ANNUAL REPORT

2016-2017

POPULATION RESEARCH CENTRE

DEPARTMENT OF ECONOMICS
THE UNIVERSITY OF KASHMIR
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INTRODUCTION

Population Research Centre, located in the University of Kashmir, Srinagar was established by the Ministry of Health and Family Welfare, Government of India in 1985. This Centre is one in the network of 18 Population Research Centres established by the Ministry in Universities and Institutions of national repute. The Centre is provided 100 percent financial assistance in the form of grant-in-aid by the Union Ministry of Health and Family Welfare and is a Type -2 (not fully developed) Centre. The Centre caters to the demographic research needs of Jammu and Kashmir and undertakes continuous research on demographic, health and population related issues of the State. Like other Centres in the country, it also conducts research based on the requirements under the National Population Policy. The main focus of the research conducted in the Centre is on applied aspect although theoretical research is also encouraged. Emphasis is also given on utilisation of research findings for policy formulation and implementation in population and development programmes.

OBJECTIVES

The objective of the PRC is to carry out demographic research in Jammu and Kashmir. It continuously provides an independent and objective assessment of the working of various policies and programmes initiated from time to time in the field of health and family welfare in the State. The PRC has completed more than 100 research projects during the last 23 years. The main areas of interest are Evaluation of Population Policies and Programmes, Reproductive Health, School Health, AIDS, RTI/STI, Nutrition, Women's Status and other socio-demographic aspects of the State. It also contributes in the teaching of population related courses in the Departments of Statistics, Economics and Geography. Besides, organizing seminars, workshops and training programs, the PRC also acts as a data bank for the faculty members, research scholars, students and the community in general. The senior faculty of the Centre also provides consultancy services to various agencies for the conduct of social, economic, demographic and health surveys in the State. Further, the PRC is actively involved in the dissemination of the survey findings to planners, policy makers and the academic community.

ORGANIZATIONAL STRUCTURE

PRC is an important part of the Department of Economics. The Head of the Department of Economics also functions as the Honorary Director of the PRC. The Centre has 1 position of Associate Professor, 1 position of Assistant Professor, 2 positions of Research Investigators, 2 positions of Research Assistants, 1 position each of Upper Division Clerk, Lower Division Clerk and a Peon. The detail of the staff working in the PRC is as follows:

Details of the Staff Working in PRC Srinagar

S.No	Name of the Official	Title
1	Dr. Effat Yasmin	Honorary Director
2	Mr. Bashir Ahmad Bhat	Associate Professor
3.	Mr. S. Khursheed Ahmad	Assistant Professor
4	Mr. Imtiaz Ahmad Bhat	Research Investigator
5	Mr. Muneer Ahmad	Research Investigator
6	Mrs. Farida Qadri	Research Assistant
7	Javeed Ahmad Mir	Research Assistant
8	Mr. Ali Mohammed	UDC
9	Mrs. Shahida	LDC
10	Mrs. Samina	Peon

INFRASTRUCTURE

The Centre has a small library as a supplement to Department of Economics Library and University Library for the staff of the Centre. The collection consists of books on a variety of topics related to demography/population studies and health. Besides, the library houses a number of research reports in the field of population, health and family welfare from national and international agencies. The Centre has a highly configured Computer lab consisting of 8 computers and 2 laptops. The required demographic and statistical software packages are also available with the Centre. The Centre is connected with the ***V-SAT facility of the University*** *f*or round the clock Internet Services. Besides, the Centre has a direct telephone line, a dedicated fax line, a photocopier, a generator and an LCD.

GRANT-IN-AID RECEIVED

The Centre receives grant-in-aid from the Ministry of Health and Family Welfare on year to year basis towards salaries of staff, books and journals, stationery, T.A/DA and other infrastructural facilities. The grant-in-aid is released to the PRC in two instalments in a year on receipt of prescribed documents/undertakings and utilization certificates. The details of the funds received and utilized by the Centre from the Ministry since 1985-86 is as follows:

Year	**Amount Released**	**Amount Utilized**
1985-86 to 2006-2007	14663467-00	16232600-93
2007-2008	4295029-07	3174847-95
2008-20009	4325413-12	2439055-50
2009-2010	4136059-62	2684133-35
2010-2011	8150038-27	6870842-00
2011-2012	7139197-27	4894035-00
2012-2013	5764162-27	5103787-00
2013-2014	6899375-27	5667376-00
2014-2015	7549554-27	6484804-00
2015-2016	9213440-00	6930764-00
2016-17	9616296-00	7493583-00

LIST OF STUDIES COMPLETED DURING 2016-2017

S.No	**Title of Study**	Year of initiation	**Status**
1	Monitoring of National Health Mission State Programme Implementation Plan-2016-17: Jammu & Kashmir	2016-17	Completed
2	A Study of Facility Based New Born Care Units in Jammu and Kashmir.	2016-17	Completed
3	District wise Analysis of Promotion of Institutional Deliveries through District Hospitals, Community Health Centres and Primary Health Centres in Jammu and Kashmir.	2016-17	Completed

