9365 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 2040 were recorded in District Hospital Badgam. On an average 3122 deliveries are recorded annually in district Badgam. In 2009, 1785 deliveries were recorded, 3876 in 2010 and 3704 in 2011 who received financial incentives of about ₹0.37 crores, ₹0.88 crores and ₹0.88 crores respectively under JSY. At block level highest deliveries (1810) were recorded in block Magam and lowest (129) from block Ompora.

Table 4.3.15. Performance of JSY in Jammu and Kashmir-district Ganderbal

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	Block Ganderbal	464	878700	765	1441050	784	1952100	2013	671
2	Block Lar	106	758500	157	626450	162	673650	425	141
3	Block Wakura	0	0	8	308000	7	388200	15	3
4	Block Kangan	947	392656	1022	818535	1127	2947736	3096	1032
Total		1517	2029856	1952	3194035	2080	5961686	5549	1850

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is obvious from the above table that in District Ganderbal 5549 deliveries were recorded from 2009 to 2011. On an average 1850 deliveries are recorded annually in district Ganderbal. In 2009, 1517 deliveries were recorded, 1952 in 2010 and 2080 in 2011 who received financial incentives of about ₹0.20 crores, ₹0.31 crores and ₹0.59 crores respectively under JSY. At block level highest deliveries (2013) were recorded in block Ganderbal and lowest (15) from block Wakura.

Table 4.3.16. Performance of JSY in Jammu and Kashmir-district Kargil

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Kargil	1193	1325000	1019	1801000	1113	1936000	3325	1108
2	Block Sankoo	56	72000	81	259000	120	410600	257	86
3	Block Kargil	0	0	0	0	1	0	1	1
4	Block Panikhar	26	36000	30	85000	33	65400	89	29
5	Block Chiktan	18	45000	16	15000	41	75800	75	25
6	Block Shargole	1	2200	21	36000	31	361900	53	17
7	Block Drass	220	190000	171	288000	179	464510	570	190
8	Block Zanskar	64	90000	60	71000	64	73550	188	62
Total		1578	1760200	1398	2555000	1582	3387760	4558	1519

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is clear from the above table that in District Kargil 4558 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 3325 were recorded in District Hospital Kargil. On an average 1519 deliveries are recorded annually in district Kargil. In 2009, 1578 deliveries were recorded, 1398 in 2010 and 1582 in 2011 who received financial incentives of about

₹0.17 crores, ₹0.25 crores and ₹0.33 crores respectively under JSY. At block level highest deliveries (570) were recorded in block Drass and lowest (01) from block Kargil.

Table 4.3.17. Performance of JSY in Jammu and Kashmir-district Kulgam

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Kulgam	898	1671800	1711	2771715	1954	3128350	4563	1521
2	Block Kulgam	103	464350	148	210250	147	286050	398	132
3	Block D. H pora	442	487700	437	582500	373	1237000	1252	417
4	Block Qaimoh	366	0	189	363250	124	587600	679	226
5	Block Yaripora	0	828000	256	586800	285	890200	541	180
6	Block Qazigund	1071	1338600	1029	1528940	708	1931600	2808	936
Total		2880	4800450	3770	6043455	3591	8030800	10241	3414

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

From the above table it is evident that in District Kulgam 10241 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 4563 were recorded in District Hospital Kulgam. On an average 3414 deliveries are recorded annually in district Kulgam. In 2009, 2880 deliveries were recorded, 3770 in 2010 and 3591 in 2011 who received financial incentives of about ₹0.48 crores, ₹0.60 crores and ₹0.80 crores respectively under JSY. At block level highest deliveries (2808) were recorded in block Qazigund and lowest (398) from block Kulgam.

Table 4.3.18. Performance of JSY in Jammu and Kashmir-district Kupwara

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Kupwara	876	947800	1267	1629615	1481	2514825	3624	1208
2	Block Kupwara	2393	0	2528	1345726	2928	4116200	7849	2616
3	Block Sogam	1044	0	1017	1181400	933	2356800	2994	998
4	Block Kalaroose	182	0	401	676800	670	1419700	1253	417
5	Block Tangdar	1050	0	1142	2866700	1116	1511400	3308	1102
6	Block Langate	463	592300	753	1173450	655	2317600	1871	623
7	Block Kralpora	566	682500	904	1108160	794	1483200	2264	754
8	Block Zachaldara	188	217000	202	440300	213	450700	603	201
9	Block Handwara	115	0	139	388150	280	1027050	534	178
10	Block Villagam	453	4000	673	759100	770	128000	1896	632
11	Block	607	0	387	762000	545	1373600	1539	513
Total		7937	1843600	9413	12331401	10385	18699075	27735	9245

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

From the analysis of above table that in District Kupwara 27735 deliveries were recorded from 2009 to 2011, out of which 3624 number of deliveries were recorded in District Hospital Kupwara. On an average 9245 deliveries are recorded annually in district Kupwara. In 2009, 7937 deliveries were recorded, 9413 in 2010 and 10385 in 2011 who received financial incentives of about ₹0.18 crores, ₹1.23 crores and ₹1.86 crores respectively under JSY. At block level highest deliveries (7849) were recorded in block Kupwara and lowest (534) from block Handwara.

Table 4.3.19. Performance of JSY in Jammu and Kashmir-district Leh

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Leh	NA	NA	1546	1996400	1541	1920800	3087	1029
2	Block Nubra	NA	NA	58	293100	200	253520	258	86
3	Block Nyoma	NA	NA	15	31500	21	27900	36	12
4	Block Khaltsi	NA	NA	17	11800	37	40900	54	18
5	Block Tangtse	NA	NA	21	24200	41	10842	62	21
6	Block Leh	NA	NA	9	16000	2	9000	11	3
Total		NA	NA	1666	2341500	1842	2262962	3508	1169

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir

It is obvious from the above table that in District Leh 3508 deliveries were recorded from 2009 to 2011, out of which highest number of deliveries i.e. 3087 were recorded in District Hospital Leh. On an average 1169 deliveries are recorded annually in district Leh. For 2009, data regarding deliveries was not available, however in 2010 and 2011, 1666 and 1842 deliveries were recorded who received financial incentives of about ₹0.23 crores and ₹0.22 crores respectively under JSY. At block level highest deliveries (258) were recorded in block Nubra and lowest (11) from block Leh.

Table 4.3.20. Performance of JSY in Jammu and Kashmir-district Pulwama

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Pulwama	1294	133000	1652	2786000	1961	3497470	4907	1636
2	Block Pampore	395	234750	616	2692750	625	283350	1636	545
3	Block Tral	432	1342470	585	1749842	528	2016895	1545	515
4	Block Pulwama	43	589000	112	637770	75	630970	230	76
Total		2164	2299220	2965	7866362	3189	6428685	8318	2773

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir.

It is clear from the above table that in District Pulwama 8318 deliveries were recorded from 2009 to 2011, out of which 4907 number of deliveries were recorded in District Hospital Pulwama. On an average 2773 deliveries are recorded annually in district Pulwama. In 2009, 2164 deliveries were recorded, 2965 in 2010 and 3189 in 2011 who received financial incentives of about ₹0.22 crores, ₹0.78 crores and ₹0.64 crores respectively under JSY. At block level highest deliveries (1636) were recorded in block Pampore and lowest (230) from block Pulwama.

Table 4.3.21. Performance of JSY in Jammu and Kashmir- district Shopian

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Shopian	578	0	669	1400500	856	1161244	2103	701
2	Block Shopian	25	0	87	1137750	123	1702350	235	78
3	Block Kellar	255	0	475	2149008	195	17960400	925	308
Total		858	0	1231	4687258	1174	20823994	3263	1088

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir.

It is apparent from the above table that in District Shopian 3263 deliveries were recorded from 2009 to 2011, out of which 2103 number of deliveries were recorded in District Hospital Shopian. On an average 1088 deliveries are recorded annually in district Shopian. In 2009, 858 deliveries were recorded, 1231 in 2010 and 1174 in 2011. The financial incentives of about ₹0.46 crores, and ₹2.08 crores were also disbursed in 2010 and 2011 under JSY. At block level highest deliveries (925) were recorded in block Keller and lowest (235) from block Shopian.

Table 4.3.22. Performance of JSY in Jammu and Kashmir-district Srinagar

S. no	Name of Institution	2009		2010		2011		Total no. of deliveries 2009 to 2011	Average deliveries
		No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure	No. of Deliveries	JSY Expenditure		
1	District Hospital Srinagar	863	293150	934	574882	986	386591	2783	927
2	Block Hazratbal	0 ⁵	504850	0	1504710	16	1430000	16	5
3	Block Zadibal	11	278600	29	390499	38	446000	78	26
4	Block S R Gunj	0	96000	0	392500	0	338000	0	0
5	Block Khanyar	88	121364	104	189500	231	419918	423	141
6	Block Batmaloo	0	578200	0	1599100	13	1649000	13	4
Total		962	1872164	1067	4651191	1284	4669509	3313	1104

Source: Department of Health and Family Welfare Services, Govt. of Jammu and Kashmir.

⁵ It indicates that the pregnant women who belonged to the respected block were referred to District Hospital due to reasons of complications and financial incentives were born by their own parent block from which they were referred.

It is evident from the above table that in District Srinagar 3313 deliveries were recorded from 2009 to 2011, out of which 2783 number of deliveries were recorded in District Hospital Srinagar. On an average 1104 deliveries are recorded annually in district Srinagar. In 2009, 962 deliveries were recorded, 1067 in 2010 and 1284 in 2011 who received financial incentives of about ₹0.18 crores, ₹0.46 crores and ₹0.46 crores respectively under JSY. At block level highest deliveries (423) were recorded in block Khanyar and lowest from block S. R. Gunj.

