SUPREME AUDIT INSTITUTION OF INDIA
लोकहितार्थ सत्यनिष्ठा
Dedicated to Truth in Public Interest

Report of the Comptroller and Auditor General of India on Public Health Infrastructure and Management of Health Services for the period ended March 2022

Government of Union Territory of Jammu and Kashmir

Report No. 2 of 2025

(Performance Audit - Civil)

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Comptroller and Auditor General of India
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Public Health Infrastructure and Management of Health Services
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PREFACE

This Report of the Comptroller and Auditor General (CAG) of India on Public Health Infrastructure and Management of Health Services for the period ended March 2022 has been prepared for submission to Lieutenant Governor of Jammu and Kashmir under Section 72 of the Jammu and Kashmir Reorganisation Act 2019 for laying in the Legislative Assembly.

This Report contains IX chapters.

Chapter I contains the organisational setup and brief introduction about the Public Healthcare facilities in the UT of Jammu and Kashmir.

Chapter II contains the audit findings pertaining to availability of Human Resources in the Health and Medical Education Department.

Chapter III contains the audit observations on availability of Healthcare services in Jammu and Kashmir (Outpatient Department and In-patient Department)

Chapter IV contains the audit observations relating to availability of drugs, medicines, equipment and other consumables.

Chapter V contains the audit observations pertaining to availability of healthcare infrastructure in J&K.

Chapter VI contains significant audit findings relating to budgetary outlay and expenditure of the Health and Medical Education Department.

Chapter VII deals with the audit findings pertaining to implementation of Centrally Sponsored Schemes in J&K.

Chapter VIII contains the significant findings pertaining to adequacy and effectiveness of Regulatory Mechanisms.

Chapter IX deals with the Sustainable Development Goal 3 and its adoption in J&K.

The instances mentioned in this Report are those which came to notice during test-check of records of 2016-17 to 2020-21. Instances relating to the period subsequent to March 2021 have also been included, wherever necessary.

The Audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

National Health Policy (NHP), 2017 was adopted to strengthen and prioritise the role of the Government in shaping health system in all its dimensions. Considering the goals laid down in NHP 2017 and experience in COVID-19 pandemic, the Performance Audit (PA) on "Public Health Infrastructure and Management of Health Services" was conducted to assess the adequacy of financial resources allocated, availability of health infrastructure, manpower, machinery and equipment in the Health Institutions (HIs) as well as efficacy in the management of health services in the State. The Performance Audit also covers the efficacy of the regulatory framework being enforced by the Government to regulate public/private health sector, schemes being implemented by Government of India through State Government and overall linkage with the Sustainable Development Goal-3. The audit was conducted for the period 2016-21 but wherever feasible, the data has been updated up to 2021-22 or later.

The Ministry of Health and Family Welfare, Government of India, has issued (first in 2007 and revised in 2012 and 2022) a set of uniform standards called the Indian Public Health Standards (IPHS) to improve the quality of healthcare delivery in the country and serve as a benchmark for assessing performance of healthcare delivery system. The IPHS norms for District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub-Centres (SCs) prescribe standards for the services, manpower, equipment, drugs, building and other facilities. These include the standards to bring the health institutions to a minimum acceptable functional grade (indicated as essential) with scope for further improvement (indicated as desired).

In addition to IPHS, various standards and guidelines on healthcare services issued by Government of India such as the Assessor's Guidebook for Quality Assurance; Bio-Medical Waste Management Rules; and Drugs and Cosmetic Rules were used to evaluate the healthcare facilities in health institutions.

As per National Family Health Survey (2019-21) and Sample Registration System (SRS) Bulletin 2020, the health indicators in Jammu and Kashmir (J&K) in respect of Infant Mortality Rate (16.3 against national average of 35.2), Neonatal Mortality Rate (9.8 against national average of 24.9 per 1,000 live births), death rate (4.6 against national average of 6 per 1000 population) and girl children born (976 against national average of 929) for every 1,000 boys were better than the national average.

However, for health indicators like mothers whose last birth was protected against neonatal tetanus, mothers who consumed iron folic acid tablets for 100 days (29.8 *per cent* against national average of 44.1 *per cent*) and 180 days (15.9 *per cent* against national average of 26 *per cent*), average out-of-pocket expenditure per delivery in a public health facility (₹ 5,145 against national average of ₹ 2,916) births delivered by Caesarean section in public (42.7 *per cent* against national average of 14.3 *per cent*) and private (82.1 *per cent* against national average of 47.4 *per cent)*

health facilities and sex ratio of the total population (females per 1,000 males) the national indicators were better than UT.

In respect of Sustainable Development Goals (SDGs), the UT adopted 34 indicators out of 41 indicators at the national level; covering 12 targets at UT level out of 13 targets at national level.

As far as Ayushman Bharat (AB) is concerned, we have included findings related to Health & Wellness Centres (HWC) and have also considered implementation of AB while making recommendations in various areas of health sector.

There were persistent shortages in all the cadres in the health institutions. Government had not ensured availability of posts in the health sector as the sanctioned posts were not in keeping with the population to be served, affecting the health services adversely. This shortage was quite high in several key posts such as doctors, staff nurses, paramedical and other staff who play a very important role in delivering comprehensive healthcare to the beneficiaries. Available manpower including the crucial manpower has not been distributed uniformly across the districts. Against the sanctioned strength of 46,115 posts, the UT of J&K had 30,745 (67 *per cent*) doctors, nurses and paramedical staff as of March 2022. One government doctor was serving a population of 2,191 (2,461 in case of allopathic doctors) in the UT of J&K. The ratio of availability of doctor was better than the States of Haryana (4,081 doctors for 2.51 crore people i.e. one allopathic doctor per 6,212 persons) and Punjab (one allopathic doctor for 6,390 persons).

There was skewed distribution of manpower as shortfall of overall manpower was lowest (11.52 *per cent*) in Kulgam District and highest (43.55 *per cent*) in Kishtwar District.

There was a shortage of specialists in Health and Medical Education Department (H&MED). Shortage of manpower in District Hospitals (DHs) had affected delivery of medical services resulting in either the patients having to wait in queues outside the OPDs for a long time or compelling the patients to approach other hospitals having such facility.

Under the National Health Mission (NHM), shortage of doctors, paramedical staff and nurses in the UT of J&K was respectively 19 *per cent,* 08 *per cent* and 16 *per cent* in 2021-22. In the six sampled districts, although most of the emergency services were available in all the sampled District Hospitals except DH, Handwara, availability of Emergency Operation Theatre was not available in seven SDHs (out of 18 test-checked). Blood storage unit was not available in 10 SDHs (out of 18 test-checked) and nine CHCs (out of 10 test-checked).

The Outpatient Department (OPD) services of ENT, Psychiatry, Ophthalmology and Skin & VD were not available in eight, nine, six and 13 DHs respectively. Moreover, all the required essential OPD services were not available in all 18 test-checked Sub-District Hospitals (SDHs) and all OPD services as required as per IPHS norms

were not available in the 10 test-checked Community Health Centres (CHCs). Registration counters were also not found adequate in Tertiary Level Hospitals (TLHs) and District Hospitals (DHs).

All In-patient Department (IPD) services as per IPHS 2012 norms were available in only three DHs out of six test-checked DHs. In respect of 28 sampled SDHs/ CHCs, all IPD services were available in only seven SDHs and one CHC. OT services were available in all test-checked DHs. Out of sampled 18 SDHs, OT facility was available in 11 SDHs. Out of 52 sampled PHCs, only two PHCs (Majalta and Achabal) had OT facility for surgical procedures such as Vasectomy, Tubectomy and Hydrocelectomy.

Ambulance service was available in all test-checked DHs and SDHs/ CHCs except SDH Langate. However, ambulance service was available in only 19 out of 52 sampled PHCs.

The Discharge Rate was more than 90 *per cent* in five out of six sampled DHs (except DH Ramban) which indicated that the hospitals are providing healthcare facility to the patients efficiently. The referral out rate in respect of five out of six sampled DHs was less than 10 *per cent* whereas the referral out rate in respect of DH Ramban was higher as compared to other HIs. It was also observed in case of DH Ramban that there was shortage of doctors, non-availability of essential drugs and poor availability of equipment.

Audit assessed availability of drugs against essential drugs list (EDL) as notified by the H&MED and equipment listed in IPHS norms. There was shortage of essential drugs and equipment in all test-checked HIs. Availability of the prescribed essential equipment was also found deficient in test-checked institutions. There was delay in finalisation of rate contracts that would have had adverse impact on timely supply of drugs/ equipment to the health institutions. There was delay in empanelment of laboratories for testing and analysis of drugs and in furnishing of test/analysis reports by empanelled laboratories. Non-implementation of e-Aushadhi/ Drug and Vaccine Distribution Management System for the entire chain of drug supply was also observed.

Estimation, planning and creation of requisite infrastructure facilities are essential for ensuring the provision of optimum level of healthcare facilities. There was inadequate availability of Sub-Centres (SCs) and CHCs in the UT of J&K. In the six sampled Districts, there was shortage of SCs (45 *per cent*) and CHCs (81 *per cent*)**.**

Although the requisite number of Health and Wellness Centres (HWCs) have been upgraded, there was shortage of infrastructure, availability of services, human resources, diagnostic services etc. in the HWCs in the six selected Districts. Out of 415 construction works taken up for execution under National Health Mission, Prime Minister's Development Programme (PMDP) and Languishing Projects programme, 177 works were completed and 238 works remained incomplete. Works under District Plan, National Bank for Agriculture and Rural Development (NABARD) and Border Area Development Programme (BADP) remained incomplete either due to dispute or

non-execution of balance works. Out of sampled 10 CHCs, six CHCs did not have beds as per norms. Out of 18 sampled SDHs, 11 SDHs had less than 31 beds. Out of 52 selected Primary Health Centres (PHCs), seven PHCs were functioning without beds and 33 PHCs were lacking required number of beds as per Indian Public Health Standards (IPHS) 2012.