4	Trends and Patterns of Antenatal, Natal and Postnatal Care in Jammu and Kashmir.	2016-17	Completed
5	HMIS Data Quality Issues in Jammu and Kashmir and Ways to Improve it.	2016-17	Completed
6	Trends and Patterns of Child Sex Ratio at Birth in Jammu and Kashmir	2015-16	Completed
7	National Family Health Survey-4 (NFHS-4) in Jammu and Kashmir.	2015-16	Completed

SUMMARY OF STUDIES COMPLETED DURING 2016-17

1. Monitoring of National Health Mission State Programme Implementation Plan-2016-17: Jammu & Kashmir

The objectives of the exercise is to examine whether the State is adhering to key conditionalities while implementing the approved PIP and to what extent the key strategies and the road map for priority action and various commitments are adhered to by the State. The present study was conducted in 12 districts namely, Baramulla, Ganderbal, Budgam, Pulwama, Leh, Ramban, Doda, Kishtwar, Poonch, Rajauri, Udhampur and Kathua,. In each district information was collected from the office of Chief Medical Officer, District Hospital, 1 Community Health Centre, 1 Primary Health Centre, and 1 Sub Centre. We also conducted some exit interviews at each of these health facilities. District wise main findings of the study are as follows:

1.1 Baramulla

a. ANMs engaged under NHM have been transferred or attached to other places from their respective places of postings.
b. No C-section delivery is done during nights or on daily bases at CHC Tangmarg. The work on the construction of separate block for MCH is going on at snail's pace.
c. Transport facility for pregnant women under JSSK is a neglected area as very few women get this facility in the district.
d. There are high referrals of pregnant women from CHC Tangmarg. PHC Hariwatnoo has been made non-functional for MCH services as the lady MO posted there has been shifted to CHC Tangmarg.
e. There is a practice in the district that most of the women (with normal delivery) are discharged before 48 hours of their stay at the health facility.
f. The SNCU at DH has virtually been made as a child ward as all the infants (who give birth in the hospital) are brought to SNCU irrespective of their health condition.
g. ANMs/FMPHWs posted at SCs are put on night duties at CHCs/DH. These FMPHWs get a pre and post night break and this severely affects the functioning of the SCs.
h. EDL is not publically displayed or updated at any level in the district.
i. Most of the ASHAs were found not accompanying their patients to the health facility.
j. Prescription audit is not taking place in the district at any health facility. Record keeping under JSSK was found unsatisfactory at various health facilities.
k. Training is not a regular feature and proper experts are not invited for training.

1.2 Budgam

a. The district faces shortage of Anesthetists, Radiologists, Cardiologists, Ophthalmologists and other Specialists due to which, large proportion of patients are referred and forced to move to territory hospitals located in Srinagar city.

b. NHM has increased the demand for health services particularly for RCH services.
c. Institutional deliveries have improved and almost 100 percent of the deliveries take place at institutions. The DH is not able to conduct C-section deliveries on 24x7 bases and one of the reasons attributed to it is lack of staff quarters for both medical and paramedical staff.
d. Buildings for health centres need to be constructed on priority basis as 45 percent of PHCs and 78 percent of SCs are functioning in old or rented buildings.
e. ARSH clinic functions in DH and its performance was satisfactory.
f. The MDR/IDR was found one of the week area in the district. There is need to reorient all the staff with MDR/IDR and recording and reporting of deaths is also of great concern.
g. District and Block Monitoring Officers should visit all the facilities in the phased manner and match the information contained in the registers with HMIS formats to ensure quality of data.

1.3 Ganderbal

a. The district has a large number of attachments/post transferred/ working against the posts of both doctors and paramedical staff (both from regular and NHM side) at various levels.
b. ISM Doctors/RBSK Doctors/DEIC Doctors/ANMs engaged under NHM are put on night duties/roster duties at various levels which have become an impediment in smooth function of these programmes.
c. Except DH Ganderbal, all other health facilities provide ready-to-eat diet under JSSK.
d. Purchase of drugs and consumables under JSSK is being made on quotation basis as no district level/block level purchase committee is in place.
e. HBNC has not been fully implemented in the district. Transport facility for pregnant women under JSSK is a neglected area as very few women get this facility in the district. Toll Free number (102) for JSSK beneficiaries is not functional.
f. Trainings for doctors and para medical staff are not conducted on regular basis.
g. IEC component is very poor and pregnant women are not motivated to get their basic services from nearby PHCs, or SCs as such facilities are easily available there.
h. The SNCU is located in the other building in the DH which is away from the labour room and provides services during the day time only.
i. Maternity wing at CHC is functioning in old building; cleanliness was not maintained in the labour room. NBSU at CHC Kangan is in separate wing away from the labour room.
j. There is no USG facility at CHC Kangan for ANC patients on daily basis.