From the analysis of the tables 4.3.1 to 4.3.22, containing the information regarding the number of deliveries and expenditure in Jammu and Kashmir, we can conclude that the highest number of deliveries were recorded in district hospitals, because of the reason that at district hospital all the necessary facilities were available including trained doctors, medicines, labor rooms, operation theatre, 24×7 facility, other equipments etc. Besides this, district hospitals are number one priority because delivering mothers are more health conscious than before and visit district hospitals for better services. The lowest numbers of deliveries recorded at block levels are due to number of reasons like non availability of manpower such as specialists, gynaecologists, infrastructure constraints etc. Besides, the health persons posted at block level always recommend the patients to visit district hospital for delivery due to non availability of necessary facilities which they require during delivery. In most of the cases even if patient complains a small complication, the health persons posted at block level refer them to district hospital with this work load at district hospital increases. In some cases, even normal deliveries are not tackled at block level and they always shift the extra burden to district hospitals, that is why district hospitals seems main priority for delivery, resulting low institutional deliveries at block level. Therefore, demand for institutional deliveries is increasing continuously, but the present infrastructure facility available is not in a position to handle this properly especially at block level.

4.4. State level performance of JSY

Performance of JSY is here judged in terms of the indicators viz. number of deliveries, utilization of funds and average money received by a beneficiary.

Number of institutional deliveries has gone up from 73697 during 2009 to 93287 during 2012, registering an annual increase of 26%. By all means, it is a modest increase. Even this small increase is not distributed uniformly across the regions of the state. Much of the institutional delivery i.e. 54% has been registered in Kashmir division. Within Kashmir division, most of the institutional deliveries have remained confined to three districts of Anantnag, Baramullah and Kupwara. Though Jammu division accounts for a small proportion of institutional deliveries, the inter-district disparities are much lower as compared to Kashmir Division.

Fund utilization has gone up from ₹13.38 crore in 2009 to ₹20.32 crore in 2012, showing an annual increase of 22%. As a consequence of higher deliveries in Kashmir Division, much of the fund utilization is concentrated in Kashmir Division as compared to Jammu Division. Average money received by a beneficiary is also higher in Kashmir Division. The district wise details regarding number of deliveries, fund utilization and average money received by a beneficiary in the regions of the State is presented in Table 4.4.1.

Table4.4.1. Average utilization of JSY money -District wise in Jammu and Kashmir

S. no	Name of Institution	2009			2010			2011			Total no. of JSY Deliveries 2009 to 2011	Average Deliveries	Deliveries as a percentage of total deliveries
		No. of deliveries	Utilization of JSY money (₹)	Average money received by the beneficiary (₹)	No. of deliveries	Utilization of JSY money (₹)	Average money received by the beneficiary (₹)	No. of deliveries	Utilization of JSY money (₹)	Average money received by the beneficiary (₹)			
1	Doda	2546	1228800	482.63	3424	4762100	1390.80	2987	4930540	1650.66	8957	2985	03.49
2	Jammu	3129	570500	182.32	5306	19382588	3652.95	5260	19808843	3765.93	13695	4565	05.33
3	Kathua	3199	6917550	2162.41	3949	8869150	2245.92	4200	8480563	2019.18	11348	3782	04.42
4	Kishtwar	1777	2781350	1621.46	1968	3700550	1880.36	2985	5359450	1795.46	6730	2243	02.62
5	Poonch	4452	2832300	636.18	5364	8217700	1532.00	6490	9974800	1536.94	16306	5435	06.32
6	Rajouri	6086	7804850	1282.42	7425	12956000	1744.91	8360	10531400	1259.73	21871	7290	08.50
7	Ramban	2101	3277500	1559.97	2909	4184500	1438.46	3193	5895490	1846.37	8203	2734	03.18
8	Reasi	1399	1788200	1278.19	2140	3209250	1499.64	2242	4106700	1831.71	5781	1927	02.24
9	Samba	1324	4635050	3500.79	1834	6134700	3344.98	1770	6407200	3619.88	4928	1642	01.92
10	Udhampur	2444	3645100	1491.44	4067	6299031	1548.81	5465	9706200	1776.06	12016	4005	04.67
Jammu Division		28457	35481200	1246.83	38386	77715569	2024.58	42952	85201186	1983.63	109835	36612	42.69
1	Anantnag	18293	59224006	3237.52	12932	10467962	809.46	13968	20149100	1442.51	45193	15064	17.57
2	Bandipora	1168	2593600	2220.54	2281	NA	NA	2359	NA	NA	5508	1836	02.14
3	Baramulla	6098	7982319	1309.00	7383	17126283	2319.69	5177	18787056	3628.94	20928	6976	08.13
4	Budgam	1785	3711920	2079.50	3876	8843150	2281.51	3704	8890000	2400.10	9365	3122	03.64
5	Ganderbal	1517	2029856	1338.07	1952	3194035	1636.28	2080	5961686	2866.19	5549	1850	02.15
6	Kargil	1578	1760200	1115.46	1398	2555000	1827.61	1582	3387760	2141.44	4558	1519	01.78
7	Kulgam	2880	4800450	1666.82	3770	6043455	1603.03	3591	8030800	2236.36	10241	3414	03.98
8	Kupwara	7937	1843600	232.27	9413	12331401	1310.03	10385	18699075	1800.58	27735	9245	10.78
9	Leh	NA	NA	NA	1666	2341500	1405.46	1842	2262962	1228.53	3508	1169	01.36
10	Pulwama	2164	14381450	6645.77	2965	7866362	2653.07	3189	6428685	2015.89	8318	2773	03.23
21	Shopian	858	0	0	1231	4687258	3807.68	1174	20823994	17737.64	3263	1088	01.26
22	Srinagar	962	1872164	1946.11	1067	4651191	4359.12	1284	4669509	3636.68	3313	1104	01.29
Kashmir Division		45240	98355965	2174.09	49934	80107597	1604.26	50335	118090627	2346.09	147479	49160	57.31
J & K (Total)		73697	133837165	1816.04	88320	157823166	1786.94	93287	203291813	2179.20	257314	85771	100.00

Source: Compiled from official data of Department of Health and Family Welfare Services, NRHM, Govt. of Jammu and Kashmir.

The state of Jammu and Kashmir is divided into two medical divisions i) Jammu division and ii) Kashmir division. From the table 4.4.1, it is evident that in Jammu and Kashmir, the total number of deliveries over three years period (2009 to 2011) were 2,57,314 who received ₹49.48 crores as JSY incentive, out of which Jammu division received ₹19.83 crores (40%) and Kashmir division received ₹29.65 crores (60%).

At state level, Jammu and Kashmir JSY beneficiaries on an average receive ₹1922 and at division level, Jammu division receives ₹1805 while as Kashmir division receives ₹2009. In the year 2009 Jammu division recorded 28,457 numbers of deliveries who received an amount of ₹3.54 crores as JSY incentive. In 2010 and 2011 the number of deliveries increased to 38386 and 42952 and amount received also increased to ₹7.77 crores and ₹8.52 crores respectively. On an average, each woman in Jammu division received an amount of ₹1246.83, ₹2024.58 and ₹1983.63 in 2009, 2010 and 2011 respectively.

Over the period 2009 to 2011, the highest deliveries in Jammu division were recorded from district Rajouri i.e. 21871 constituting share of 8.5% to States total number of deliveries and lowest number of deliveries from district Samba i.e. 4928 constituting 1.92%.

As for as, Kashmir division is concerned, the total number of woman i.e. 45240 delivered in 2009, who received an amount of ₹9.83 crores as JSY incentive. The number of deliveries increased to 49934 in 2010 and 50335 in 2011, who received an amount of ₹8.01 crores and ₹11.80 crores respectively. In Kashmir division each woman on an average received an amount of ₹2174.09, ₹1604.26 and ₹2346.09 in 2009, 2010 and 2011 respectively. Moreover, the highest deliveries were recorded from district Anantnag i.e. 15064 constituting share of 17.57% to States total number of deliveries and lowest from district Shopian i.e. 1088 constituting 1.26%.

4.5. Conclusion

Janani Suraksha Yojana, an integral component for safe motherhood under National Rural Health Mission (NRHM), was launched on April 12, 2005 with the dual objective of improving maternal and neonatal health through the promotion of institutional deliveries. With the introduction of JSY the number of institutional deliveries started picking up. The state of Jammu and Kashmir is among one of the low performing states. For the successful implementation of the scheme, efforts were being made both at state and central level in order to ensure increase in the number of safe institutional deliveries. The state has made tremendous progress since its inception about 4.25 lac women have received JSY incentive so far ending Oct. 2012. In order to increase the institutional deliveries further, government should take appropriate steps for strengthening JSY scheme particularly in the disbursement of funds availability and expenditure incurred.

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Chapter - 5



*Impact of JSY on Utilization of
RCH Services in J & K- a case
study of district Pulwama*

This chapter is based on the primary data collected through field survey. The survey was conducted in different villages covering the three medical blocks of district Pulwama. The study is designed to make an analysis of Janani Suraksha Yojana at gross root level among beneficiaries through binary logistic regression model. District Pulwama came into being in the year 1979, with the land area of 0.61 lacs hectares. The district comprises of four tehsils namely Pulwama, Tral, Awantipora and Pampore, with 332 villages. As per 2011 Census, the District Pulwama has a population of 5.70 lacs. The total literacy rate of the district is at 65% with 75% male and 53% female population. The information regarding registration, awareness, utilization of antenatal, neonatal and postnatal care services among beneficiaries were collected with the help of an open-end questionnaire which was framed strictly in accordance with the objectives and hypothesis of the study. In doing so our endeavour will be to identify the impact of Janani Suraksha Yojana on utilization of Reproductive and Child Health services in district Pulwama, we have attempted to capture various social, economic and demographic aspects of sample beneficiaries.