Total expenditure of GoJ&K during 2016-17 to 2021-22 was ₹ 3,60,198.78 crore while expenditure on the health sector was ₹ 25,127.63 crore against budget allotment of ₹ 30,513.98 crore. Expenditure on Health sector *vis-a-vis* total expenditure of the erstwhile State/ UT Government had increased from 5.84 *per cent* in 2016-17 to 7.98 *per cent* in 2021-2022. Expenditure on the health sector accounted for 6.98 *per cent* of the total expenditure of the erstwhile State/ UT for the period 2016-17 to 2021-22. The expenditure on Health sector to erstwhile State/ UT GSDP had increased from 2.25 *per cent* in 2016-17 to 2.95 *per cent* in 2020-21 but decreased to 2.80 *per cent* during 2021-22. Further, the shortfall in utilisation of allotted funds ranged between three *per cent* and 26 *per cent* during the period 2016-22.

The objective of *Janani Suraksha Yojana* (JSY) under NHM was to reduce the maternal and infant mortality rate. The percentage of institutional deliveries remained in the range of 92 *per cent* and 95 *per cent* during 2016-2022. During 2016-22, cash incentives under JSY were provided to beneficiaries ranging between 56 *per cent* and 73 *per cent* of institutional deliveries in erstwhile State/ UT of J&K. However, in six selected Districts cash incentives were provided to 97 *per cent* beneficiaries. Maternal mortality and infant mortality had decreased from 132 to 84 and 2,288 to 2,108 respectively during 2016-22.

In the six sampled Districts, maternal deaths declined from 31 to 23 during 2016-21 and again increased to 31 during 2021-22, whereas infant deaths declined from 234 to 76 during 2016-22.

Under Janani Shishu Suraksha Karyakram (JSSK), an initiative to assure free services to all pregnant women and sick new-borns accessing public health institutions, achievements in respect of targets for deliveries to be benefitted declined from 90 *per cent* to 77 *per cent* during 2016-21. The achievement increased to 95 *per cent* in 2021-22.

The achievement against the targets in respect of sick new-borns to be treated was more than the targets fixed in four years (2017-18 to 2019-20 and 2021-22).

Against target of 13,49,948 doses each for BCG, OPV, PV, IPV, Hep-B, DPT-B, and Measles, the achievement had ranged between 71 *per cent* and 94 *per cent* whereas the achievement in respect of DPT-5, TT-10 and TT-16 was 64, 56 and 40 *per cent* respectively during 2016-22 in the erstwhile State/ UTof J&K.

There was lack of an adequate mechanism whereunder drug samples were to be referred to State Drugs Controller (SDC) for testing on regular basis. For registration

and regulation of the Clinical Establishments (CEs), no survey was conducted to ascertain the actual number of CEs eligible for registration. As a result, the possibility of CEs operating without registration could not be ruled out. There was disparity in rates of various pathological/radiological tests. Requisite annual reports were not submitted by some of the Health Care Facilities (HCFs) under Bio-Medical Waste (BMW) Management Rules, 2016 and authorisation was not obtained by the occupier or operator handling BMW in all cases.

Recommendations:

In view of the above mentioned findings, Audit recommends the following:

The Government should consider revising the sanctioned strength of Health Department at par with the IPHS norms and posting of staff in health institutions at par with the sanctioned strength in the primary, secondary and tertiary healthcare institutions. Government should bring out a long-term strategy and policy to reduce variations in doctor-population ratio across districts.

Government should ensure availability of all OPD services, IPD services, emergency services, OT services, maternity services and ICU services in all health institutions and basic diagnostic services at secondary level health facilities as prescribed under IPHS norms. Steps should be taken to improve and strengthen auxiliary and support services to improve overall healthcare experience.

Availability of essential drugs and equipment should be ensured at all health institutions. Delay in finalisation of rate contracts should be avoided to ensure timely supply of drugs/ equipment to the health institutions. e-Aushadhi/ Distribution Management System (DVDMS) portal should be utilised optimally by end users for maintenance of stocks and distribution of items to their sub-stores and to the patients.

The Government may look into the issues of delays in commencement and completion of planned infrastructural works with a view to removing bottlenecks and ensure speedy completion.

Government may consider utilising the allocated budget to ensure availability of ample and quality healthcare infrastructure and services to the people. Government may release funds to the State Health Society well in time for effective utilisation of funds in programme implementation.

Government may consider disbursement of incentive to all the beneficiaries under Janani Suraksha Yojana (JSY) and providing adequate essential drugs and consumables under Janani Shishu Suraksha Karyakram (JSSK) for effective implementation of the schemes. Government may also attempt to increase awareness and outreach through various activities for making the target population aware of the benefits of sterilisation and spacing methods.

The targeted number of inspections may be carried out to ensure quality of the drugs and drug samples may be referred to State Drug Controller for testing on regular

basis. Government may ensure that all utilities generating Bio-Medical waste comply with the provisions with regard to authorisation and submission of annual returns.

CHAPTER-I
INTRODUCTION

CHAPTER-I

Introduction

The health sector is one of the important social sectors, which is directly concerned with the welfare of the populace and is the barometer of the structural and technological developments/ improvements of any State/ Union Territory. Access to preventive, promotive and curative healthcare services is a basic right of the people.

National Health Policy, 2017 consists of Specific Quantitative Goals and Objectives outlined under three broad components viz. (a) Health Status and Programme Impact (b) Health Systems Performance and (c) Health Systems Strengthening. These goals are aligned to achieve sustainable development in the health sector in keeping with the policy thrust.

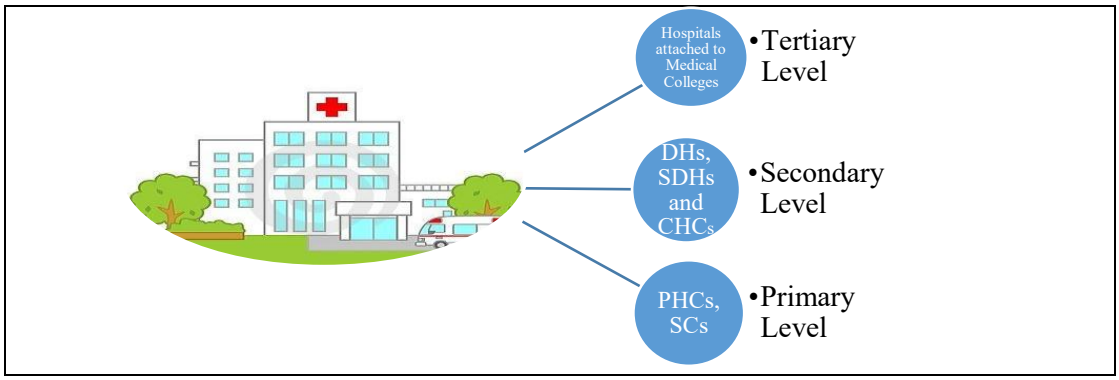
1.1 Public healthcare facilities in the UT of Jammu and Kashmir

India's public health system has been developed over the years as a three-tier system, namely primary, secondary, and tertiary level of health care. Sub-Centres (SCs) and Primary Health Centres (PHCs) including New Type Primary Health Centres[1] (NTPHCs) and Urban Primary Health Centres (UPHCs) are primary level healthcare units which provide initial healthcare services to the people. Patients requiring more serious health care attention are referred to the second tier of the healthcare system consisting of Community Health Centres (CHCs), Sub-District Hospitals (SDHs) and District Hospitals (DHs) established in each district for providing preventive, promotive and curative healthcare services. A Tertiary Hospital is a hospital that provides tertiary care, which is healthcare from specialists in a large hospital after referral from primary care and secondary care. Tertiary healthcare services are provided by the hospitals associated with the Government Medical Colleges. All the three levels of primary, secondary and tertiary healthcare services in the UT are administered by the Department of Health and Medical Education, Jammu and Kashmir.

Indian Public Health Standards (IPHS) are a set of uniform standards envisaged to improve the quality of healthcare delivery in the country. IPHS norms were revised in 2012 and 2022 keeping in view the changing protocols of the existing programmes and introduction of new programmes, especially for Non-Communicable Diseases. The UT Government of Jammu and Kashmir has not adopted IPHS norms so far.

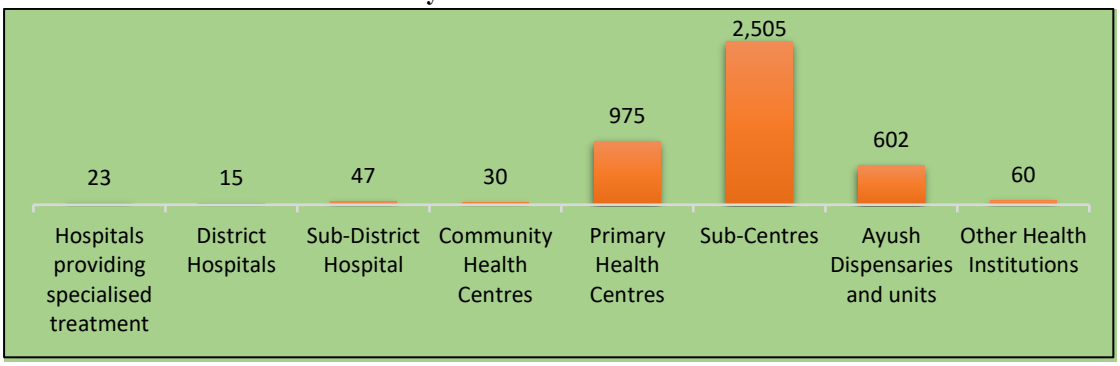
[1] Vide G.O. No. 345-HME of 2012 dated 16.05.2012, the nomenclature of 'Allopathic Dispensary (AD)' was changed to New Type Primary Health Centres (NTPHCs) and AD has been treated as PHC.