1.4 Pulwama

a. Compared to the other districts of the State, the situation of medical and paramedical staff in Pulwama district is better. Of the 203 regular positions of Specialists and MBBS doctors, only 172 (85 percent) are in place. Almost 92 percent of paramedical positions in the district are in place. NHM support has also lead to improvement in human resource, infrastructure facilities, drugs and fund availability. This has resulted in an increase in OPD services.
b. Non availability of proper teaching faculty and other infrastructural support in ANMT School is adversely affecting the quality of training being imparted in the ANMT School. There is a need to put in place regular staff in the ANMT School on priority basis.
c. Second ANM and Pharmacist sanctioned for SC Satpokhren has been attached with some other health facility. This has severely affected the working of SC. There is a need to transfer both these position back to Satpokhren.

d. The drugs supplied to the health facilities just meet less than 50 percent of the demand of drugs at the health facilities. As the Government has initiated the policy of providing free drugs to all patients, there is a need to assess the actual demand of various drugs and provide them to the health facilities.
e. State government has made it mandatory for doctors to write only generic names of drugs in capital letters on prescriptions, but all generic drugs are not available at the hospitals and therefore, the doctors generally do not write the generic names of the drugs.
f. Institutional deliveries have improved much and around 98 percent of the deliveries still take place at institutions. However, there has been a phenomenal increase in C-section deliveries in the district which needs to be arrested.
g. DH has started diagnostic facilities which otherwise are not available at the DH in Private Public Partnership (PPP) mode. This is a good initiative and needs to be replicated at CHCs also.

1.5 Leh

a. A sizable number of specialists, assistant surgeons, and various positions of paramedical staff has been deputed to various other departments (in and outside the district) which has created a vacuum in the district and many CHCs and PHCs are non-functional.
b. Transport facility for pregnant women under JSSK is a neglected area.
c. There is a practice in the district that most of the women (with normal delivery) are discharged before 48 hours of their stay at the health facility after the delivery.
d. IEC component is very poor and pregnant women are not motivated to get their basic services from nearby CHCs, PHCs, or SCs which results in maximum pressure on DH.
e. Record keeping in laboratories in some health facilities is not up to mark.
f. Family Planning is a neglected area and the use of various family planning methods has come down (as compared to previous PIP Monitoring) in the district.
g. AYUSH doctors engaged under NHM for various health facilities have been engaged in RBSK activities as no separate AYUSH doctors have been appointed under RBSK.
h. Prescription audit is not taking place in the district at any health facility.
i. Trainings for doctors and para medical staff are not conducted on regular basis.
j. HBNC kit has not been provided to ASHAs. The ASHA kit is not refilled on regular bases.
k. The quality of HMIS data is not so good, as still there is duplicity of data at various levels.

1.6 Ramban

a. There is an acute shortage of Specialists and Medical Officers in all health institutions in Ramban district. Although, NHM has been in a position to fill up critical gaps in human resource. But still DH, CHCs and PHCs in the district are short of doctors and Specialists.
b. The institutional deliveries in the district have improved from 60 percent in 2010-11 to 70 percent in 2016-17. Round the clock availability of caesarean section service at DH and day time availability at most of the CHCs is a big challenge.
c. The district has ensured almost 100 percent JSY payments both to beneficiaries and ASHAS through DBT, which is an achievement in itself.
d. Citizen charters available at all the facilities and is displayed in the local language at the entrance of the health facilities in almost all the facilities.
e. The norm of 48 hours stay in health facility is not being followed in most of the facilities visited. Beneficiaries were found to be leaving the facilities within 12 hours of deliveries due to lack of heating and non availability proper medical staff during night.

f. MMUs and Critical Care Ambulance need to be made functional/replaced keeping in view the topography of the State.
g. ASHAs 10 points performance monitoring is weak and needs strengthening. Replenishment mechanism of ASHA's drug kits was not streamlined and are facing regular stock outs.
h. NPCDCS not yet made functional and should be started across the district with a focus on the early screening of diabetes and hypertension and common cancers
i. The Tuberculosis Units have shortage of staff, diagnostic facilities and supplies. There is a need to establish a separate full-fledged RNTCP Unit in Ramban and detach it from District Kishtwar.

1.7 Doda

a. The district has acute shortage in the fields of Cardiology, Pathology, Radiology, Pediatrics, Ophthalmology, ENT and Dermatology. Therefore, there is a dire need to address at least the shortage of Specialist doctors at the DH.
b. Funds under NHM are not released in time, therefore, NHM staff does not get their salaries in time. Consequently, doctors working under NHM prefer private practice than attending their duties at the health facilities. Essential Drug List is maintained and displayed in all the facilities, however, it is not updated as per guidelines.
c. All the health facilities complained of inadequate supply of drugs (other than JSSK). There is a huge gap between the supply of drugs and their demand; this could be addressed to some extent by prescribing generic drugs, prescription audits and opening of Jan Aushadhi drug stores at CHC level.
d. Institutional deliveries have improved and 60 percent of the deliveries take place at institutions. Referrals from district hospital and CHC have not yet witnessed any major decline due to the non availability of adequate number of Gynecologists.
e. RBSK is functioning in the district without the medicines and funds, rather it has shifted its load on normal supply of medicines received.
f. SNCU has been made operational in the district and requisite infrastructure has also been put in place. Similarly, NBSU established at CHC Thathri is non functional due to lack of requisite manpower.