5.1. Binary Logistic Regression Model results

5.1.1. Descriptive Statistics of Socio Economic Variables

The descriptive statistics of the variables are presented in table 5.1.1 in order to get background information regarding their location (rural/urban), age,

education level, family size, economic status (APL/BPL) of sample beneficiaries. The descriptive statistics of the socio-economic variables are:

Table 5.1.1: Socio-economic Statistics of sample beneficiaries

Variables	N	Minimum	Maximum	Mean	Std. Deviation
Rural1	300	0	1	0.66	0.473
AGE	300	18	35	27.69	4.481
Education (EDU)	300	0	4	1.31	1.346
Elementary=E1	300	0	1	0.13	0.341
Secondary=E2	300	0	1	0.20	0.403
Higher secondary=E3	300	0	1	0.17	0.373
Higher education=E4	300	0	1	0.07	0.250
BPL1	300	0	1	0.51	0.501
APL0	300	0	1	0.49	0.501
FSIZE	300	1	3	1.72	0.734
Family 0-5members=F1	300	0	1	0.45	0.498
Family 5-8 members=F2	300	0	1	0.38	0.487
Family 8 & above=F3	300	0	1	0.17	0.373
Cash Received Yes1/No0	300	0	1	0.87	0.333
ANC YES1/No2	300	0	1	0.90	0.305
Immunization (IS)Yes1/No0	300	0	1	0.92	0.267
Institutional Delivery (INSTDELVRY)(Yes1/No 0)	300	0	1	0.87	0.337
Valid N (listwise)	300				

After refining the data collected from the field through the open ended questionnaires, the sample of 300 household respondents were used for analysis. Majority of the beneficiaries i.e. 43% were illiterate. The minimum age of the beneficiaries was found to be 18years which means JSY guidelines regarding age are properly followed. The average probability of receiving ANC was found to be 0.90 which means 90% of beneficiaries received ANC checkups. Similarly, the average probability of receiving Immunization was

0.92 which means 92% of beneficiaries received ANC Immunization services. The average probability of having ‘INSTDELVRY’ was 0.87 (87%) which is quite high. Likewise, the average probability of receiving cash incentives was found to be 0.87, which means 87% beneficiaries received cash incentives under JSY scheme.

5.2. Results of binary logistic regression model

Table 5.2.1: Binary logistic regression model results for ANC

Variables in the Equation	β - coefficients	p-value(significance level)	
R1(Rural)	0.106	0.003*	
AGE	0.003	0.967	
E1(Primary Education)	18.121	0.997	
E2(Elementary Education)	2.084	0.059***	
E3(Higher Secondary Education)	1.264	0.057***	
BPL1	-0.206	0.006*	
F1(0-5 members)	1.824	0.053***	
F2(5-8 members)	2.447	0.024**	
CashReceivedYes1/No0	5.628	0.000*	
Constant	2.161	0.000*	
Statistics	Results	Df	Significance level
Model Chi-Square	142.97	9	0.000
-2LogLikelihood	57.210	-	-

* 1%, **5% and ***10% level of significance

The findings of the binary regression models along with its statistical tests were found to be quite expected and in line with the established literature as are presented in the table 5.2.1. In the first binary logistic regression equation seven out of nine independent variables were found significantly associated with ANC recipients. The coefficient of Cash Received has positive sign and was found significant at 1% level. It implies that more the individual was cash recipient more was the probability of utilising ANC check-ups. Cash Received is a dummy variable (yes=1) is expected to have direct relation with ANC. It is considered as a robust variable of determining the ANC. The level of Education level (Edu) particularly higher secondary education (E3) has a

positive sign and is significant at 10% level. Similarly, Rural/Urban (Rural1) have positive sign and are significant at 10% level. This means that more are the people educated and located in rural areas more are the chances of having higher ANC. The economic status-BPL1 shows a negative coefficient and is significant at 1% level. This means more are the women living in BPL households less is the utilization of ANC checkups i.e. there is inverse relationship between ANC and BPL households. The sizes of family also show a positive sign and are significant at 1% and 10% level. This means as size of family increases ANC utilization also increases. The variables like Age, Primary education are statistically insignificant in this model. The above table also showed the test statistics of the binary logistic regression model which reflects that the model was quite robust with Chi-square of over 142.97 at 99% level of confidence. It is hypothesized that lower the log-likelihood statistic for a binary logistic regression better is the model. The log-likelihood statistic of 57.210 was quite comparable with other similar studies respectively. The overall test-statistics from the Binary Logistic Regression were quite robust and similar to many studies.

Table 5.2.2: Binary logistic regression model results for Immunization services

Variables in the Equation	β - coefficients	p-value (significance level)	
R1(Rural)	1.113	0.048**	
AGE	0.311	0.051***	
E1(Primary Education)	-1.385	0.036**	
E2(Elementary Education)	1.166	0.047**	
E3(Higher Secondary Education)	0.692	0.010*	
BPL1	-0.421	0.013**	
F1(0-5 members)	0.238	0.691	
F2(5-8 members)	0.824	0.240	
CashReceivedYes1/No0	2.363	0.000*	
Constant	2.489	0.000*	
Statistics	Results	Df	Significance level
Model Chi-Square	135.115	9	0.000
-2LogLikelihood	39.216	-	-

* 1%, **5% and ***10 level of significance

In the second binary logistic regression equation seven out of nine independent variables were found significantly associated with immunisation recipients. Cash received is highly significant at 1% level of significance with a positive sign of coefficient. This implies that cash received has positive impact on immunization services. This variable has a robust determining relationship. Likewise, the level of Education (Edu) particularly elementary education has a positive sign and is significant at 10% level, also when level of education increases further utilization of immunization services also increases as depicted from table. This means that more are the people educated more are the chances of having higher immunization. Similarly, Age also has a positive sign and is significant at 10% level; it means that with the increase in age, utilization of Immunisation services also increases. Rural/Urban variables were significant at 5% level and have coefficient with a positive sign. It means rural people were receiving more Immunisation services. The economic status-BPL1 again shows a negative coefficient and is significant at 5% level. This means more are the women living in

BPL households less is the utilization of immunization services. The other variables like family size are statistically insignificant in this model. Table 5.2.2. also shows the test statistics of the binary logistic regression model which reflects that the model was quite robust with Chi-square of over 135.115 at 99% level of confidence. The log-likelihood statistic of 39.216 was quite comparable with other similar studies respectively.

Table 5.2.3: Binary logistic regression model results for Institutional Delivery

Variables in the Equation	β - coefficients	p-value (significance level)	
R1(Rural)	-1.814	0.025*	
AGE	-0.027	0.684	
E1(Primary Education)	19.875	0.997	
E2(Elementary Education)	3.535	0.007*	
E3(Higher Secondary Education)	3.013	0.004*	
BPL1	-0.025	0.037**	
F1(0-5 members)	1.216	0.068***	
F2(5-8 members)	0.329	0.638	
CashReceivedYes1/No0	4.527	0.000*	
Constant	1.901	0.000*	
Statistics	Results	Df	Significance level
Model Chi-Square	126.356	9	0.000
-2LogLikelihood	105.476	-	-

* 1%, **5% and ***10 level of significance

In the third binary logistic regression model, where ‘INSTDELVRY’ is a dummy variable (1 and 0) showed that six out of nine variables were highly significant. Likewise, the other two binary regression models ‘Cash Received’ has positive sign with a significance level of 1%. It implies that more the beneficiaries were a cash recipient more are the chances for institutional delivery. In the present study, about 87% of respondents were cash recipients and an equal number were of institutional delivery (both in govt/pvt health institutions). Family size has a positive sign with a significance of 10% level. The ‘Education level, has a positive sign and are highly significant at 1% level. The rural/urban variable has a negative coefficient but is significant at 5% level

of significance. This means urban women have highest odds for institutional deliveries as compared to rural women. The economic status-BPL1 again shows a negative coefficient and is significant at 5% level. This means more are the women living in BPL households more is the probability for home delivery. The other variables have positive coefficients but were statistically insignificant in this model. Table 5.2.3, showed the test statistics of the binary logistic regression model for Institutional Delivery in which reflects that the model was quite robust with Chi-square of over 126.356 at 99% level of confidence. The log-likelihood statistic of 105.476 was quite comparable with other similar studies respectively.

5.3. Socio-economic Profile

Socioeconomic background plays an important role for the analysis of data regarding any problem under study. It gives us certain characteristic features for carrying out the research work in a proper manner. Information on household characteristics provides framework for understanding the demographic profile of the population under study.

5.3.1. Education Status

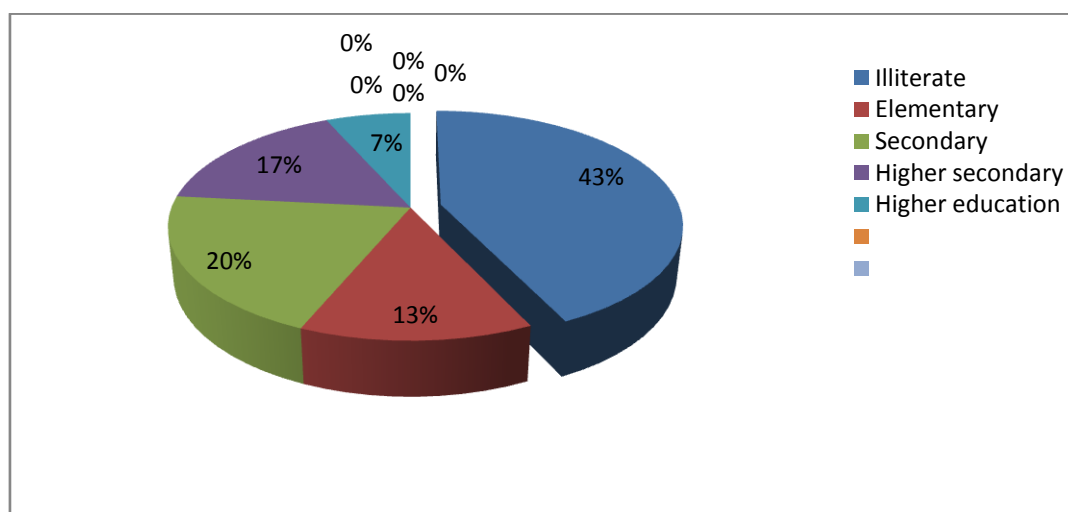
Education is one of the important indicator of the society's stock of human capital and its level of social development, which in turn enhances the ability of individuals health status and helps to achieve desired demographic and health goals. Education is regarded as one of the key elements for primary health care which helps in understanding the basis of healthy life that can enable people to make rational decisions regarding their needs and life styles. The education profile of sample beneficiaries is as follows:

Table 5.3.1: Education level of sample beneficiaries

S. no	Level of Education	Number of beneficiaries	Percentage
1.	Illiterate	129	43.00
2.	Elementary	40	13.30
3.	Secondary	61	20.30
4.	Higher secondary	50	16.70
5.	Higher education	20	6.70
Total		300	100

Source: Field Survey

Fig 5.3.1: Level of education



It is revealed from the table and diagram 5.3.1 that majority of respondents i.e. 43% are illiterate. It was found that about 20% respondents attain secondary education, followed by higher secondary education, elementary and higher education, i.e. 17%, 13% and 7% respectively. The inferences drawn from the above table, that maximum number of beneficiaries were illiterate.