Public healthcare facilities in Jammu and Kashmir



As per Census 2011, UT of Jammu and Kashmir[2] had a population of 1.23 crore. As of March 2022, there were 4,257 healthcare facilities in the UT of JK. The category-wise details are given in **Chart 1.1**.

Chart 1.1: Availability of healthcare facilities as of 31 March 2022



(Source: Information furnished by the Administrative Department, Directors, Health Services, Jammu/ Kashmir, Director AYUSH, JK and Chief Medical Officers concerned)

(Other health institutions includes Emergency/ Accident Hospitals, District Tuberculosis Centres, Mobile Medical Units, Leper Hospital, District Malaria units, STD/ VD Centres etc.)

1.2 Health Services

Health services provided by the hospitals can broadly be divided into following categories:

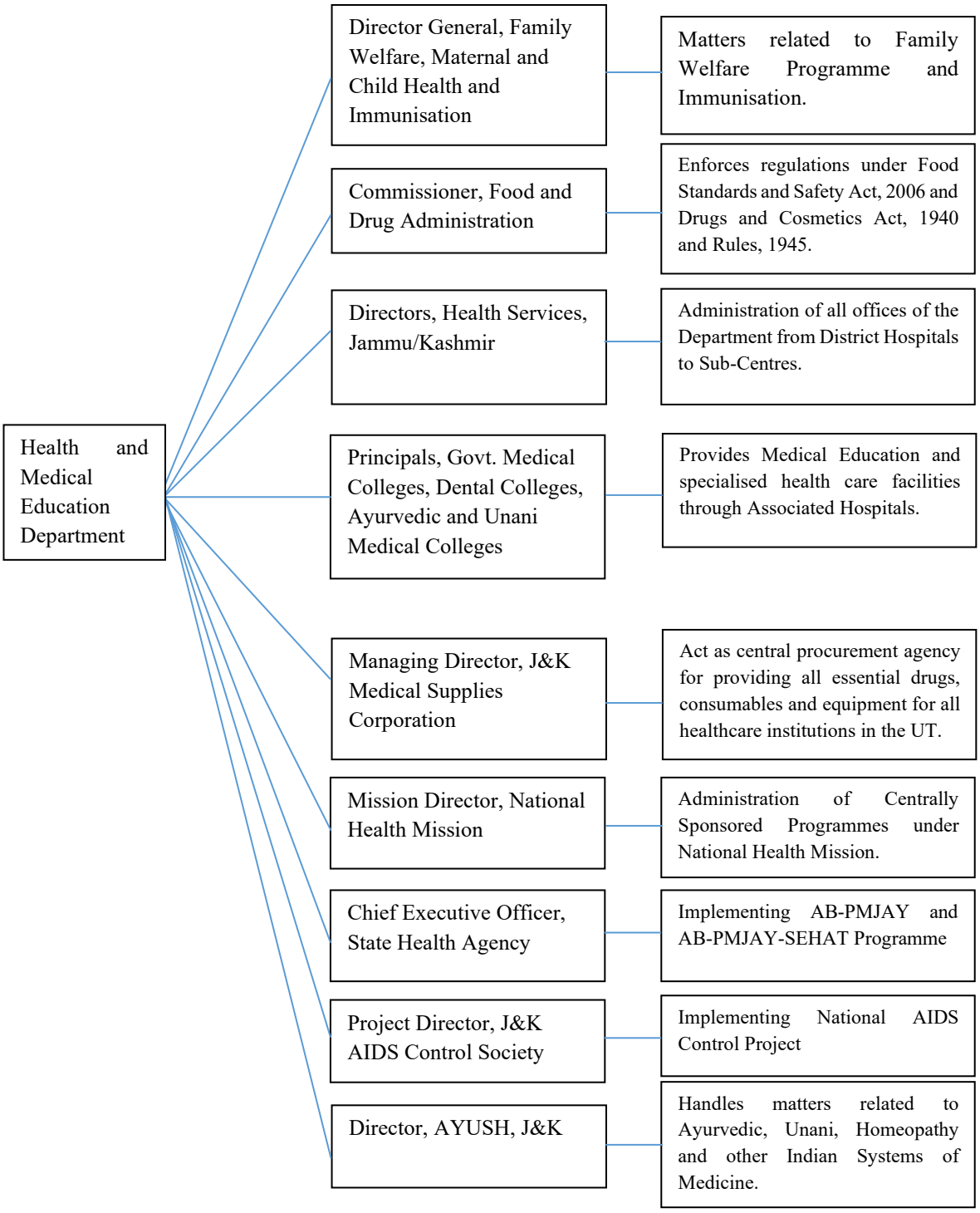
Line services ➢ Outdoor Patient Department ➢ Indoor Patient Department ➢ Emergency services ➢ Super Specialty (Operation Theatre, Intensive Care Unit) ➢ Maternity services ➢ Blood Bank ➢ Diagnostic services	***Support services*** ➢ Oxygen services ➢ Dietary services ➢ Laundry services ➢ Bio-Medical Waste Management ➢ Ambulance services ➢ Mortuary services
Auxiliary services ➢ Patient safety ➢ Patient registration ➢ Grievances/complaint redressal ➢ Stores	***Resource Management*** ➢ Building infrastructure ➢ Human Resource ➢ Drugs and Consumables ➢ Equipment

[2] excluding Union Territory of Ladakh

Given the importance of the health sector in Jammu and Kashmir, a Performance Audit (PA) on 'Public Health Infrastructure and Management of Health Services' (PHIMS) covering the period from 2016-17 to 2020-21 was conducted during December 2021 to December 2022. The information has been updated to 2021-22 (wherever applicable).

1.3 Organisational Setup

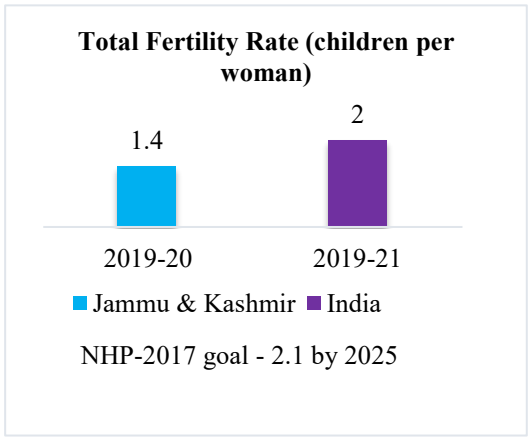
The organisational setup of the Health and Medical Education Department (H&MED) is as under:

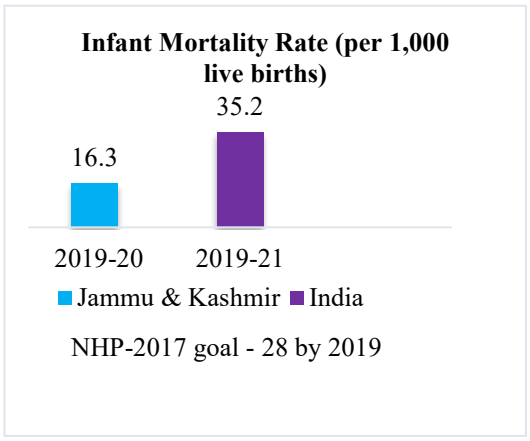


1.4 Status of Health Indicators in the UT of J&K

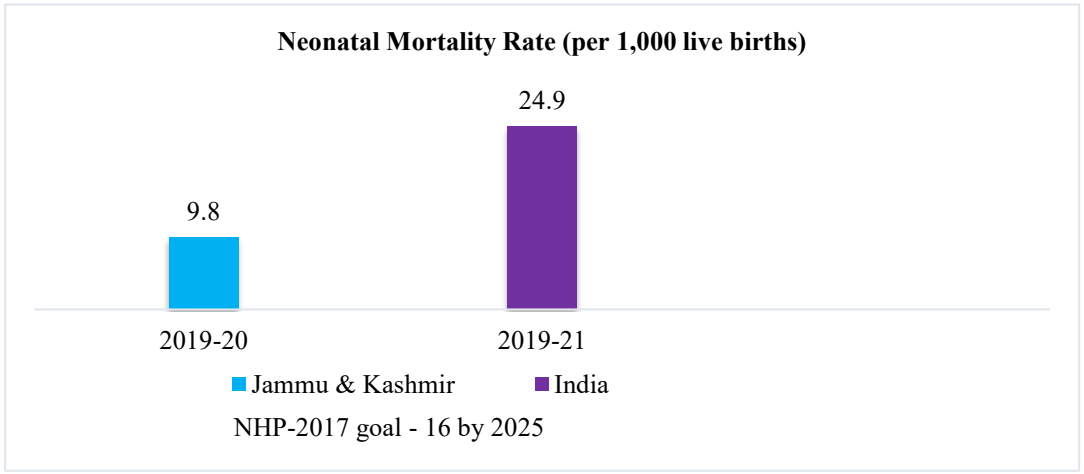
The healthcare services in a State/UT can be evaluated on the basis of the achievement against the benchmark of health indicators. Data of health indicators at an all-India level was depicted in the National Family Health Survey (NFHS-5) for the period 2019-21 whereas data of health indicators for Jammu and Kashmir was included in the said survey for the year 2019-20. The status of some important health indicators of UT of J&K *vis-a-vis* the national average and National Health Policy (NHP)-2017 goals is given in **Chart 1.2**.