1.8 Kishtwar

a. All the health schemes are functioning smoothly under the supervision of the different Nodal Officers.
b. There are no sanctioned posts for Cardiologist, ENT and blood bank officer in the district.
c. NHM has vastly helped and contributed the district in filling the gaps for improvement of human resource, infrastructure facilities, drugs, diagnostics and funds.
d. Institutional deliveries have improved and 80 percent of the deliveries take place at institutions. Almost all the institutional deliveries take place at the government facilities.
e. The district has well established SNCU at DH. All the necessary equipments at SNCU have been installed. But the important position of child specialist is still vacant.
f. There is need to implement strictly free essential drug policy so that there are no pocket expenses of beneficiaries under JSSK especially during ANC.
g. JSSK is implemented and the free entitlements (medicines, diet, referral transport and user charges) under JSSK are provided to the beneficiaries. It was found that transport facility from home to facility is hardly provided. However, all the expectant mothers need to be sensitized about free entitlements under JSSK during ANC visits. Almost all the diagnostic facilities are

freely available under JSSK but thyroid testing facility like T3, T4 and TSH is neither available nor has been outsourced to facilitate the beneficiaries.

1.9 Poonch

a. Except DH Poonch, all other health facilities either do not provide or in very few cases provide ready-to-eat diet under JSSK to women during their stay at health facility.
b. Most of the women who deliver at the health facility are not sensitized about early breast feeding (with colostrums).
c. There is a practice in the district that most of the women (with normal delivery) are discharged within 3-4 hours after delivery.
d. Most of the ASHAs were found not accompanying their patients to the health facility.
e. Transport facility for women under JSSK is a huge issue as transport facility for pregnant women under JSSK is a neglected area. Even drop-back facility is very low in the district.
f. Some doctors who are associated with deliveries/ANC have mixed up their private practice with the official job and in the process have brought bad repute to the DH Poonch.
g. The record keeping at all the levels is not satisfactory.
h. Though the district has adopted the DTB transfer of JSY money but still there is a huge backlog in this regard.
i. HBNC kits have been received by the district for ASHAs but are short of many items.
j. CHC Surankote has the requisite staff for the blood storage unit but this facility is defunct.

1.10 Rajauri

a. The district faces shortage of staff in the fields of Cardiology, Pathology, Radiology, Pediatrics, Ophthalmology, ENT and Dermatology.
b. The CMO has organised various trainings to various categories of health staff in the district during 2015-16.
c. Computerized inventory management in the health facilities need to be prioritized. The procurement of sub standard drugs/medicines is to be addressed and stopped at the initial stage.
d. All the pregnant women are not registered in the first trimester. Hence, there is urgent need to reorient the ASHAs including the FMPHWs/ANMs regarding the importance of early registration of the pregnant woman.
e. Eighty two percent of the deliveries take place at institutions in the district. Referrals from district to Jammu also have experienced a decline.
f. Line-listing of severe anaemia cases should be stressed given the higher incidence of malnutrition among women and children in the district.
g. The immunization coverage in the district is low despite the fact that HMIS shows a high coverage. More efforts are needed to improve the immunization in hilly and remote areas and particularly among the Gujjars, Bakerwals and Nomads.

1.11 Udhampur

a. There is dearth Medical Officers in the district from both regular as well as from NHM side and because of it patient care is not done properly. Most of the MOs appointed under NHM or from regular side are posted at DH and CHCs while as the rural parts of district remain unattended.
b. Medical officers posted at PHC Ghordi have many other assignments and they are not able to attend the PHC on regular bases.

c. Most of the women who deliver at the health facility are not sanitized about early breast feeding (with colostrums) as most of women breast fed their infants after a long time.
d. Meals during delivery time at PHC level is not provided to the eligible women.
e. Most of the ASHAs were found not accompanying their patients to the health facility.
f. Transport facility for women under JSSK is a huge issue as transport facility for pregnant women under JSSK at the time of delivery is a neglected area.
g. SNCU is without a pediatrician and almost defunct as the only MO appointed for SNCU is being put on general duty.
h. There is a huge backlog under JSY to ASHAs and beneficiaries.
i. The information among pregnant women for PPIUCD was found to be a neglected area.
j. Mass awareness programmes regarding immunization, family planning and other related services was found unsatisfactory.