5.3.2. Age of the beneficiaries

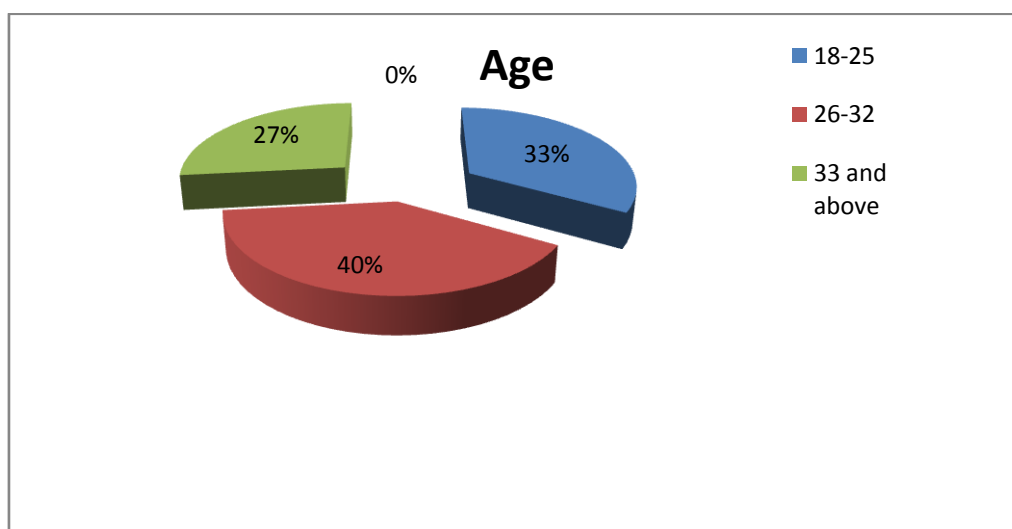
The sample collected regarding the age wise number of beneficiaries is presented in the following table. The numbers of beneficiaries are grouped in different age groups and the percentage is calculated for each group.

Table 5.3.2: Age of sample beneficiaries

S. no	Age group	Number of beneficiaries	Percentage
1.	18-25	100	33.33
2.	26-32	120	40.00
3.	33 and above	80	26.67
Total		300	100

Source: Field Survey

Figure 5.3.2: Age of the sample beneficiaries



As is clear from the above table and diagram, that maximum number of beneficiaries i.e. 40% fall in the age group of 26-32 years, followed by 33% in the age group of 18-25 years and 27% in the age group of 33 years and above. The inferences drawn from the above data reflect that majority of the beneficiaries are in the fertile age group of 26-32 years.

5.3.3. Economic Status

We have not used monthly expenditure or any other economic indicator to measure the well being of the household. We have instead classified the beneficiaries on the type of ration card viz. Above Poverty Line (APL), Below

Poverty Line (BPL) including Antodaya Ana Yojana (AAY) and others which include those who have no ration cards. This type of categorization can partially overestimate the number of poor beneficiaries. With this care in mind, the distribution of beneficiaries is as follows:

Table 5.3.3: Economic status of beneficiaries

S. no	Status	Number of beneficiaries	Percentage
1.	APL	146	48.70
2.	BPL	154	51.30
3.	Other	0	00.00
Total		300	100.00

Source: Field Survey

From the above table, it is evident that maximum number of beneficiaries falls in the Below Poverty Line category i.e. 51% followed by 49% in Above Poverty Line category.

5.3.4. Family size

The following table shows number of beneficiaries arranged according to their family size. The number of beneficiaries are categorised on the family strength and the percentage calculated is presented in the following table.

Table 5.3.4: Family size of sample beneficiaries

S. no	Family members	Number of beneficiaries	Percentage
1.	Less than 5	135	45.00
2.	5-8 members	115	38.33
3.	8 and above	50	16.67
Total		300	100

Source: Field Survey

The size of the family depends to some extent on the nature of the family. It is presumed that joint families are large in size as compare to the nuclear families. The size of family determines the number of dependents, health and hygiene and standard of living. Table5.3.4. shows that 45% beneficiaries have family members less than 5, followed by 38% having 5- 8 members.

5.4. Awareness and source of awareness

The level of awareness is of paramount importance for the success of any scheme. The following table shows the awareness and sources of awareness. The following table depicts the information regarding sources of awareness and the person who prompted to avail the scheme.

Table 5.4.1: Awareness and sources of awareness about JSY

S. no	Source of Awareness	Number of beneficiaries	Percentage
1.	ASHA	190	63.34
2.	ANM/AWW	27	09.00
3.	Govt. Publicity	55	18.33
4.	Friends, relatives	12	04.00
5.	Others	16	05.33
Total		300	100.00
Source (s) prompting the beneficiaries to avail JSY service			
1	Husband, friends, relatives,	20	06.67
2	ASHAs	204	68.00
3	ANMs	60	20.00
4	Others	16	05.33
Total		300	100.00

Source: Field Survey

From the table 5.4.1, it is evident that all the beneficiaries were aware about the JSY scheme i.e. there is 100% awareness among the beneficiaries.

Among the sample beneficiaries who had knowledge about JSY, 64% reported that ASHAs was the main source of information about JSY, 18% were aware through Govt. Publicity and 9% of respondents revealed that ANM/AWW were their source of information.

The sample beneficiaries were asked another question regarding the motivation towards JSY. Majority of beneficiaries i.e. 68% were motivated by ASHAs, 20% by ANMs and only 7% by husband, friends and relatives. The inferences drawn from the above data is that the ASHAs were playing major role for making JSY programme more effective.

5.5. Registration process

In order to avoid the risks of pregnancy and child bearing the antenatal care is an essential link between women and the health system in all respects. A pregnant woman, therefore, is supposed to visit the health centre for her check-up at the early stage of pregnancy. For this registration process is an important component. This enables the health worker to evaluate any abnormality of the pregnancy or the deficiency so that she can take the necessary measures at the appropriate time to manage the complications and ensure safe delivery. To know whether women are registered under JSY and provided services as per JSY guidelines, all the women who had heard about JSY were asked a series of questions regarding registration, person associated with registration process, timing and place of registration.

Table 5.5.1: Registration process, person, timing and place of registration

Registration	Number of beneficiaries	Percentage
Yes	300	100.00
Person who registered you with JSY		
ASHA	200	66.67
AWW/ANM	70	23.33
Doctor	20	06.66
Others	10	03.33
Total	300	100.00
Timing of registration		
At Ist month of pregnancy	95	31.67
Ist Trimester of pregnancy	140	46.66
Before one month of expected date of delivery	60	20.00
At the time of delivery	05	01.67
Total	300	100
Place of registration		
District/Sub-District Hospital	120	40.00
PHC/CHC	90	30.00
Sub-centre	20	06.67
Home	35	11.66
Pvt. Institution	35	11.66
Total	300	100.00

Source: Field survey

In the above table, it is evident that all of the women i.e. 100% were registered with JSY. The beneficiaries were asked questions regarding sources

of registration in order to ascertain the implementation of the scheme at the gross root level. It was reported that about 67% of the beneficiaries were registered by ASHAs and rest 33% of the beneficiaries were registered through other sources like ANM/AWW, Doctors etc.

So for as timing of registration is concerned the above table also points out that 47% beneficiaries were registered during the first trimester of pregnancy, 31% of the beneficiaries were registered in the first month of their pregnancy. Hence, about 78% of the beneficiaries were registered during the first trimester.

As for as the place of registration is concerned, out of 300 beneficiaries majority of the beneficiaries i.e. 40% had registered themselves at district/sub-district hospitals, followed by 30% in PHC/CHCs and about 12% of the beneficiaries had registered in private institutions. Hence, it is evident that lower level health facilities are yet to emerge popular places for the registration among the beneficiaries. District/sub-district hospitals are still the number one priority for prospective mothers.

5.6. JSY card and difficulties faced

Table 5.6.1: Receipt of JSY card and difficulties faced by sample beneficiaries in getting JSY card

S.no	Characteristics	Number of beneficiaries	Percentage
1	No. of respondents having JSY card	300	100.00
2	Cards were not available	10	02.00
3	Formalities in getting JSY card were cumbersome	15	03.33
4	Made expenditure in getting card	4	01.33
5	Any other	3	02.00

Source: Field Survey

In order to know the implementation of the scheme, the beneficiaries were asked about the receipt of JSY card and problems faced to get the JSY card. It is evident from the table that all the beneficiaries have received JSY card and only 13 beneficiaries (more than 8%) reported that they have faced problems in getting JSY card, out of which 3% reported that formalities in

getting JSY card are difficult, followed by 2% who reported cards were not available and 1% reported that they had to made an expenditure in getting JSY card.