Chart 1.2: Health Indicators in the UT of J&K





(Source: NFHS-5 (2019-20) for J&K, 2019-21 for India and NHP-2017)

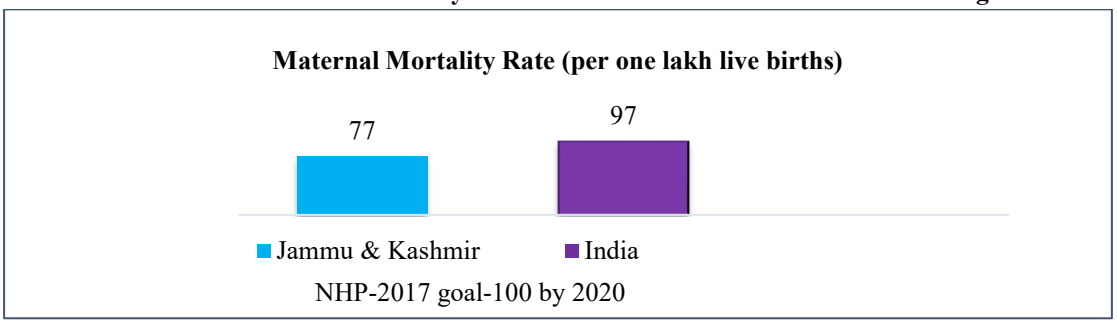


(Source: NFHS-5 (2019-20) for J&K, 2019-21 for India and NHP-2017)

The UT of J&K performed better in terms of IMR and NMR and achieved the targets of NHP-2017. Total Fertility Rate (TFR) (children per woman) in the UT was 1.4, whereas it was 2 at the national level and Infant Mortality Rate (IMR) was 16.3 against the national average of 35.2. Neonatal Mortality Rate (NMR) was 9.8, whereas it was 24.9 at the national level.

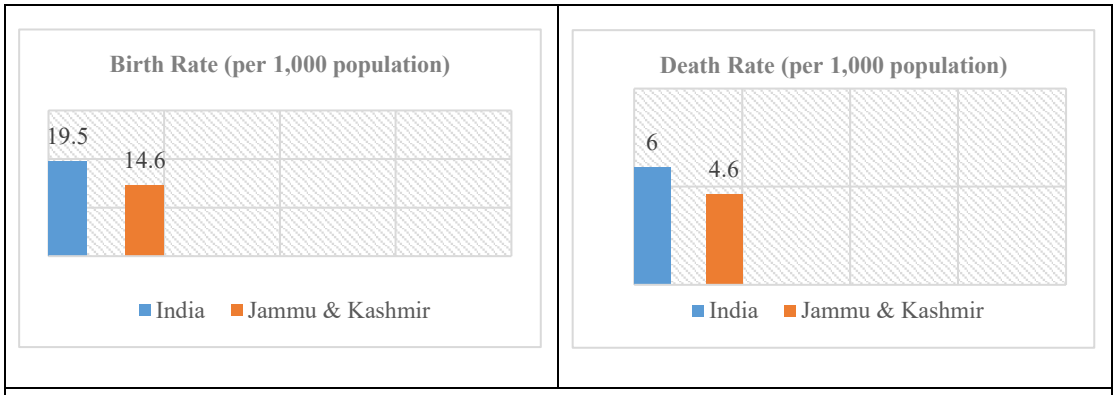
As per Sample Registration System (SRS) Bulletin 2018-20, Maternal Mortality Rate (MMR) of 77 in respect of UT of J&K was better than the national average of 97 as detailed in **Chart 1.3.**

Chart 1.3: Maternal mortality rate in the State/ UT *vis-a-vis* National average



The birth rate and death rate of a State/UT is also considered as one of the indicators for evaluation of healthcare services. A comparison of the birth rates and death rates of Jammu and Kashmir with the national average as per SRS Bulletin, 2020 is given in **Chart 1.4**.

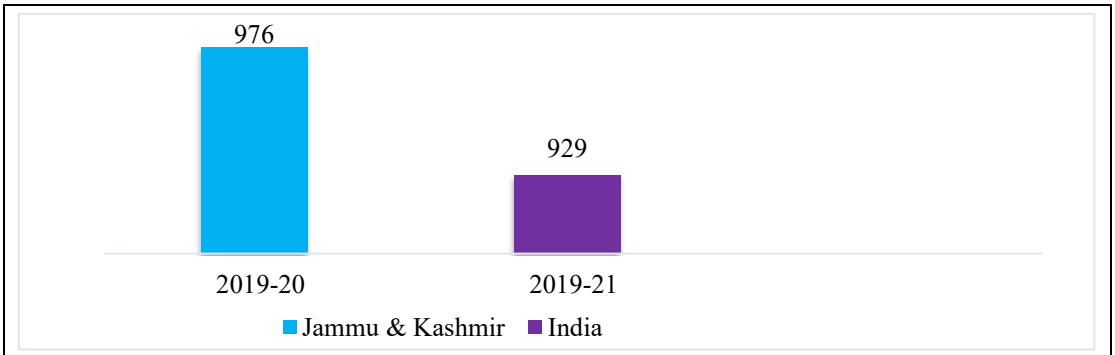
Chart 1.4: Comparison of birth/ death rate of Jammu and Kashmir with national average



(Source: SRS Bulletin, 2020)

The sex ratio at birth is a crucial index to determine how many females are born in comparison to males. Sex ratio at birth of children in the State/UT in 2019-20 and at the national level in 2019-21 are given in **Chart 1.5**.

Chart 1.5: Sex Ratio at birth for children born in the last five years (females per 1,000 males)



(Source: NFHS-5 (2019-20 for J&K and 2019-21 for India)

UT of J&K has a better sex ratio as compared to national average. Against the national average of 929 girl children born for every 1,000 boys as per NFHS-5 (2019-21), J&K has 976 girl children for every 1,000 boys as per NFHS-5 (2019-20).

1.5 Performance of UT of J&K in National Family Health Surveys

The National Family Health Survey provides information on population, health and nutrition for India and each State/ Union Territory (UT). Some of the important health indicators of J&K are given in **Table 1.1**.

Table 1.1: Performance of UT of J&K *vis-a-vis* India in important health indicators

Indicator	NFHS-4 (2015-16)		NFHS-5	
	J&K	India	J&K (2019-20)	India (2019-21)
Sex ratio of the total population (females per 1,000 males)	971	991	948	1020
Under-five mortality rate (U5MR)	37.6	49.7	18.5	41.9
Mothers who had an antenatal check-up in the first trimester (*per cent)*	76.7	58.6	86.6	70
Mothers who had at least 4 antenatal care visits (*per cent*)	81.2	51.2	80.9	58.1
Mothers whose last birth was protected against neonatal tetanus[3] (*per cent)*	87.3	89	91.9	92
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (*per cent)*	30.2	30.3	29.8	44.1
Mothers who consumed iron folic acid for 180 days or more when they were pregnant (*per cent)*	16.7	14.4	15.9	26
Registered pregnancies for which the mother received a Mother and Child Protection (MCP) Card (*per cent)*	88.7	89.3	97.3	95.9
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (*per cent)*	74.7	62.4	84.2	78
Average out-of-pocket expenditure per delivery in a public health facility (₹)	4,225	3,197	5,145	2,916
Children born at home who were taken to a health facility for a check-up within 24 hours of birth (*per cent)*	1.0	2.5	3.3	4.2
Children who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (*per cent)*	NA	NA	81.5	79.1
Institutional births (*per cent)*	85.5	78.9	92.4	88.6
Institutional births in public facility (*per cent)*	77.9	52.1	86.8	61.9

[3] Includes mothers with two injections during the pregnancy for their last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth.

Indicator	NFHS-4 (2015-16)		NFHS-5	
	J&K	India	J&K (2019-20)	India (2019-21)
Home births that were conducted by skilled health personnel[4] (*per cent)*	2.2	4.3	3.0	3.2
Births attended by skilled health personnel (*per cent)*	87.4	81.4	95.1	89.4
Births delivered by Caesarean section (*per cent)*	33.4	17.2	41.7	21.5
Births in a private health facility that were delivered by caesarean section (*per cent)*	75.5	40.9	82.1	47.4
Births in a public health facility that were delivered by caesarean section (*per cent)*	35.5	11.9	42.7	14.3

	Health indicators above National average
	Health indicators below National average

(Source: NFHS 4 (2015-16) and NFHS 5 (2019-20 for J&K and 2019-21 for India)

(i) In NFHS-5 (2019-21), the performance of J&K was better than the National average for parameters like Under-five mortality rate (U5MR), mothers who had an antenatal check-up in the first trimester and mothers who had at least 4 antenatal care visits. The UT also featured better in the areas of institutional births, institutional births in public facility and births attended by skilled health personnel.

However, in the following areas the UT was below the national level: Sex ratio of the total population (females per 1,000 males) was 1,020 at the national level whereas in J&K, it was 948. Mothers whose last birth was protected against neonatal tetanus was marginally below the national level. Similarly, mothers who consumed iron folic acid tablets for 100 days and 180 days were also below the national level. Average out-of-pocket expenditure per delivery in a public health facility in J&K was higher than the national average. Moreover, births delivered by Caesarean section in public and private health facilities were higher than the national level.