1.12 Kathua

a. The non availability of proper teaching faculty and other infrastructural support in ANMT School Kathua is adversely affecting the quality of training being imparted in the School. The school building as well as the Hostel is in dilapidated conditions and both needs major repairs.
b. Essential Drug List has been prepared for various facilities but an updated list of drugs available at the facility is not displayed in any of the facilities visited by us.
c. With the functioning of the J&K State Medical Supplies Corporation, drug supply has improved in all the facilities and for the first time during the last 4 years we could find adequate supplies of drugs at PHC and SC level. Availability of IFA has improved in the health facilities.
d. Institutional deliveries have not improved much and around 30 percent of the deliveries still take place at home. Institutional deliveries mainly take place at DH. Due to the non availability of Gynecologists at CHC, referrals from CHC to Kathua/Jammu based institutions have not yet witnessed any major decline.
e. Despite irregular/late release of funding, district has been in a position manage free drugs and diet under JSSK. Free referral transport is ensured in all facilities visited by us.
f. JSY payments in the district have been streamlined to a great extent. The district has started implementation of DBT system for disbursement of JSY incentive.
g. SNCU at DH and NBSU at CHC Basholi have been made operational in the district but due to lack of manpower, services of CHC Basholi units are grossly underutilized. Information about services provided by SNCU shows that referral of infants from DH to Jammu has showed signs of decline. No infant is shown to have died in SNCU during the last one year.
h. HBNC kits have been provided to ASHA and they have conducting HBNC visits.
i. RBSK in the district has been started and it is still in the infancy as the DEIC has not yet been established. Referred children do not get any special treatment at referred institution. Further, proper mechanism for cost estimation and approvals for referral cases is somewhat complicated and needs to be simplified.

2. A Study of Facility Based New Born Care Units in Jammu and Kashmir.

The objective of this study is to assess the functioning of the Specialized New Born Care Units (SNCUs) in Jammu and Kashmir. The study covered 5 SNCUs located in districts Baramulla, Ganderbal, Leh, Udhampur and Poonch. The main findings of the study are as follows:

1. Most of the SNCUs and NBSUs under reference have started functioning in 2011-12. Every SNCU was unique in its lay out and suffered from its own space constraints making it difficult to adhere to the norms of the laid down designated spaces.
2. Most of the SNCUs have paucity of staff. It was found that of the 5 SNCUs, only two (Baramulla and Leh) have by and large the sanctioned manpower in place. Most of the SNCUs are without a pediatrician and Pediatricians are generally not ready to work in remote areas on contractual basis with low salaries.
3. The number of beds sanctioned in the SNCUs is not commensurate with the number of deliveries performed at District hospitals. Nearly all the essential equipments were available in almost all the SNCUs. However, the incidence of non functional equipment was high at some of the units like Leh, Udhampur and Poonch. The reason could be high work load as compared to other units under reference.
4. It was found that all the SNCUs are mostly dependent on general laboratory of the hospital for diagnostic services.
5. No Annual Maintenance Contract (AMC) has been done at the time of setting up of the units. Serious effort is needed for repair of non-functional equipment at these SNCUs otherwise the equipment would be near their shelf life and the frequency of breakdown would further increase in all the SNCUs.
6. Essential drugs are available and supplied regularly to all the SNCUs except Ganderbal. Supply of disposable items like gloves, IV cannula and needles are usually present but the quantity needs to be increased.
7. Coordination with peripheral units is strong in Leh as referral transport facility is available under JSSK from the peripheral health facilities. In other districts neonates were generally referred directly to tertiary care hospitals.
8. The number of inborn cases formed the bulk of admissions in all the SNCUs. For out born cases there is always a probability of attending private clinics or getting admitted in other government hospitals especially nearer to capital cities.
9. During 2015-16 nearly 80 percent of the babies were discharged after treatment and 16 percent were referred to higher facilities. Three percent deaths were reported during the same period and 36 percent of them died within 24 hours after admission.
10. The four major causes of morbidity experienced in the SNCUs were found as Asphyxia, Sepsis, Prematurity and Macanium Asperiation Syndrome. It was noticed that during 2015-16 and 2016-17 asphyxia is the most common cause of morbidity in all the SNCU admissions.
11. In most of the cases free referral transportation has been provided to all neonates. The interviews conducted with the beneficiaries also revealed that hardly any free transport facility is provided for their neonates at the time of admission or discharge from the hospital.
12. Beneficiaries reported that free diagnostic facilities are provided during their stay in the hospital. But some blood tests and USGs are also done from outside.
13. The information on funds received and utilized during 2016-17 shows that only two SNCUs Baramulla and Ganderbal have received funds worth Rs. 10.0 lack and Rs.80,000 respectively.
14. During an assessment of community perception out of 27 respondents 18 were (66%) aware of the presence of SNCU before having availed the service.
15. The attitude of both doctors and nurses was perceived to be nice by all the respondents interviewed. The satisfaction amongst the community was exclusively a function of the treatment outcome. Ninety eight percent of respondents were satisfied with the care rendered at the SNCU.

3. District wise Analysis of Promotion of Institutional Deliveries through District Hospitals, Community Health Centres and Primary Health Centres in J&K.