5.7. Place of delivery

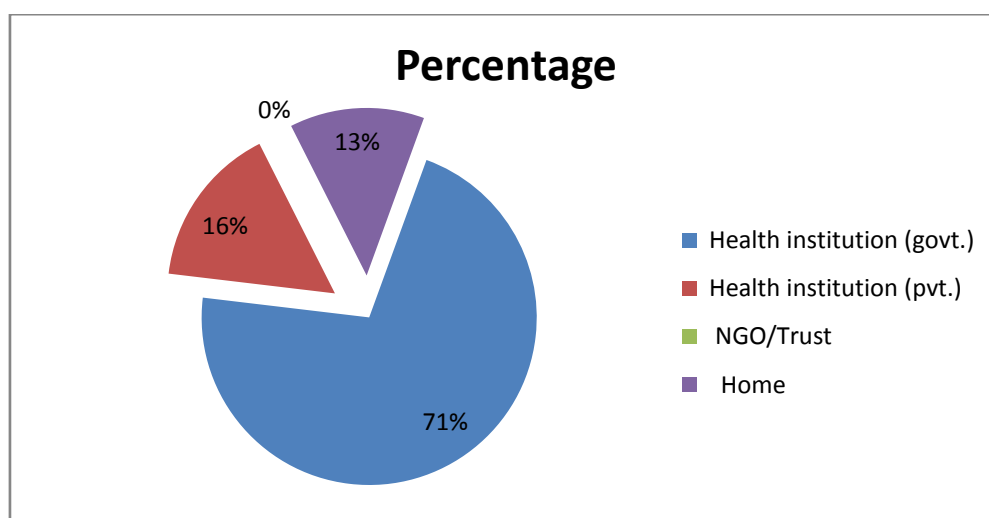
The place of delivery for a pregnant woman is closely associated with the survival status of mother and the child. Place of delivery plays an important role for encouraging deliveries in proper hygienic conditions under the supervision of trained health professional. Further, the success of the scheme can be judged by the proportion of all the deliveries conducted in the govt. health facility or in the private hospital accredited under the scheme.

Table 5.7.1: Place of delivery of sample beneficiaries

S. no	Place of delivery	Number of beneficiaries	Percentage
1.	Health institution (govt.)	214	71.33
2.	Health institution (pvt.)	47	15.67
3.	NGO/Trust	0	00.00
4.	Home	39	13.00
Total		300	100.00

Source: Field survey

Fig 5.7.1: Place of delivery of sample beneficiaries



The table 5.7.1 gives the information of all JSY beneficiaries regarding place of delivery. Nearly 87% of deliveries among the beneficiaries had taken place in different health institutions both govt. and private while as 13% beneficiaries had their delivery at their homes. Most of the institutional deliveries had taken place in government health institutions i.e.71% and 16% in private institutions. This means JSY is doing very well in District Pulwama and has helped a lot in increasing the institutional deliveries considerably.

Table 5.7.2: Reason for opting for institutional deliveries

Reason for opting for institutional delivery	Number of beneficiaries	Percentage
Money available under JSY	40	15.32
ASHA motivated to deliver in a hospital	50	19.15
Better services for mother and newborn child	111	42.52
Previous child was born in health institution	35	13.40
Home delivery is not safe	25	09.57
Total	261	100.00

Source: Field Survey

The JSY aims at ensuring more and more institutional deliveries through an incentive based approach and it was expected that all beneficiaries would opt for institutional deliveries for getting monetary benefit but it was not the driving force for beneficiaries to opt for institutional deliveries as only 15% beneficiaries out of 87% institutional deliveries reported that the availability of money under JSY was one of the reasons for opting institutional delivery. The main reasons mentioned by beneficiaries for institutional delivery were better services for mother and child i.e. 43%, followed by 19% motivated by ASHA to deliver in a health facility and 13% beneficiaries reported that they had their previous child born in a health institution and 10% beneficiaries responded that home delivery is not safe. Beneficiaries are not tempted by the monetary incentive provided by JSY. It is the safety of mother and new born through better services provided by Govt. and private health institutions that is of paramount importance to the people.

Table 5.7.3: In spite of cash assistance available, reason for not opting for institutional delivery

S. no	Reason for home delivery	Number of beneficiaries	Percentage
1.	Too much costs	15	38.46
2.	Lack of transportation	07	17.94
3.	Poor quality services	10	25.64
4.	Home delivery is safe	08	20.51
5.	Cannot say	01	02.55
Total		39	100.00

Source: Field survey

The beneficiaries who were registered under JSY were asked question regarding the reason for not opting for institutional delivery in spite of the cash incentive available under the JSY. Out of 39 beneficiaries who had delivered at their homes, most of the them i.e. 38% cited the high expenditure as a main hindrance for not opting for institutional delivery, 18% reflected lack of transportation, 26% mentioned the poor quality services in the hospital, 21% quoted that home delivery is more convenient and safe and 2% were without any answer.

5.8. Cash incentives

As per the norms under the JSY, each beneficiary is given ₹1400 in rural areas and ₹1000 in urban areas for institutional delivery. For this purpose a woman must have a JSY card and the immunization card, and must have availed three ANCs, 100 IFA tablets, two doses of TT injections and one measles injection. If the beneficiary has arranged transportation at her own cost, then a sum of ₹250 would also be paid to the beneficiary towards the cost of transportation and the incentives should be paid vide cheque on the same day in case of institutional delivery at the respective institution. In case of home deliveries, ₹500 are paid in the form of cash disbursed through ASHAs provided delivering mother should be aged 19 years and above and from BPL family up to two live births.

Table 5.8.1: Cash incentives received by JSY beneficiaries

Cash incentive received	Number of beneficiaries	Percentage
Yes	261	87.00
Amount of Cash incentive		
≤ ₹500	00	00.00
₹600-1000	126	48.27
₹1100-1400	135	51.72
Total	261	100.00
Timing of receipt of incentive		
Immediate at the time of delivery	95	36.25
During the 1 month after delivery	115	43.89
2-6 months after delivery	52	19.84
Not received yet	00	00.00
Total	262	100.00
Person who delivered incentive		
Doctor	151	57.63
ASHA	76	29.00
ANM/FHW	35	13.35
Other	00	00.00
Total	262	100.00

Source: Field Survey

From the above table it is evident that among 300 beneficiaries about 87% have received cash incentives, among which major beneficiaries i.e. 51% have received cash amount in the range of ₹1100-1400, followed by 48% between ₹600-1000 and 0.38% received below ₹500 as cash incentive. According to JSY guidelines cash incentives should be given to delivering mother when admitted for delivery or soon after the delivery, however, it was observed from the field that this money is not paid as per the guidelines. Majority of respondents about 44% mentioned that cash incentives were given during the one month after delivery, 36% were given immediate at the time of delivery and 20% have received incentive between 2-6 months. Delay in payment of cash incentive is a major weakness of JSY in the district. Efforts should be more on to pay this incentive as per the guidelines of the scheme. Further the distribution regarding disbursement of the cash incentives shows that majority of the respondents i.e. 58% have received cash incentives through

doctors, over 29% have received it from ASHAs and 13% have received incentives through ANMs/FHWs.

5.9. Utilization of JSY Money

Table 5.9.1: Utilization of cash incentives by JSY beneficiaries

S. no	Utilization of JSY money	Number of beneficiaries	Percentage
1.	For travel cost	111	42.52
2.	For food	30	11.49
3.	For medicines	40	15.32
4.	Payment to Nurses/ASHAs	10	03.83
5.	Neo natal care	30	11.49
6.	Others	40	15.32
Total		261	100.00

Source: Field Survey

From the above table, the information was collected regarding utilisation of JSY money out of which 42% of beneficiaries have utilised JSY incentives for travel cost, 15% for medicines, 11% each for food and neonatal care, 3% for payment to Nurses/ASHAs and 15% for other purposes.

5.10. Mode of Payment

Table 5.10.1: Mode of payment

Mode of payment	Number of beneficiaries	Percentage
Cheque	225	86.53
Cash	35	13.47
Total	260	100.00

Source: Field Survey

The beneficiaries were asked questions regarding mode of payment and problems faced in receiving the cash incentives. From the above table, it was observed that 86% have received cash incentives in the form of cheques and 14% in the form of cash. It was observed from the field study that most of the respondents were against the cheque system due to non availability of banks in

local rural areas and the collection of cash from banks became hindrance for beneficiaries.

5.11. Transport facility

In order to facilitate the institutional deliveries, the JSY envisages arrangement of transport facility for pick and drop facility.

Table 5.11.1: Availability of transport facility

S.no	Characteristics	Number of beneficiaries	Percentage
1	Own cost	200	66.67
2	Arrangement by ASHA/AWW/ FHW	100	33.33
Accompanied by			
1	Husband, relatives etc.	200	66.67
2	ASHA/AWW/FHW	100	33.33

Source: Field Survey

From the above table it is evident that only 33% have availed the transport facility under JSY which was arranged by either ASHA/AWW/FHW while as majority of the beneficiaries i.e. 67% have arranged the transport facility at their own cost. The reason for non utilisation of transport facility under JSY is non availability of ambulance services at the time of delivery and most often the delivering women requiring transport facility at odd hours. In case of majority of beneficiaries i.e. 67% were accompanied by husband, relatives to the health institution for delivery and ASHAs accompanied to only 33% of beneficiaries to the health institution.

5.12. Antenatal Care Services

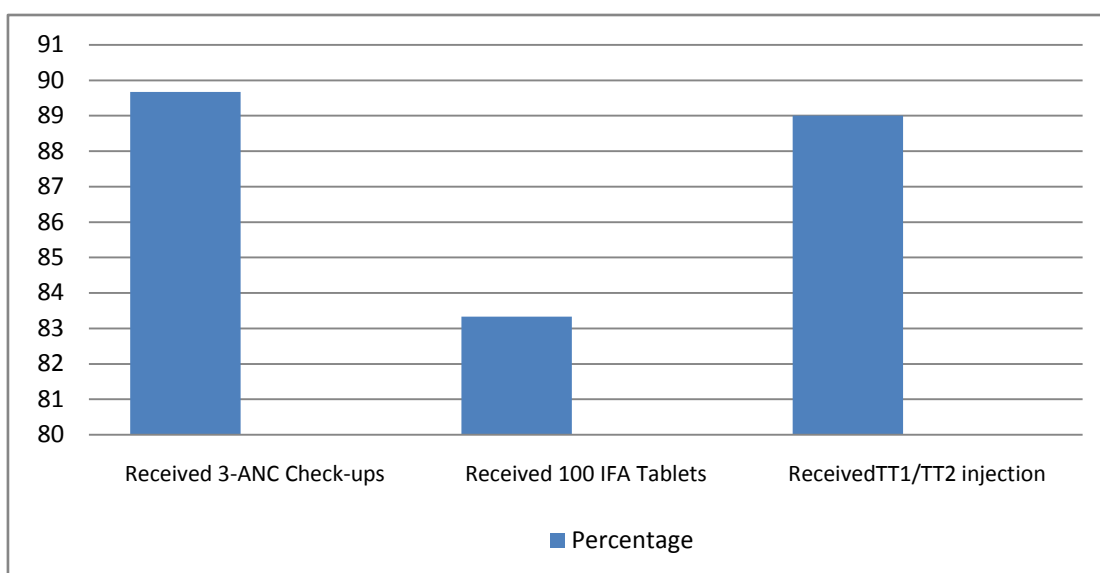
In order to avoid any complication arising throughout pregnancy, a pregnant woman is supposed to visit the health facility for at least three ANC check-ups to ensure safe delivery. A series of questions were asked to beneficiaries regarding utilization of ANC services.