(ii) Performance of J&K in NFHS-5 (2019-20) in comparison to the previous survey, i.e. NFHS-4 (2015-16) improved for parameters like Under-five mortality rate (U5MR), mothers who received antenatal check-up in the first trimester, institutional births, births attended by skilled health personnel. The performance also deteriorated on many health indicators such as sex ratio of the total population (females per 1,000 males), mothers who consumed iron folic acid for 100 days and 180 days or more when they were pregnant also decreased marginally. Further, the average out-of-pocket expenditure per delivery in a public health facility has risen from ₹ 4,225 to ₹ 5,145 while the number of births delivered by Caesarean section in public as well as private health facilities has increased.

[4] Doctor/ Nurse/ LHV/ ANM/ midwife/ other health personnel.

1.6 Audit Objectives

The National Health Policy (NHP) 2017 builds on the progress made in 14 years since the last NHP came out in 2002. The context had changed in four major ways:

- First, although maternal and child mortality have rapidly declined, there is a growing burden on account of non-communicable diseases and some infectious diseases.
- The second important change is the emergence of a robust healthcare industry estimated to be growing at double digit.
- The third change is the growing incidences of catastrophic expenditure due to healthcare costs, which are presently estimated to be one of the major contributors to poverty.
- Fourth, rising economic growth enables enhanced fiscal capacity.

Therefore, National Health Policy (NHP) was adopted to respond to these contextual changes. The primary aim of NHP 2017 is to inform, clarify, strengthen and prioritise the role of the Government in shaping health systems in all its dimensions.

Considering the goals laid down in NHP 2017 and experience in COVID-19 pandemic, it has become crucial to assess the adequacy of financial resources, availability of health infrastructure, manpower, machinery and equipment in the health institutions, as well as efficacy in the management of health services in the Union Territory (UT), through existing policy interventions and look at the scope for further improvement.

Thus, to ensure timely and systematic corrections, a Performance Audit (PA) on the Public Health Infrastructure and Management of Health Services in the UT of Jammu and Kashmir was taken up.

The objective of the Performance Audit is to provide a holistic view of the healthcare sector in the UT of J&K, i.e. a macro picture using State-level information and data and a micro-picture arising from detailed audit analysis/ findings on maintenance of infrastructure and delivery of healthcare services. This has been done by assessing the following:

- The availability of the necessary human resources at all levels, e.g. doctors, nursing, paramedics, etc;
- The availability of drugs, medicines, equipment and other consumables;
- The availability and management of healthcare infrastructure;
- Adequacy of the funding for healthcare;
- The funding and spending under various schemes of the Government of India;

- The adequacy and effectiveness of the regulatory mechanisms for ensuring that quality healthcare services are provided in/ by the public/ private healthcare institutions/ practitioners; and

- Whether Government spending on health has improved the health and well-being conditions of the people as per SDG-3.

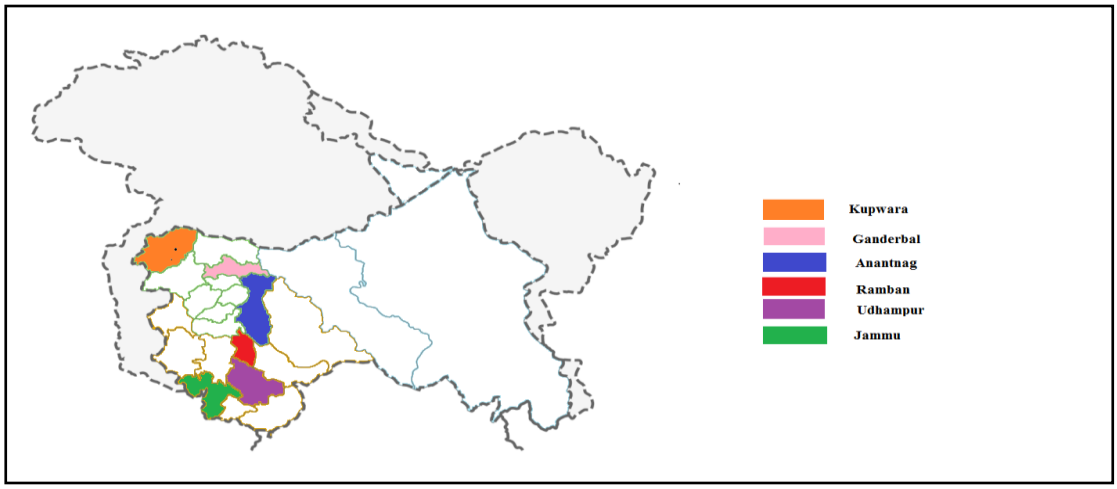
1.7 Audit Scope and Methodology

The Performance Audit covering the period from 2016-17 to 2020-21 was conducted from December 2021 to December 2022 and wherever feasible, the data has been updated up to 2021-22. The audit scope covered the healthcare facilities (both Allopathic and AYUSH) at primary, secondary and tertiary levels by scrutinising the records of the Administrative Department, Mission Director, National Health Mission; Director General Family Welfare, Maternal and Child Health (MCH) and Immunisation; three[5] Directors; Managing Director, Jammu and Kashmir Medical Supplies Corporation Limited (JKMSCL); State Drug Controller (SDC) including Drug Testing Laboratories; two[6] Principals; Medical Superintendents concerned; Chief Medical Officers; District AYUSH Officers and Block Medical Officers (BMOs). Previously Performance Audit of National Rural Health Mission, Jammu Division (Paragraph 2.1 of Report No. 01 of the year 2017) and Performance Audit of National Rural Health Mission, Kashmir Division (Paragraph 2.2 of Report No. 03 of the year 2018) were published in the CAG's Audit Report highlighting the issues of financial management, infrastructure and availability of human resources. The above reports were not discussed in Public Accounts Committee as of March 2022.

Selection of offices/ healthcare institutions for scrutiny of records was conducted at two stages. In Stage-I, six[7] out of 20 Districts of UT of J&K were selected by applying the sampling method of Probability Proportional to Size Without Replacement (PPSWOR). In Stage-II, Sub-Centres (SCs), Primary Health Centres (PHCs) and AYUSH Dispensaries/ units were sampled by applying the method of Simple Random Sampling Without Replacement (SRSWOR) in respect of six selected Districts as detailed in **Chart 1.6.** In respect of tertiary level health institutions, nine out of 19 were selected by judgmental sampling in the capital cities of Srinagar and Jammu. Districts selected for field audit in UT of J&K are depicted in **Map 1.1**.

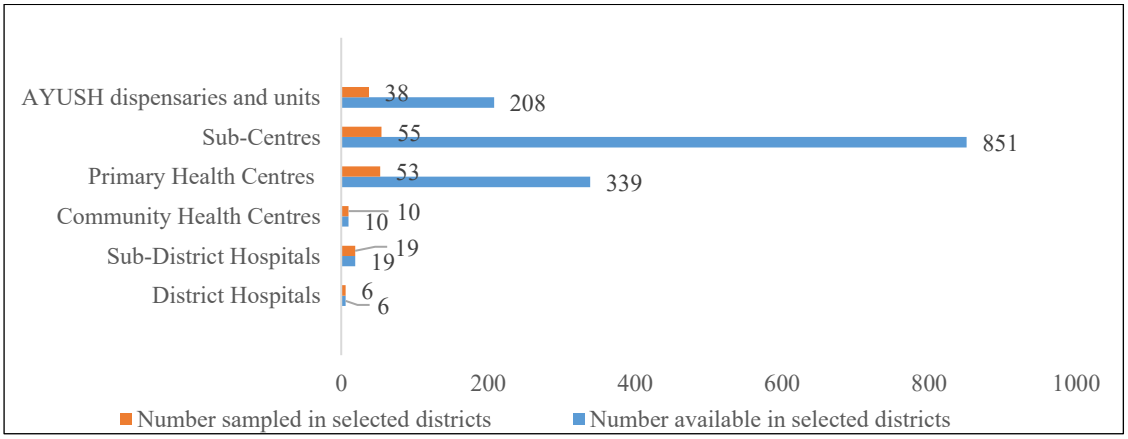
5 Directors Health Services, Kashmir and Jammu and Director, AYUSH, Jammu and Kashmir.
6 Principals Government Medical Colleges, Srinagar and Jammu.
7 Anantnag, Ganderbal, Jammu, Kupwara, Ramban and Udhampur.

Map 1.1: Districts selected for field audit in UT of J&K



The details of the number of health institutions in the selected Districts and the number of sampled health institutions are given in **Chart 1.6**.

Chart 1.6: Number of health institutions in selected Districts as of March 2022 and number of sampled HIs



The list of sampled[8] health institutions (HIs) is given in ***Appendix 1.1***.

The audit methodology involved scrutiny of records/ documents, eliciting response to audit queries, collection of information through questionnaires/ proformas as well as survey of doctors and patients for end-user satisfaction. Apart from that, joint physical inspection of assets of HIs, stores and civil works was also conducted.

An entry conference was held (December 2021) with the Additional Chief Secretary, H&MED, Jammu and Kashmir wherein the audit objectives, audit criteria, audit scope

8 After selection of the sample, SDH Achabal (May 2022) and PHC Kanalwan (February 2022) were found to be non-functional at a later stage. As such, 18 SDHs and 52 PHCs were test-checked. Out of selected nine hospitals providing specialised services, only seven were test-checked. Further, the DH, Anantnag was designated as 300-bedded District Hospital Vide G.O. No. 298-HME of 2018 dated 24.04.2018 and the administrative control of DH, Anantnag was transferred to Govt. Medical College, Anantnag vide G.O. No. 753-HME of 2019 dated 05.08.2019. However, for the purpose of data collection, it was treated as DH, Anantnag. In order to cover the maternity services in District Anantnag, the data from Maternal and Child Care Hospital (MCCH), Anantnag was obtained as the maternity services were not available in DH, Anantnag.

and methodology were discussed.