The study uses HMIS data for 2011-12 to 2015-16 to examine whether there has been any shift in the deliveries from State Hospitals to District Hospitals and sub District Hospitals. Further, it also analyses the trends and patterns of cesarean section deliveries among various districts of Jammu and Kashmir. The main findings of the study are as follows:

1. The gap between the number of cases registered for ANC and actual number of deliveries seems to be very wide, which clearly indicates that there is huge duplication in reporting of ANC cases in almost all districts of the State.
2. The HMIS data portrays that the pace of institutional deliveries has picked up in the State as a whole as 86 percent of the reported deliveries have been delivered at various health institutions in the State during 2011-12. Institutional deliveries have increased by 4 percentage points during 2011-2016 and it has reached 90 percent during 2015-16.
3. There is 3 percent points increase in the institutional deliveries performed at district hospitals alone during the years 2011-12 to 2015-16 from 58 percent to 61percent.
4. Similarly, there is 5 percent points increase in the institutional deliveries performed at CHCs during the years 2011-12 to 2015-16 from 28 percent to 33 percent.
5. The data also shows that there is 3 percent points decrease in the institutional deliveries performed at PHCs during the years 2011-12 to 2015-16 from 11 percent to 8 percent.
6. Simultaneously, there is also 2 percent points decrease in the institutional deliveries performed at SCs during the years 2011-12 to 2015-16 from 3 percent to 1 percent.
7. The HMIS data significantly shows that in Jammu division the trend of institutional deliveries is in increasing mode towards the district hospitals than the Kashmir division. In Kashmir division the trend of institutional deliveries is also in increasing mode towards the CHCs than the Jammu division. However there is no variation so far as the deliveries conducted at PHCs and SCs are concerned in both the divisions.
8. The private nursing homes are either not reporting the deliveries or are under reporting the deliveries conducted by them. These nursing homes should be directed to report the deliveries as per HMIS guidelines.
9. Reluctance to use institutional services may also be a problem with many mothers preferring to deliver at home even when services are affordable, accessible and of acceptable quality but such mothers need strong motivation by the ASHAs and ANMs.
10. Services in general need to be made more user-friendly, higher quality up to PHC level and the community should be mobilized to utilize them.
11. The belief that delivery is a natural process not requiring medical attention is thought to be particularly strong in some hilly areas of the State and hence prefer to deliver at home. That is why some districts of Jammu division have still high rate of home deliveries as per HMIS report which needs special treatment.
12. The cash incentive succeeded in reducing the inequalities in maternal health outcomes, it needs to be supported by the provision of quality health care services including EmOC at the PHC level so that the workload of district hospitals could be shifted to other health facilities.

4. Trends and Patterns of Antenatal, Natal and Postnatal Care in Jammu and Kashmir.

The broad objective of the present study is to examine the trends in antenatal, postnatal care and delivery in Jammu and Kashmir at district level. In this process we also aim to examine the authenticity, consistency and uniformity of HMIS data pertaining to some selected maternal health during the last four years (2012-13 to 2015-16). The main findings of the study are:

1. ANC registration is not consistent with expected number of pregnancies in some districts of J&K particularly the capital districts of Srinagar and Jammu.
2. Of all HMIS indicators ANC registration is the most problematic one. For each expected pregnancy, HMIS has registered 1.8 ANC registrations indicating duplication of ANC registration. Therefore, there is a need to stop this duplication of ANC registration. Reasons for this duplication need to be investigated, so that remedial measures can be initiated to address the problem of over reporting and duplication of ANC registration.
3. Private health institutions are either not reporting their performance or are under reporting the deliveries. This is one of the reasons for lesser number of reported deliveries in the State. State needs to take some hard steps to compel the private nursing homes to report their performance as per HMIS guidelines.
4. Further, some districts like Doda, Rajouri are under reporting home deliveries resulting in lesser number of reported deliveries as compared to expected number of deliveries.
5. Institutional deliveries have registered a sharp increase in the State but other credible surveys have shown that home deliveries account for about 10-15 percent of all deliveries. This means all home deliveries are not reported by ANMs at Sub Centres. There is a need to investigate the reasons why ANMs at SCs are not reporting all home deliveries.
6. Due to the heavy workload at District and State Maternity Hospitals, and lack of manpower, it is becoming very difficult to record the information about all the services delivered by these hospitals. Some of the services are not recorded at all and for some services, hospitals record the information on IPD/OPD tickets only, which is not available at the time of compiling of HMIS reports. This results in under reporting of services by District and State Maternity Hospitals. This issue can be addressed by putting in extra HMIS person in District/State Hospitals based on work load. HMIS person at these institutions should be used for only HMIS related work and not for disbursement of JSY or managing JSSK funds.
7. The distribution of IFA has suffered a severe setback in all districts once its supply by Directorate of Family Welfare was stopped after implementation of JSSK. Health facilities had no idea that they also have to purchase IFA out of JSSK funds.
8. The data quality of Srinagar and Jammu districts is very poor. There is a need to give more attention to these districts as these two districts account for 33 percent of reported deliveries. If we are in a position to improve recording, maintaining, reporting and uploading of HMIS in these two districts, HMIS data quality of J&K will improve to a great extent and it can be used in micro-level planning, programme implementation and effective monitoring.

5. HMIS Data Quality Issues in Jammu and Kashmir and Ways to Improve it.

The present study entitled "HMIS Data Quality Issues in District Hospitals, CHCs, PHCs and SCs in Jammu and Kashmir" was carried out during October- December 2016 in Kishtwar, Pulwama and Doda. We collected information from the District Hospitals of these three districts. In each district we also collected information from 1 CHC, I PHC and 1 SC. We examined the HMIS formats submitted by these facilities for the period July-September 2016 and matched them with the

information contained in the registers and also with the information uploaded on HMIS website. The major findings of the study are given below.