Table 5.12.1: Sample beneficiaries who received ANC checkups

Received ANC Check up	Number of beneficiaries	Percentage
Received 3-ANC Check-ups	269	89.67
Received 100 IFA Tablets	250	83.33
ReceivedTT1/TT2 injection	267	89.00

Source: Field Survey

Figure 5.12.1: Sample beneficiaries who received ANC checkups



It is clear from the above table and figure that out of 300 beneficiaries interviewed, about 90% have received 3-ANC check-ups, 83% have consumed 100-IFA tablets and about 89% beneficiaries reported that they have received 2-booster injections (TT1 & TT2). While the performance with regard to 100 IFA and 2-booster injections is very satisfactory, much needs to be done to ensure 100% ANC check-ups in the district.

Table 5.12.2: Different health officials involved in providing ANC services

Utilization of ANC services	Number of beneficiaries	Percentage
Yes	269	89.67
Health official who provided ANC service		
Doctor	190	70.63
ANM	49	18.21
AWW	00	00.00
ASHA	30	11.16
Total	269	100.00
Place where ANC was received		
Govt. / Pvt. health facility	230	85.50
NGO/Trust	0	00.00
Received at home	39	14.50
Total	269	100.00

Source: Field survey

Out of 269 beneficiaries (89%) who have utilised ANC services, 70% were provided by Doctors, 18% by ANMs and only 11% by ASHAs. ASHAs are yet to be accepted as major ANC providers. Beneficiaries are doubtful about their capabilities regarding the quality of the ANC services.

With regard to place of ANC provided, 85% received ANC through govt. /pvt. health facility and 15% received at home. This means majority of population depends upon govt. institutions for their health needs and there is a large scope for private sector to come forward for making investments in health sector.

5.13. Postnatal care

The health of a mother and her newborn depends not only on the health care she receives during her pregnancy and delivery, but also on the care she and the infant receive during the first few weeks after delivery.

Table 5.13.1: Utilization of PNC checkups, sources and timing of PNC

S. no	Utilization of PNC services	Number of beneficiaries	Percentage
1	Yes	260	86.67
Sources of PNC provider			
1	Doctor	135	51.92
2	ANM/AWW/Nurse	75	28.84
3	ASHA	50	19.24
Timing of PNC			
1	PNC within 2-days	200	76.92
2	PNC within 42-days	60	23.08

Source: Field survey

As it is revealed from the above table, that 87% beneficiaries have utilized post natal care after delivery. Out of which, most respondents mentioned doctors (52%) as the source of PNC provider followed by ANM/AWW/Nurse (29%) and ASHAs (19%) as the source of postnatal care provider. It was found from the above table that out of 260 beneficiaries, i.e. more than 76% respondents have received PNC check up within 2-days after delivery and 23% have received PNC check up within 42 days after delivery. The reason for delay in PNC checkups is mainly due to non availability of trained medical persons at block level. As in case of ANC, doctors continue to be the much sought after source for PNC services. Delayed PNC check-ups for more than 23% of the beneficiaries remains a cause of concern.

5.14. Immunization services

Immunization of children against the diseases like Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Polio and Measles are crucial for reducing infant and child mortality. According to WHO guidelines, children are considered fully vaccinated when they have received a vaccination against Tuberculosis(BCG),three doses of Diphtheria, Whooping Cough (Pertussis), and Tetanus (DPT) vaccine, three doses of the Poliomyelitis(Polio) vaccine and one dose of Measles vaccine by the age of 12 months.BCG should be given

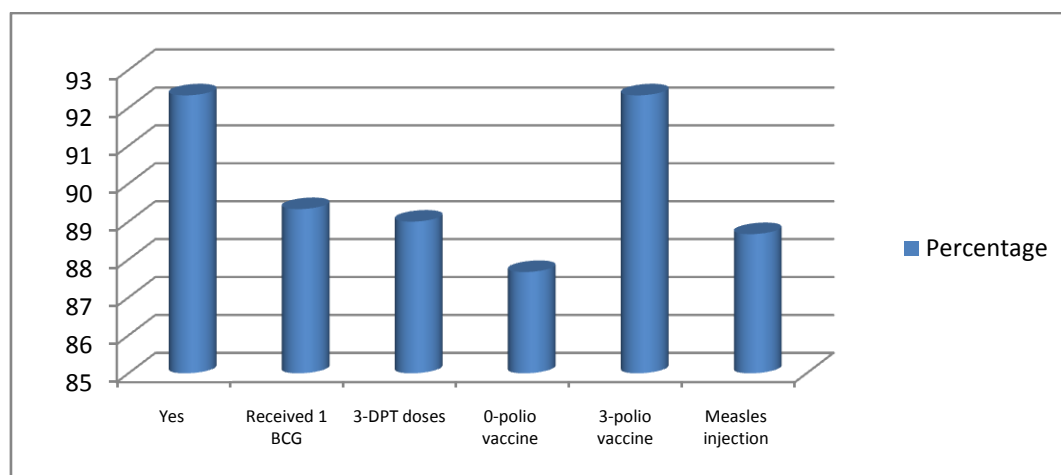
at birth or at first clinical contact, DPT and Polio require three vaccinations at approximately 4, 8, and 12 weeks of age, and Measles should be given as soon after reaching 9 months of age.

Table 5.14.1: Utilization of Immunization Services

S. No	Immunization schedule	Number of beneficiaries	Percentage
1	Yes	277	92.33
3	Received 1 BCG	268	89.33
4	3-DPT doses	267	89.00
5	0-polio vaccine	263	87.67
6	3-polio vaccine	277	92.33
7	Measles injection	266	88.67

Source: Field survey

Figure 5.14.1: Utilization of Immunization services



From the table and diagram 5.12.1, it is evident that among the 300 beneficiaries 92% immunization was recorded. About 89% have utilized 1 BCG vaccine, 89% have received 3 DPT doses, 87% have received 0-polio vaccine, 92% have received 3-polio vaccine and 88% have received measles injection

5.15. Major achievements and hypothesis of the study

1. Majority of the beneficiaries i.e. 43% were illiterate.
2. The minimum age of the beneficiaries was found to be 18 years which means JSY guidelines regarding age are properly followed.

3. The average probability of receiving ANC was found to be 0.90 which means 90% of beneficiaries received ANC checkups.
4. The average probability of receiving Immunization was 0.92 which means 92% of beneficiaries received ANC Immunization services.
5. The average probability of having institutional delivery was found to be 0.87 (87%) which is quite high.
6. The average probability of receiving cash incentives was found to be 0.87, which means 87% beneficiaries received cash incentives under JSY scheme.
7. Cash incentives have significant impact on ANC, Immunization and Institutional deliveries as their coefficients were found positive and highly significant at 1% level. It means that more the individual was cash recipient more was the probability of utilising ANC check-ups, immunisation services and higher chances for institutional delivery.
8. The higher educated people have more chances of utilizing ANC and immunization services and significantly associated with institutional delivery.
9. The women living in BPL households have lower chances of utilizing ANC and Immunization as compared to woman living in APL households. Similarly, BPL women have lower chances for institutional delivery as compared to urban woman. This means more are the women living in BPL households more is the probability for home delivery.

Before accepting or rejecting the hypothesis, it is necessary to have base year figures from the secondary sources. For this purpose we depend on District Level Household Survey-2007-08 (DLHS-3)⁶. This survey shows that 60.7% mothers were registered in the first trimester of their pregnancy, 86.7% mothers received 3-Ante Natal checkups, 93.3% mothers received at least one

⁶ District Level Household and Facility Survey under Reproductive and Child Health-2007-08 (DLHS-3), District Fact sheet Pulwama-J&K, Conducted by International Institute of Population Sciences (IIPS), Mumbai.

TT injection, 77.7% were institutional deliveries and 63.0% received post natal care during 48 hours of delivery. The survey also shows that 79.9% children are fully immunised among which 97.1% received BCG dose, 84.4% children received 3 doses of polio vaccine, 83.7% received 3 doses of DPT vaccine, 87.0% received Measles vaccine. Besides the above statistics, the data collected from the field were analysed through binary logistic regression models which showed that cash incentives has positive impact on utilization of ANC, Immunization of children and Institutional deliveries in all the three binary logistic regression equations as the coefficients of cash received were found positive and highly significant at 1% level of significance, therefore we rejected the null hypothesis and accepted the alternative hypothesis that JSY incentives has made positive impact on utilization of antenatal care services, institutional delivery and immunization of children in district Pulwama.

Chapter - 6



Summary and Conclusions

This chapter is based on findings and suggestions regarding implementation of the NRHM in Jammu and Kashmir in general and JSY in particular. The study tried to evaluate the JSY in the state of J&K, in order to know about certain bottlenecks and suggestions underway in the successful implementation of the scheme. In order to assess the impact of JSY on utilization of Reproductive and Child Health services in J&K, a case study of district Pulwama was taken up for field study and a sample of 300 beneficiaries was chosen on the basis of simple stratified random sampling technique, from three medical blocks of district Pulwama. First of all, population was divided into three strata's i) population above 5000, ii) population between 2000-5000 and iii) population below 2000. From each stratum two villages were chosen for the study and six villages from each block thereby taking 18 villages from whole district. From each village maximum number of 17 beneficiaries was taken, thereby completing a sample of 300 beneficiaries. For rigorous and analytical study the sample beneficiaries were asked questions regarding awareness, registration and their sources and timing criteria about the JSY scheme. The sample beneficiaries were asked certain questions regarding utilization of ANC, Delivery care, PNC and Immunization services. Certain questions were posed regarding problems faced, their types and nature of problems faced, followed by certain suggestions. The necessary statistical tools and econometric tools i.e. binary logistic regression models were used to analyse and interpret the data.