The exit conference was held (October 2023) with the Administrative Secretary, H&MED, Jammu & Kashmir wherein the audit findings were discussed. The Administrative Secretary, H&MED acknowledged the audit findings.

1.7.1 Doctors'/ patients' survey

A survey of 77 doctors, 1,545 Outpatient Department (OPD) patients and 574 In-patient Department (IPD) patients, selected on random basis, was conducted during the performance audit in order to obtain feedback from doctors and patients. The outcome of the survey has been depicted in **Chapter III**.

1.8 Audit Criteria

The PA was benchmarked against criteria derived from the following sources:

- Indian Public Health Standards, 2012;
- National Health Policy, 2017;
- Sustainable Development Goals;
- Professional Conduct, Etiquette and Ethics Regulation, 2002;
- Drugs and Cosmetics Act, 1940;
- Bio-Medical Waste Management Rules, 2016;
- National AYUSH Mission;
- Atomic Energy (Radiation Protection) Rules, 2004;
- National Accreditation Board for Hospitals;
- Assessors Guidebook for Quality Assurance;
- Clinical Establishment Act;
- Medical Council of India (MCI) Act, 1956 replaced by National Medical Commission Act, 2019;
- NITI Aayog Reports;
- Orders/instructions/reports issued by the GoI/ State/ UT Government from time to time; and
- Jammu and Kashmir (J&K) Financial Rules, General Financial Rules and Book of Financial Powers.

1.9 Consideration of Ayushman Bharat in this Report

Ayushman Bharat (AB), the flagship health scheme of the Government of India, was launched in September 2018 to achieve Universal Health Coverage as recommended in the National Health Policy, 2017. AB adopts a continuum of care approach, comprising two inter-related components which are detailed in **Table 1.2**.

Table 1.2: Components of Ayushman Bharat

Health and Wellness Centres (HWCs)	• Transform existing 1,50,000 Sub-Centres and Primary Health Centres into HWCs. • Delivery of Comprehensive Primary Health Care (CPHC) including free essential drugs and diagnostic services covering maternal and child health services and non-communicable diseases. • Operationalise 12,500 Health and Wellness Centres under AYUSH in a phased manner during 2019-20 to 2023-24.
Pradhan Mantri Jan Arogya Yojana (PM-JAY)	• Provides a cover of ₹ 5 lakh per family per year for secondary and tertiary care hospitalisation in public and private empaneled hospitals in India. • Over 10.74 crore poor and vulnerable families (approximately 50 crore beneficiaries) are eligible for these benefits. • Provides cashless access to healthcare services for the beneficiary at the point of service, that is, the hospital. • Services include approximately 1,393 procedures covering all the costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT and ICU charges etc. • In order to provide the benefits of AB PM-JAY to all residents of Jammu and Kashmir (more than 20 lakh families), a scheme by the name of AB PM-JAY SEHAT was launched on 26 December 2020.

The State Health Agency (SHA), a society registered under the J&K Societies Registration Act, 1941 has been implementing PMJAY for poor and vulnerable families since 2018. After the launch of PM-JAY SEHAT in December 2020, the scheme is being implemented by the SHA for all beneficiaries of Jammu and Kashmir under PM-JAY SEHAT. In the UT of J&K, 207[9] Public and Private Hospitals were empaneled with AB-PM-JAY/ AB- PM-JAY SEHAT as on January 2023.

As per the Beneficiary Identification System[10] (BIS) data, there were 102.45 lakh beneficiaries under PM-JAY/ PM-JAY SEHAT under 25.72 lakh families as of March 2022. In order to avail the benefits under PM-JAY/ PM-JAY SEHAT, these beneficiaries were required to get themselves registered under these schemes. Out of 102.45 lakh beneficiaries, 66.11 lakh (65 *per cent*) beneficiaries were registered under PM-JAY/ PM-JAY SEHAT as on 31 March 2022. Coverage of beneficiaries across districts is detailed in **Table 1.3**.

Table 1.3: Coverage of Beneficiaries across districts under PM-JAY/ PM-JAY SEHAT (as on 31 March 2022)

Sl. No.	Name of District	Total number of beneficiaries	Total number of beneficiaries registered	Percentage of registered beneficiaries
1.	Anantnag	7,87,365	5,25,857	66.78
2.	Bandipora	3,43,622	2,13,879	62.24
3.	Baramulla	9,00,814	5,73,748	63.69
4.	Budgam	6,20,922	4,09,689	65.98

9 Public Hospitals: 115 and Private Hospitals: 92

10 Beneficiary Identification System is a process of applying the identification criteria on the Social Economic and Caste Census (SECC) and *Rashtriya Swasthya Bima Yojana* (RSBY) database to approve/ reject the applications entitled for the benefits.

Sl. No.	Name of District	Total number of beneficiaries	Total number of beneficiaries registered	Percentage of registered beneficiaries
5.	Doda	3,55,117	2,35,737	66.38
6.	Ganderbal	2,68,057	1,70,371	63.55
7.	Jammu	13,00,828	7,76,502	59.69
8.	Kathua	5,35,720	3,47,028	64.77
9.	Kishtwar	2,09,231	1,29,779	62.02
10.	Kulgam	3,89,602	2,65,657	68.18
11.	Kupwara	7,04,816	3,76,984	53.48
12.	Poonch	3,94,691	2,57,029	65.12
13.	Pulwama	5,05,151	3,29,488	65.22
14.	Rajouri	5,43,072	4,29,178	79.02
15.	Ramban	2,56,057	1,83,402	71.62
16.	Reasi	2,64,481	1,83,529	69.39
17.	Samba	2,52,638	1,78,492	70.65
18.	Shopian	2,56,713	1,74,566	68.00
19.	Srinagar	9,03,762	5,09,393	56.36
20.	Udhampur	4,52,418	3,40,741	75.31
	Total	**1,02,45,077**	**66,11,049**	**64.52**

(Source: State Health Agency)

An All-India Performance Audit of PM-JAY in which Jammu and Kashmir was one of the sampled States/ UTs was conducted for the period up to March 2021. In the current Report, audit findings regarding infrastructure relating to Health and Wellness Centres (HWCs) have been included in **Chapter-V**.

1.10 Acknowledgement

Audit acknowledges the cooperation of the Government of Jammu and Kashmir (GoJ&K). Audit also appreciates the assistance provided by the field functionaries of the Department of Health and Medical Education for smooth conduct of audit.

1.11 Organisation of audit findings

The audit findings, conclusions and recommendations relating to the audit objectives have been reported in the succeeding chapters as detailed below:

Chapter-II	Human Resources
Chapter-III	Healthcare Services
Chapter-IV	Availability of drugs/medicines, equipment and other consumables

Chapter-V	Healthcare Infrastructure
Chapter-VI	Financial Management
Chapter-VII	Implementation of Centrally Sponsored Schemes
Chapter-VIII	Adequacy and effectiveness of regulatory mechanisms
Chapter-IX	Implementation of Sustainable Development Goal-3

CHAPTER-II
HUMAN RESOURCES

CHAPTER-II

Human Resources

2.1 Introduction

The health workforce can be defined as "all people engaged in actions whose primary intent is to enhance health". The health workforce includes staff that provide health services such as doctors, nurses etc. as well as administrative and support staff that do not deliver services directly but are essential to the performance of the health systems.

Availability of manpower and related issues have been discussed in the succeeding paragraphs.

2.2 Human Resources in the erstwhile State/ UT

Delivery of quality healthcare services in hospitals largely depends on adequate availability of doctors, nurses, paramedical and other supporting staff. Availability of human resources (including AYUSH) in the erstwhile State/UT of J&K during the period 2016-22 is detailed in **Table 2.1**.

Table 2.1: Sanctioned/ effective strength of human resources in the State/ UT

Year	Sanctioned strength					Effective strength				
	Doctors	Nurses	Paramedical staff	Other supporting staff	Total	Doctors	Nurses	Paramedical staff	Other supporting staff	Total (percentage shortfall)
2016-17	8,373	3,874	12,780	14,084	39,111	4,743	2,955	9,612	9,283	26,593 (32)
2017-18	8,522	3,874	12,764	14,143	39,303	4,933	3,042	9,471	8,346	25,792 (34)
2018-19	9,991	4,396	13,524	15,841	43,752	5,575	3,179	9,657	8,688	27,099 (38)
2019-20	9,820	4,707	11,563	15,509	41,599	6,096	3,288	8,118	8,191	25,693 (38)
2020-21	9,841	4,793	13,800	16,163	44,597	6,093	3,471	9,036	8,534	27,134 (39)
2021-22	9,886	4,837	13,897	17,495	46,115	5,926	3,389	11,021	10,409	30,745 (33)

(Source: Figures provided by the Administrative Department)

It may be seen from **Table 2.1** that there was overall shortfall ranging between 32 *per cent* and 39 *per cent* in human resources during the period 2016-17 to 2020-21. However, the shortfall decreased to 33 *per cent* in 2021-22 from 39 *per cent* in 2020-21 mainly due to increase in paramedical and other supporting staff.

In addition to the above, 3,292 personnel were outsourced as of March 2022 under various categories such as security staff, sanitary workers, data entry operators, unskilled attendants, drivers, sweepers etc. in respect of both allopathy and AYUSH services in the UT of J&K.

The availability of staff under various categories in various health institutions (HIs) as of March 2022 is given in **Table 2.2**.