1. Over the last 3 years, HMIS in the State has improved to a great extent. The districts have shifted to facility based uploading of data. Block Programme Management Units need to carefully examine all HMIS formats for completeness, accuracy and examine all data validation issues and inconsistencies in reporting formats before uploading them and discuss them in the monthly meetings. They should also visit the SCs and PHCs in a phased manner and match the HMIS reports with the information contained in various registers.
2. MCTS and ANC Registers are available. FMPHWs generally use MCTS register for preparing HMIS format and thus include some services which have not been provided by the facility.
3. Almost all FMPHWs have no clarity between HMIS and MCTS. When HMIS reports are prepared from MCTS registers, this completely violates the concept of facility based reporting as it results in over reporting of services. It was also found that there are misconceptions regarding various HMIS reporting terminologies. Therefore, it is suggested that training of the health workers should become a continuous and integral part of the monthly meetings.
4. Generally services are not denied if the clients do not belong to the catchment area of SC/PHC. Facilities generally do not report such services because it is assumed that such services will be reported by the facility with which the client is actually linked. This step has been taken to stop the duplication, but it is resulting in under reporting of services.
5. IFA was not available in most of the facilities visited by us. Most of these facilities had irregular or no IFA supply. Due to the irregular supply, IFA is provided in installments and each installment is reported as 100 IFA given. In some cases, FMPHWs have stopped recording and reporting of IFA. There is a need to streamline the IFA supply.
6. Equipments are available in some SCs but HB tests are not conducted due to lack of training. Most FMPHWs report HB level from MCTS register, despite the fact most of these tests have been conducted at PHCs/CHCs/DH. PHCs generally do not maintain the results of the HB tests conducted and there is therefore no record available with the PHC which they can use to fill up the HB indicators in HMIS format. Therefore, HB reporting (HB<11 and <7) is far from grassroots reality. There is a need to direct all FMPHWs to report only those cases that have been tested and detected at their facility. Further, there is a need to provide requisite stationery to labs and develop a uniform register for recording the results of investigations, so that they can report the HB indicators properly.
7. Record and report immunizations doses in the service area provided by other facilities also leading to multiplicity of reporting.
8. SC and PHCs generally do not maintain records of the Oral Pills and Condoms distributed by them. Sometimes they report for HMIS by counting the present stock. However, most of the SCs and PHCs report OP and Condom figures without maintaining any record.
9. HMIS uploading is regular. However, for unknown reasons BPMUs sometimes resort to fudging of information at the time of uploading. This is substantiated by the fact that there is hardly a facility where HMIS figures report in format match with what has been uploaded on HMIS web portal.
10. All the health facilities need to be encouraged to use HMIS in planning, implementation and supervision of public health services. It will make the workers to realize the importance of good data quality.

11. A lot of variations were observed in the figures submitted by the DHs, CHCs, PHCs and SCs and those available on web portal. There is a need to investigate why these differences are there and who takes this decision to change the figures submitted by the facilities. Block Monitoring and Evaluation Officers be directed not to fudge the figures and instead return the formats back to the facilities for rectification of errors.

6. Trends and Patterns of Child Sex Ratio at Birth in Jammu and Kashmir.

The objective of this study was to analyze the district wise variation in child sex ratio in Jammu and Kashmir during 2001-2011 and find out the reasons for the decline in the child sex ratio during this period. We use data from Census, Sample Registration System, Civil Registration System and National Family Health Survey-3. HMIS data was used to analyse the sex ratio at births at district level to portray the recent trends in sex ratio at birth in Jammu and Kashmir. The main findings of the study are as follows:

1. The overall sex ratio in Jammu and Kashmir has declined but the situation is not as grim as depicted by Census, 2011. If we calculate the sex ratio for the population age 7 years and above, there is a dramatic improvement in the sex ratio in the State.
2. However, once we look at the Child Population, 0-6 years, the Census has shown a sharp decline in child sex ratio. But at the same time it has shown an increase in the percentage of population age 6, indicating that there has been an increase in crude birth rate in Jammu and Kashmir during the 6 years before the Census. Surprisingly, it is only J&K where an increase in the fertility and increase in the proportion of children 0-6 can be observed. All States which are not so developed as J&K have also witnessed a decline in fertility. Further, other credible sources of data like SRS, NFHS, HMIS show a clear decline in the fertility rates of J&K, therefore, there is a contradiction between Census CBR and CBR based on other credible surveys in Jammu and Kashmir. This clearly indicates, that Census 2011 child population is over reported in various districts of J&K.
3. While calculating the CBR at regional level, it can be observed, that this issue of contradiction in fertility estimates between Census and Survey is more evident in Kashmir region than in Ladakh and Jammu region. Within the Jammu region also there are only three districts namely Jammu, Samba and Kathua, where there is an agreement in fertility between the two sources. Thus these three districts have really witnessed a decline in child sex ratio. While analyzing the CBR and Child Sex Ratio, it was found that districts which have a very low sex ratio happen to be districts which have a high CBR particularly in South Kashmir.
4. If we analyse the age specific Child Sex Ratio, it can be seen that CSR increases with age and in fact the sex ratio for most districts in the State particularly in Kashmir region is fairly high for ages 2-6. CSR is low for all ages in Jammu, Kathua, and Samba, these three districts are notorious for sex selective infanticide and these three districts had a low child sex ratio in 2001 also. There is also a very strong negative correlation between sex ratio at age 0 and percentage of population age 0 among various districts of the State, indicating that the districts which have reported a higher percentage of child population have a very low child sex ratio.
5. The results of this study show that the SRB is extremely very low in almost all districts particularly in districts with a high proportion of children age 0 and the difference in sex ratio between age 0 and age 1 in some districts is more than 200 and nowhere in the world, this much of decline in sex ratio has taken place in a single year and nowhere in the world, an increase in fertility of the magnitude of J&K has taken place in a single year, therefore, it is more likely that child population in most districts of J&K particularly in Kashmir region is over reported and in