In J&K, the JSY was implemented in all the districts of the state from Dec. 2005. During the course of data collection from various departments, offices and implementing agencies it was observed that JSY is doing well in the state as number of institutional deliveries increased substantially in all the districts of the valley. However, during field work in one of the districts of the Kashmir valley the actual position regarding JSY was somewhat different as against paper writing. The data records were not properly maintained and various figures and components showed mismatching records as data collected from DPMU was contradictory with State Health Society. When this issue was raised with the concerned officials they cited shortage of skilled manpower and heavy workload for poor data quality.

6.1. Main Findings of the Study

So far as present study is concerned various findings and suggestions were highlighted. The main findings of the study were:

- 6.1.1. Majority of the beneficiaries i.e. 43% were illiterate.
- 6.1.2. The minimum age of the beneficiaries was found to be 18years which means JSY guidelines regarding age are properly followed.
- 6.1.3. The average probability of receiving ANC was found to be 0.90 which means 90% of beneficiaries received ANC checkups.
- 6.1.4. The average probability of receiving Immunization was 0.92 which means 92% of beneficiaries received ANC Immunization services.
- 6.1.5. The average probability of having institutional delivery was found to be 0.87 (87%) which is quite high.
- 6.1.6. The average probability of receiving cash incentives was found to be 0.87, which means 87% beneficiaries received cash incentives under JSY scheme.
- 6.1.7. Cash incentives have significant impact on ANC, Immunization and Institutional deliveries as their coefficients were found positive and highly significant at 1% level. It means that more the individual was cash recipient more was the probability of utilising ANC check-ups, immunisation services and higher chances for institutional delivery.

- 6.1.8. The higher educated people have more chances of utilizing ANC and immunization services and significantly associated with institutional delivery.
- 6.1.9. The women living in BPL households have lower chances of utilizing ANC and Immunization as compared to woman living in APL households. Similarly, BPL women have lower chances for institutional delivery as compared to urban woman. This means more are the women living in BPL households more is the probability for home delivery.
- 6.1.10. The awareness level was very much satisfactorily as all the beneficiaries (i.e.100%) were aware about the JSY scheme. Among beneficiaries who had knowledge about JSY, 63% reported that ASHAs were the main sources of awareness, 18% aware through Govt. publicity.
- 6.1.11. The study outlined the fact that most of the beneficiaries were motivated towards JSY by ASHAs i.e. 68%, 20% by ANMs and only 7% by husband, friends and relatives.
- 6.1.12. The study highlighted that the ASHAs were playing major role for making JSY programme more effective.
- 6.1.13. The registration of beneficiaries was mostly done by ASHAs about 67% indicating that ASHAs are fully involved in the scheme.
- 6.1.14. So far as timing of registration is concerned the study pointed out that majority of beneficiaries i.e. 79% were registered during the third trimester of pregnancy, which is a matter of concern as it has its direct consequence on utilization of ANC services.
- 6.1.15. As for as the place of registration is concerned, majority of the respondents i.e. 77% were registered in government institutions.
- 6.1.16. The study also pointed out that most of the deliveries i.e. 87% among the beneficiaries had taken place both in govt. and private health institutions while as 13% were home deliveries.
- 6.1.17. Most of the institutional deliveries had taken place in government health institutions i.e.71% and 16% in private institutions. This means JSY has helped in increasing the number of institutional deliveries considerably

and demand for health services has also increased and the main objective of the scheme has also been achieved successfully.

6.1.18. The study also pointed out that cash incentives were disbursed among 87% beneficiaries among which majority of beneficiaries i.e. 48% have received cash amount between ₹600-1000, followed by 52% in the range of ₹1100-1400 as cash incentive.

6.1.19. Study findings indicate huge increase in institutional deliveries in district Pulwama of Jammu and Kashmir; this can be attributed to the immense popularity of the JSY scheme in the district.

6.1.20. The JSY aims at ensuring more and more institutional deliveries through an incentive based approach and it was expected that all beneficiaries would opt for institutional deliveries for getting monetary benefit but it was not the driving force for beneficiaries to opt for institutional delivery as only 15% beneficiaries out of 87% institutional deliveries reported that the availability of money under JSY was the reason for opting for institutional delivery.

6.1.21. The main reasons mentioned by beneficiaries for institutional delivery were better services for mother and child i.e. 43%, followed by 19% motivated by ASHA to deliver in a health facility and 13% beneficiaries reported that they had their previous child born in a health institution and 10% beneficiaries responded that home delivery is not safe. Therefore, government should focus on providing more and more infrastructural set up in order to provide better health services and meet the growing demand for health services.

6.1.22. Out of 39 beneficiaries who delivered at their homes, 38% cited the high expenditure as a main hindrance and 26% mentioned the poor quality services in the hospital for not opting for institutional delivery.

6.1.23. The study also pointed out that despite transport facility available under JSY only 33% have availed the transport facility which was arranged by either ASHA/AWW/FHW while as majority of the beneficiaries i.e. 67% have arranged the transport facility at their own cost.

6.1.24. It was also observed that 58% beneficiaries were accompanied to the health institution for delivery by their husbands, relatives etc and ASHAs accompanied to only 33% of beneficiaries to the health institution.

6.1.25. It was also observed from the field that 90% have received 3-ANC check-ups, 83% have consumed 100-IFA tablets and 89% beneficiaries reported that they have received 2-booster injections (TT1 & TT2).

6.1.26. With regard to provision of ANC services, 70% ANC services were provided by Doctors, 18% by ANMs and only 11% by ASHAs.

6.1.27. With regard to place of ANC provided, 77% received ANC through govt., and 15% received at home. This means majority of population depends upon govt. institutions for their health needs and there is a large scope for private sector to come forward for making investments in health sector.

6.1.28. It was observed from the field study that 87% beneficiaries have utilized post natal care after delivery. Out of which, most respondents mentioned doctors (52%) as the source of provider followed by ANM/AWW/Nurse (29%) and ASHAs (19%) as the source of postnatal care.

6.1.29. It was found that out of 300 beneficiaries, i.e. more than 77% beneficiaries have received PNC check up within 2-days after delivery and 23% have received PNC check up within 42 days after delivery.

6.1.30. The study shows that among 300 beneficiaries 92% immunization was recorded. About 89% have utilized 1BCG vaccine, 89% have received 3 DPT doses, 88% have received 0-polio vaccine, 92% have received 3-polio vaccine and 89% have received measles injection.

6.2. Problems in the implementation of the Scheme

6.2.1. With regard to mode of payment most of the payments i.e. 87% were made through cheque system as per the guidelines but most of the beneficiaries cited it as a major problem because of reasons such as non availability of rural banks, cumbersome procedure for opening up of bank accounts and the collection of cash from banks as hectic.

- 6.2.2. Another issue which needs serious concern from the higher officials involved in the scheme is with regard to JSY card and MCH card. It was observed from the field study that most JSY and MCH cards were not properly maintained as some beneficiaries showed their Cards without any date and month written which means routine immunization schedules are not properly monitored.
- 6.2.3. The study analysis also points out that the awareness among beneficiaries increased only due to the intervention of ASHAs. The awareness level was not much satisfactorily because most of the beneficiaries got aware about the scheme in the third trimester of pregnancy.
- 6.2.4. It was also observed from the field study that beneficiaries had very least knowledge regarding various components like transport facility (pick and drop), financial incentives etc.
- 6.2.5. So far as the disbursement of financial incentives are concerned, the scheme aims at that JSY incentive should be paid at the health facility immediately after the delivery and before discharge from the institution, but from the field study it was observed that delay in payments was a usual practice and most of the payments i.e. 64% were paid after the discharge of the patient from the institution which means guidelines are not properly followed.
- 6.2.6. The study also pointed out the fact that high expenditure acted as a major hindrance in case of home deliveries for not opting for institutional delivery in spite of the cash incentive available under the JSY.

6.3. Suggestions

The main suggestions recommended are presented below:

- 6.3.1. In order to reach the goal of 100% institutional deliveries, more capacity needs to be created in health systems to cater to this increased JSY-induced demand. In this context, there is a need for policy level thrust

with respect to the engagement of the private sector in JSY and private institutions should be accredited for the success of JSY.

- 6.3.2. The JSY scheme should be managed properly and utmost care should be taken for strengthening it at all levels, proper planning for fund utilization, service utilization and proper attention should be given to socially disadvantaged groups, areas and the government should take positive steps to set up facilities in these areas.
- 6.3.3. JSY guidelines provide detailed information about monitoring of the scheme at different levels. However, issues related to less payment, inordinate delays in making payments, early discharge etc. can be addressed largely through periodic monitoring visits by District Level Programme Managers. It is suggested that appropriate monitoring visits may be chalked out in advance.
- 6.3.4. Check-lists should be developed for use during monitoring visits. One of the important components of these visits should be interactions with the beneficiaries receiving services, grievance cells which redress problems should be established at the district level to specifically look into complaints of the beneficiaries.
- 6.3.5. Districts should be encouraged to have a sound communication activity plan for JSY. The plan should identify key target groups and relevant communication messages in order to meet knowledge gaps in the community regarding key features of the scheme.
- 6.3.6. Financial planning also needs attention. While district plans are supposed to provide the overall resource requirement, a system of giving adequate advance also needs to be devised so as to avoid interruptions in funds availability at the facility level.
- 6.3.7. It is also suggested that in extreme cases of non-availability of funds in an emergency, the officer in-charge of the facility should be in a position to use either Rogi Kalyan Samities funds or untied funds available. Some programme managers articulated the need for additional hands to handle payments, etc. especially at the high volume facilities.