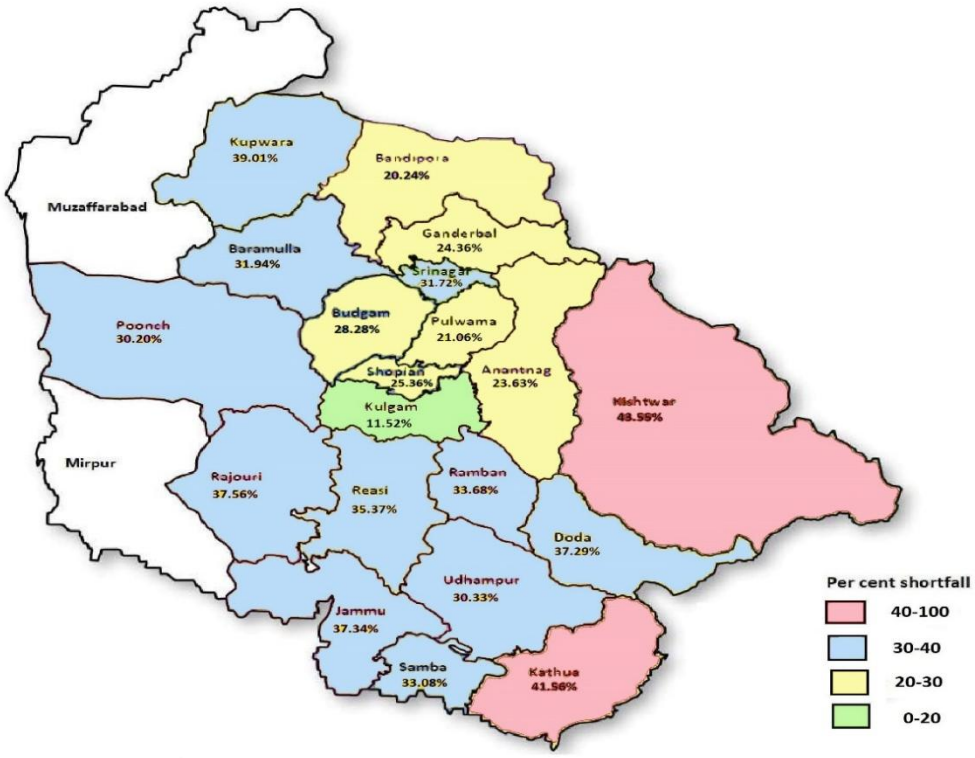
Table 2.2: Staff strength in various types of health institutions as of March 2022

Health Institutions	Doctors			Nurses			Paramedics			Others		
	SS	PIP	SF	SS	PIP	SF	SS	PIP	SF	SS	PIP	SF
Medical Colleges	3,154	1,604	1,550 (49)	1,054	754	300 (28)	1,074	657	417 (39)	3,274	1,702	1,572 (48)
Hospitals associated with Medical Colleges	909	426	483 (53)	2,512	1,899	613 (24)	1,755	1,115	640 (36)	4,238	2,750	1,488 (35)
DHs	748	538	210 (28)	333	208	125 (38)	699	448	251 (36)	589	400	189 (32)
SDHs	908	700	208 (23)	451	309	142 (31)	1,460	1,025	435 (30)	758	517	241 (32)
CHCs	413	283	130 (31)	205	109	96 (47)	708	483	225 (32)	488	314	174 (36)
PHCs	2,024	1,340	684 (34)	520	382	138 (27)	3,515	2,626	889 (25)	3,140	2,310	830 (26)
SCs	0	0	0	0	0	0	0	0	0	5,150	3,933	1,217 (24)
Other HIs	152	94	58 (38)	47	30	17 (36)	162	104	58 (36)	149	92	57 (38)
AYUSH Dispensaries and units and hospitals	664	614	50 (8)	3	3	0	575	412	163 (28)	167	112	55 (33)
Total	**8,972**	**5,599**	**3,373 (38)**	**5,125**	**3,694**	**1,431 (28)**	**9,948**	**6,870**	**3,078 (31)**	**17,953**	**12,130**	**5,823 (32)**

(Source: Information furnished by HIs/CMOs/BMOs etc.)
SS: Sanctioned Strength; PIP: Person-in- Position; SF: Shortfall. Figures in brackets indicate percentage

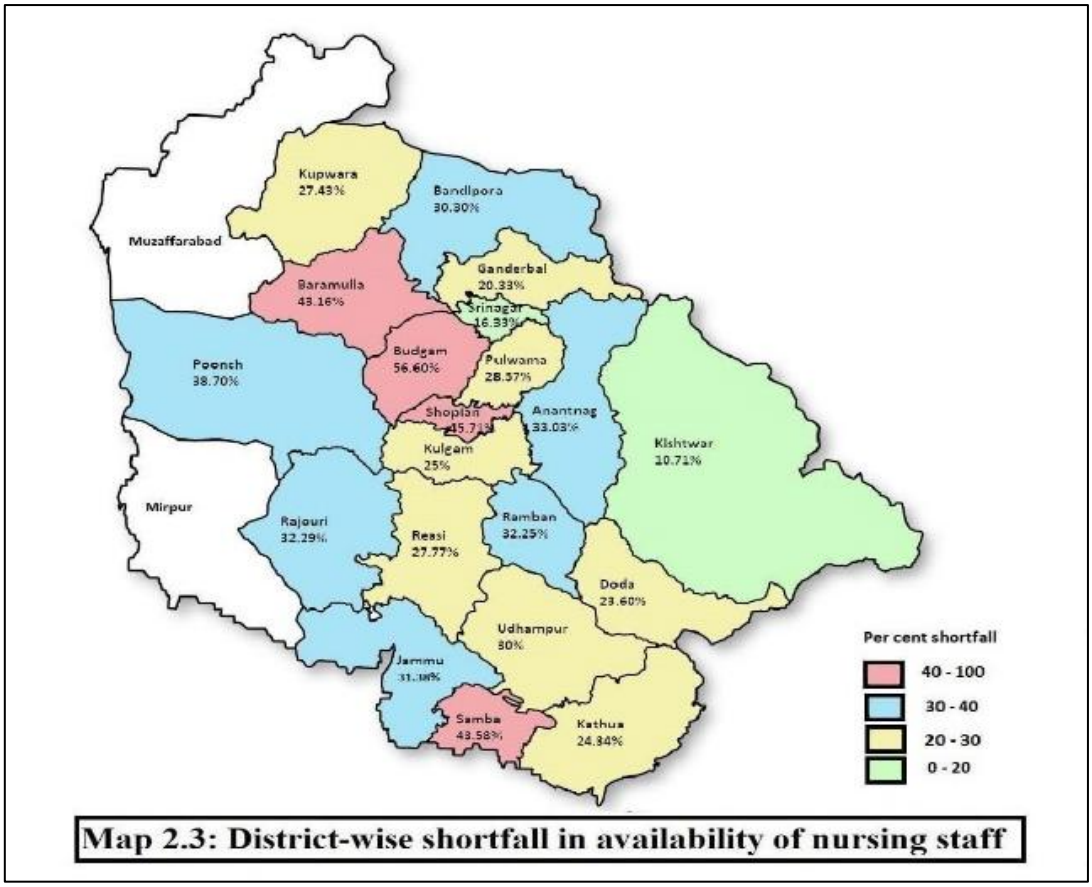
It may be seen that the figures furnished by the health institutions for the year 2021-22 differ from those in Table 2.1 (as provided by the Administrative Department). The matter of reconciliation of data of these two tables was taken up with the Department; despite repeated reminders, the response was awaited (January 2025).

As detailed in **Table 2.2**, there was overall shortfall of 32.63 *per cent* in human resources under the HIs of the UT of J&K. The details of district-wise shortfall in human resources as of March 2022 as compared with the sanctioned strength are shown in **Maps 2.1 to 2.5**.