this process of over reporting, the enumerators seem to be biased in favor of male children, probably due to the fact that son preference in the State is as strong as in other parts of the country.

6. The SRB in the State as per HMIS has increased slightly during the last 7 years. The SRB is almost normal in the districts located in Kashmir and Muslim majority districts located in Jammu region. However, there is not much improvement in SRB in Jammu, Udhampur, Samba and Kathua. So government efforts which due to Census 2011 results were misdirected on Kashmir region should now focus more on Jammu region and there is a need to implement PCPNDT Act strictly in the Jammu region particularly in Kathua, Samba, Jammu and Udhampur districts and some areas of Rajauri like Sunderbani and Nowshera.

7. National Family Health Survey-4 (NFHS-4) in Jammu and Kashmir

The National Family Health Survey 2015-16 (NFHS-4), the fourth in the NFHS series, provides information on population, health and nutrition for India and each State / Union territory. NFHS-4, for the first time, provides district-level estimates for many important indicators. Ministry of Health and Family Welfare, Government of India designated International Institute for Population Sciences, Mumbai as the nodal agency to conduct NFHS-4. NFHS-4 fieldwork for Jammu & Kashmir was conducted by Population Research Center, University of Kashmir, Srinagar from 31 January 2016 to 16 November 2016 and gathered information from 17,894 households, 23,800 women, and 5,584 men. Fact sheets for Jammu and Kashmir State and each district of Jammu & Kashmir have been prepared by IIPs, Mumbai and printed by the PRC, Srinagar. These fact sheets provide information on key indicators and trends for Jammu & Kashmir and each of the 22 districts. **These fact sheets are also available on the website of the IIPS and Ministry of Health.**

No. G.20011/16/2016--Stats(PRC Srinagar)
Government of India
Ministry of Health & Family Welfare
Statistics Division

Nirman Bhavan, New Delhi,
Dated the 28 August, 2017

To

The Pay & Accounts Officer (Sectt.),
Ministry of Health and Family Welfare,
Nirman Bhavan,
New Delhi.

Sub: Utilization Certificate for Grant-in-aid (Recurring) released during 2016-17 to Population Research Centre, University of Kashmir, Srinagar - regarding

Sir,

I am directed to enclose a copy of the Utilization Certificate forwarded by the Population Research Centre, University of Kashmir, Srinagar vide their letter no. (UC-PRC)KU/17 dated 10th August, 2017 and e-mail dated 22nd August, 2017 in respect of the following grants released to PRC, University of Kashmir, Srinagar :

S.No.	Sanction Letter No.	Date	Amount (Rs.)
1.	G.20011/16/2016-Stats(PRC Srinagar)	31.10.2016	32,04,000/-
2.	G.20011/16/2016-Stats(PRC Srinagar)	17.03.2017	40,79,000/-
TOTAL			72,83,000/-

This is to certify that out of the above mentioned amounts together with the Unspent Balance of Rs. 22,82,676/- allowed to carry forward from previous year 2015-16 along with Bank Interest for the year 2016-17 amount of Rs. 50,620/-, a sum of Rs 74,93,583/- has been utilized for the purpose for which it was sanctioned and that the Unspent Balance of Rs.21,22,713/- at the end of the year will be adjusted with the onwards grants-in-aid of the next year, i.e 2017-18.

Certified that I have satisfied myself that the condition on which the grants-in-aid was sanctioned have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

Kind of checks exercised:
Utilization Certificate received from PRC vide their letter no. (UC-PRC)KU/17 dated 10th August, 2017 and e-mail dated 22nd August, 2017 (Copy enclosed).

Yours faithfully

(Navanita Gogoi)
Director

Copy to :
(i) The Registrar, University of Kashmir, Hazratbal, Srinagar-190006
(ii) The Director, Population Research Centre, Department of Statistics, University of Kashmir, Hazratbal, Srinagar-190006