- 6.3.8. JSY is not about promoting institutional deliveries alone. Programme objectives for reduction of maternal mortality and morbidity will be achieved when women coming to facilities receive quality delivery and post partum care services. In the absence of corresponding inputs for human resources, additional labour rooms and post natal beds, drugs and other supplies, quality of services etc have been a major casualty.
- 6.3.9. In many instances providers may not adhere to the evidence-based guidelines. Hence, it has been proposed to monitor the quality of facilities as an integral component of JSY monitoring so that service providers and programme managers also appreciate the importance of the focus in the quality of services provided and don't see their role only as mere distributors of money.
- 6.3.10. Study findings indicate that optimum engagement of ASHAs is yet to be achieved. Any changes in the payment schedule for ASHAs should be communicated in advance to the ASHAs. It will be useful to have a uniform charter of performance-based reimbursement prominently displayed for ASHAs. Grievance cells should also be set up to look into the complaints related to non-payment of ASHAs. The remuneration paid to ASHAs should be increased in a proper manner so that they become actively involved in the scheme.
- 6.3.11. The knowledge imparted in the ASHA training provided by the government is considered useful by the majority. But majority feel that further training is required for resolving practical problems they face in the field. However, the lack of orientation of the health staff other than ASHAs on JSY is a significant finding emerging from this study.
- 6.3.12. Less than half of beneficiary mothers knew about the various aspects of the JSY scheme like provision for escort by ASHA, stay during hospital delivery and cash assistance. In approximately half of the beneficiaries, the first contact of ASHA with the mother was for ANC in between the third trimester of the pregnancy. The ASHAs also played a major role in motivation for institutional deliveries in two-thirds of the beneficiaries. The JSY scheme has a continuum of services to be availed of by the

mothers. Services like three ANCs are perceived as useful by the majority of beneficiaries. However, the need for 100 IFA tablets figure low in the perception of all the respondents.

- 6.3.13. Most of the beneficiaries are of the view that there is a lack of transparency in money distribution as they are forced to induce the staff for getting the JSY Card or getting the cash assistance. Nearly all, except the district officials, feel that the JSY assistance comes late, mostly because of the complicated procedures of filling in and sending out forms or due to interruption of money flow to the PHC.
- 6.3.14. Most of the respondents feel that there are problems of communication and transport. Hiring transport at odd hours, high cost of transportation and even being denied by transporters are some of the barriers in availing of the JSY services.
- 6.3.15. Non -availability of 24×7 health centres and lack of staff are also other major deterrents for prospective mothers in accessing the JSY services.
- 6.3.16. There is very little or no involvement of PRI members in the scheme. So is the case with community leaders, women groups and local NGOs. There is an urgent need for active involvement of all the community members, women groups, NGOs and other civil society members in the scheme and adequate measures should be adopted in a proper possible time bound manner.
- 6.3.17. The policy level suggestions include reformation of the flow of funds from the states to PHCs, creation of core banking system, release of cash assistance under the scheme on the day of the delivery and simplifying the paper work for releasing of payment.
- 6.3.18. The process of making JSY Card should be made simpler and should be issued as soon as possible. The JSY Card issued in one state should be accepted in other states as this is a Centrally-sponsored scheme.
- 6.3.19. Thrust should be given on improving the quality of services and institutional capacity building for better performance.

- 6.3.20. There is an urgent need for focusing on the benefits of the scheme with special attention to clearing the myths and misconceptions about the scheme.
- 6.3.21. All recruited ASHAs should be trained within a time frame and post training field appraisal should be done and thereafter refresher trainings should be imparted in a planned manner.
- 6.3.22. All the recruited ASHAs should be given the remunerations which will enable them to meet both the ends and so that they will get actively involved in the scheme for its success.
- 6.3.23. Training of other categories of health staff on the scheme should be planned so that the services to expecting mothers are more user friendly.
- 6.3.24. Service centres should be provided with better infrastructure and supplies to provide round-the-clock services and to avoid unnecessary referrals and out of pocket expenses.
- 6.3.25. More impetus should be given to increase involvement of PRIs, community leaders, women groups and local NGOs for enhancing coverage of the scheme. Villagers should be informed through ASHAs about the 24×7 services available nearest to the village.
- 6.3.26. There should be policy level thrust for provision of financial incentives to female children in order to restrict female foeticide and increase the sex ratio of population particularly in J&K where sex ratio shows a declining trend.

6.4. Conclusion

Public spending on health is a small percentage of the total government expenditure and a huge portion of the expenditure is inefficient due to certain institutional factors such as health service access, health service delivery, lack of physical infrastructure, equipments, human resource, weak link between programmes and incompetent management of cash flow, drugs supply, quality of care, monitoring mechanism, referral and other communication act as a barrier to the success of public spending. Modern health care is a relatively newer concept in the rural masses most of which are

unaware of its advantages and are dependent on traditional system of health care, so in order to produce better health outcomes health policies and programmes should be framed to generate for modern health care and institutionalization of traditional health practices and efficiency of health care supply by providers should be checked at regular intervals and policies should be framed accordingly.



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Questionnaire

Questionnaire
**Impact of JSY on Utilization of RCH Services in Jammu and Kashmir-A
Case Study of District Pulwama**

General Information

Name of Block -----
Name of Village / town -----
Residence Rural/Urban -----
Name of Beneficiary -----
Age (yrs) -----
Educational level -----
Economic status APL/BPL/Any Other -----
Family size -----

Awareness

Have you heard about JSY? Yes/No

If yes, from whom you heard about JSY?

- a) ASHA b) ANM/AWW b) Govt. publicity
c) Friends, relatives etc d) others

When you came to know about JSY?

- a) Before pregnancy b) during pregnancy
c) After delivery d) can't say

What type of things you have heard about JSY?

- a) Free institutional delivery b) Monetary incentive is available
c) both a and b d) don't know

Who prompted you to avail JSY benefits?

- a) Husband, friends, relatives b) ASHA
c) ANM d) others

Registration process

Are you registered with JSY? Yes/No

If yes, when you were registered?

- a) At the time of 1st month of pregnancy b) 1st trimester of pregnancy
c) Before one month of expected date of delivery d) At the time of delivery

Who registered you with the JSY?

- a) ASHA b) ANM c) Doctor d) any other

Place of registration for JSY?

- a) District/Sub-District Hospital b) CHC/PHC
c) Anganwadi centre d) at home e) other

Whether you have JSY card? Yes/No

If yes, who assisted you to receive the JSY card?

- a) ASHA b) ANM c) Doctor d) Any other

Cash incentives

Have you received monetary compensation under JSY? Yes/no

If yes, how much Rs ----- year-----

When did you receive the cash incentive?

- a) Immediate at the time of delivery b) During one month after delivery
c) one to six months after delivery d) Delayed, specify reasons-----
e) Not received yet

Name of the person who delivered the cash incentive to the beneficiary?

- a) Doctor b) ASHA c) AWW
d) ANM e) other

For what reasons you have utilized JSY money

- a) Travel cost b) food c) drugs d) payment to doctor
e) Payment to nurse f) Neonatal care g) others

Mode of payment of the compensation

- a) Cheque b) cash c) not received

Antenatal care

Whether received 3 ANC checkups? Yes/No

Whether received 100 IFA tablets? Yes/No

Whether received TT1 or TT2 booster Injections? Yes/No

Who was the ANC provider?

- a) Doctor b) ANM/Nurse/Mid Wife/LHW c) AWW/Dai d) don't know

Number of months pregnant at the time of First ANC visit

- a) less than 4 months b) 4-6 months c) 6 and above d) don't know

Which were the sources of Antenatal Care provider?

- a) Govt. b) private/NGO only c) both a&b d) ANC received at home.

Delivery care

What was the place of delivery?

- a) Health institution (govt.) b) Health institution (Pvt.)
c) NGO/Trust d) Home.

What was your intended place of delivery?

- a) Health institution b) Home

If delivered at home, main reason for not opting institutional delivery?

- a) Cost too much b) no transportation/too far
c) Poor quality service d) Facility not open
e) no female health provider at health facility
f) Other

Who was the person providing assistance during delivery?

- a) Doctor b) ANM/Nurse/Mid Wife/LHW c) other health personnel
d) Don't know

What was the reason for not availing the service?

- a) Did not know about JSY b) had incomplete information
c) No one from health dept. approached me d) any other

Postnatal Care

Whether received all the three post natal checkups? Yes/No

What was the time between delivery and first post natal check up?

a)less than 4 hours b)4-23 hours c) 1-2 days d)3-41 days

e) Don't know f) no post natal check up

Who was the provider of first post natal check up?

a) Doctor b) ANM/Nurse/Mid Wife/LHV

c) other health personnel d) Don't know

Immunization services

Whether vaccination or immunization done? Yes/No

Whether received at least one BCG Vaccine? Yes/No

Whether 3-DPT-doses were given to the child? Yes /No

Whether zero polio vaccine was given to the child? Yes/No

Whether 3- polio vaccines were given to the child? Yes/No

Whether Measles Injection was given to the child? Yes/No

Problems

Did you face any problems in getting JSY card?

a)Cards were not available b) Formalities in getting card were cumbersome c) made any expenditure in getting the card d) any other

Did you face any problems in receiving JSY incentive? Yes/No

If yes, nature of problem

a) Received the cash in installments b) was paid through checks/drafts c) was asked to make some expenditure d) others

What were the reasons to opt for home deliveries?

a) Home delivery is more convenient b) insufficient money

c) Lack of transport d) other reasons

Suggestions

Did you think, this scheme is fruitful in providing health services? Yes/No

If yes, give suggestions -----

Have you any suggestion in improving this scheme? Specify -----

Are you satisfied with the services rendered by ASHA? Yes/No

If no, state reasons-----

What is your assessment about JSY incentive?

a) Good b) Satisfactorily c) can't say anything d) not well

Does this JSY incentive meet the expanses of medical care? Yes/No

Signature of Scholar -----

Name of Scholar -----