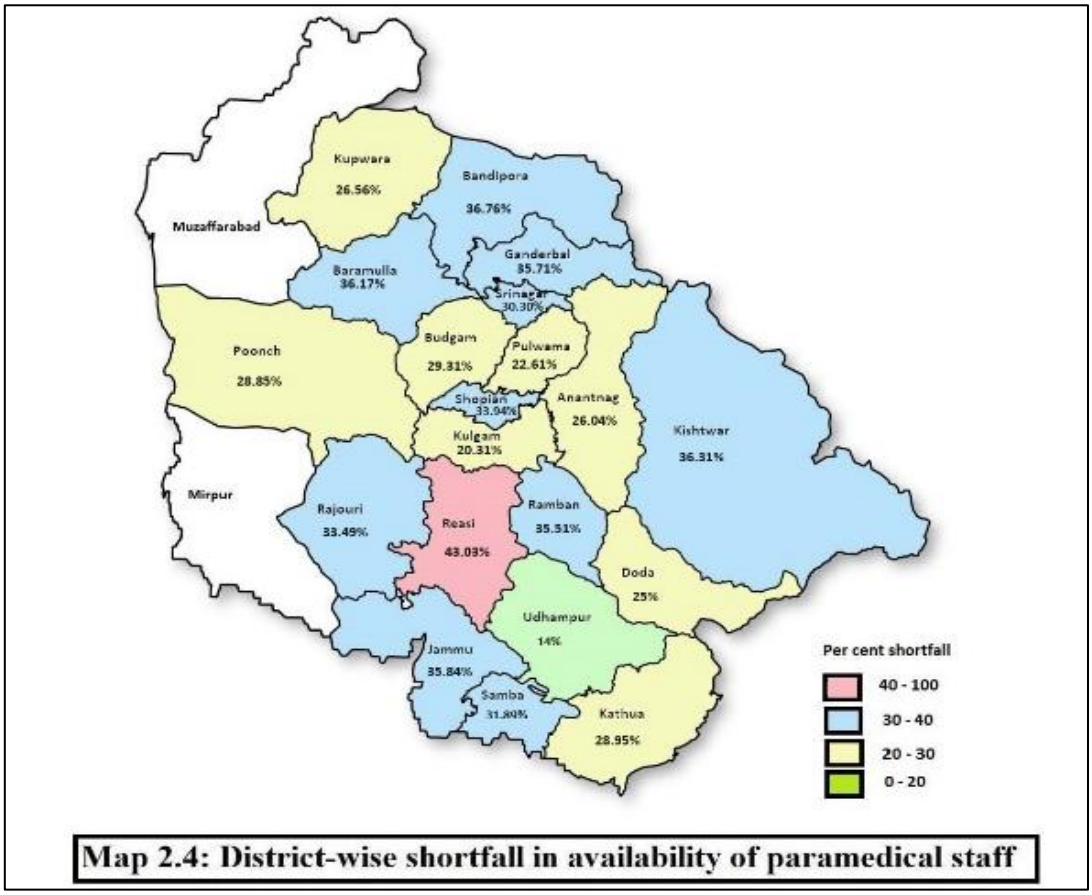


Map 2.1: District-wise overall shortage of manpower

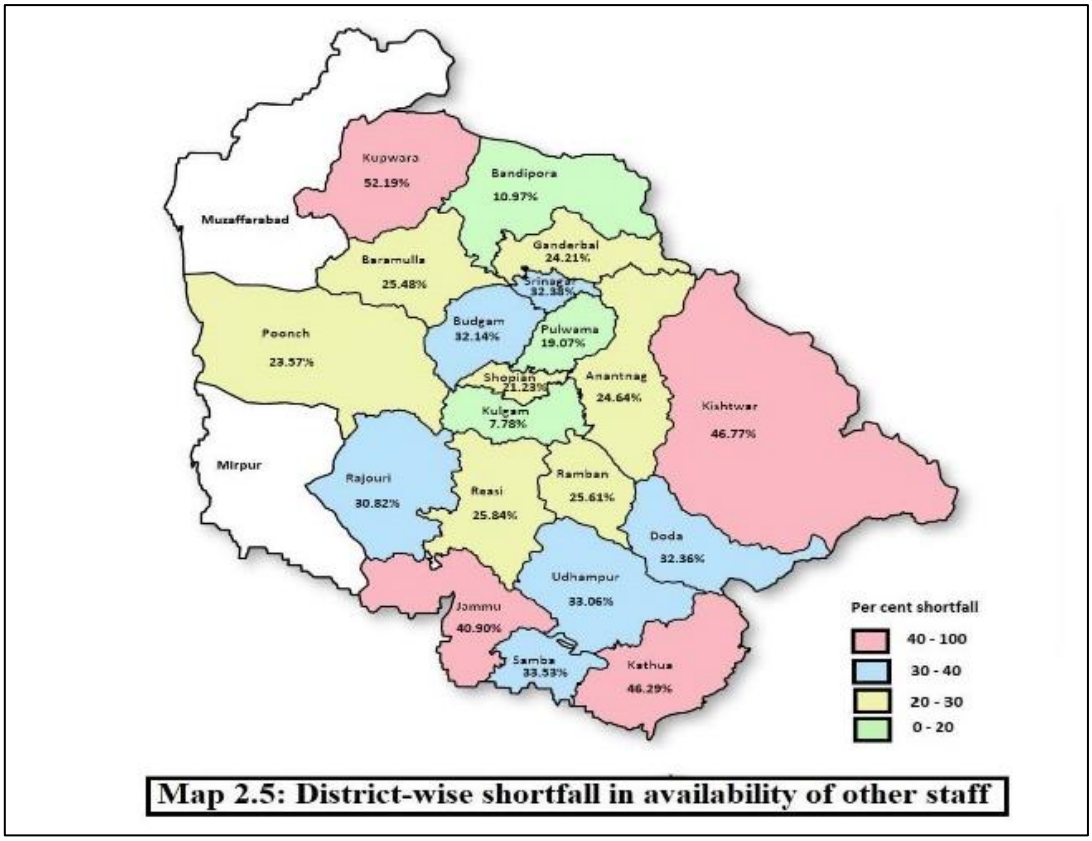
Map 2.2: District-wise shortfall in availability of doctors



Map 2.3: District-wise shortfall in availability of nursing staff



Map 2.4: District-wise shortfall in availability of paramedical staff



Map 2.5: District-wise shortfall in availability of other staff

It is evident from **Maps 2.1 to 2.5** that the distribution of available manpower in the 20 districts of Jammu and Kashmir was not uniform as detailed below:

- Shortfall of overall manpower was lowest (11.52 *per cent*) in Kulgam District and highest (43.55 *per cent*) in Kishtwar District.
- It was observed that posts of doctors were lying vacant in all the districts. Shortfall in the category of doctors was more than 40 *per cent* in nine districts[1]. It was lowest (4.26 *per cent*) in Kulgam District and highest (60.86 *per cent*) in Doda District.
- Shortfall in the category of nursing staff was more than 40 *per cent* in four districts[2]. It was lowest (10.71 *per cent*) in Kishtwar District and highest (56.60 *per cent*) in Budgam District.
- Shortfall in the category of paramedical staff was more than 40 *per cent* only in Reasi District (43.03 *per cent*) while it was lowest (14 *per cent*) in Udhampur District.
- Shortfall in the category of other staff was more than 40 *per cent* in four districts[3]. It was lowest (7.78 *per cent*) in Kulgam District and highest (52.19 *per cent*) in Kupwara District.

1 Doda, Kathua, Kishtwar, Poonch, Rajouri, Ramban, Reasi, Srinagar and Udhampur
2 Baramulla, Budgam, Samba and Shopian
3 Jammu, Kathua, Kishtwar and Kupwara

This shows a skewed distribution of available manpower across districts.

The details of vacancies of doctors, nurses and paramedical staff referred by H&MED to J&K Public Service Commission (JKPSC) and J&K Services Selection Board (JKSSB) and recruitment made during 2016-22 are given in **Table 2.3**.

Table 2.3: Details of posts referred and recruitments made during 2016-22

Year	Doctors			Nurses			Paramedical staff		
	Posts referred	Recruitments made	Vacancy at the end of the year	Posts referred	Recruitments made	Vacancy at the end of the year	Posts referred	Recruitments made	Vacancy at the end of the year
2016-17	380	146	3,630	292	88	919	47	380	3,168
2017-18	629	404	3,589	69	2	832	102	60	3,293
2018-19	1,060	1,437	4,416	590	0	1,217	490	15	3,867
2019-20	32	21	3,724	80	575	1,419	214	211	3,445
2020-21	926	637	3,748	496	0	1,322	292	11	4,764
2021-22	585	171	3,960	25	0	1,448	392	0	2,876
Total	**3,612**	**2,816**	**-**	**1552**	**665**		**1,537**	**677**	

(Source: Information furnished by JKPSC/ JKSSB)

The **Table 2.3** indicates that 2,816 doctors, 665 nurses and 677 paramedical staff were recruited during 2016-22. However, even after the recruitments, there was shortage of 3,960 (40 *per cent*) doctors, 1,448 (30 *per cent*) nurses and 2,876 (21 *per cent*) paramedical staff as of March 2022 as also indicated in **Table 2.1**.

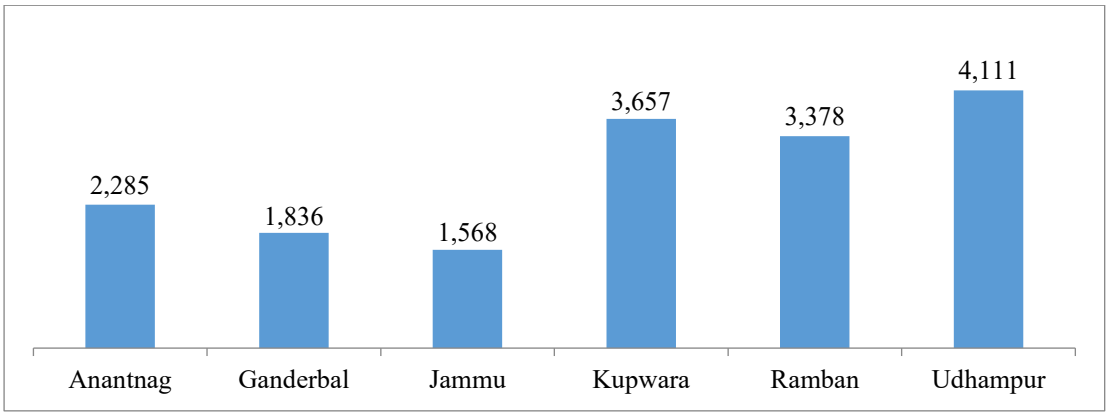
2.3 Doctor Population Ratio

As per 2011 Census, population of UT of Jammu and Kashmir was 1,22,67,013[4]. World Health Organisation (WHO) prescribes norm of one doctor per thousand population.

As of March 2022, one Government doctor[5] was serving a population of 2,191 (2,461 in case of allopathic doctors) in the UT of J&K. The ratio of availability of doctor was better than the States of Haryana (4,081 doctors for 2.51 crore people i.e. one allopathic doctor per 6,212 persons) and Punjab (one allopathic doctor for 6,390 persons). The availability of Government doctors at district level was not uniform in the selected six Districts, and it varied from as low as one Government doctor for 1,568 people in Jammu District to as high as one Government doctor for 4,111 people in Udhampur District as depicted in **Chart 2.1**.

[4] After excluding the population of UT of Ladakh as per Census-2011.
[5] Audit examined availability of only Government doctors per thousand population.

Chart 2.1: Population per Government doctor in the selected Districts



2.4 Human Resources under AYUSH

Against the sanctioned strength of 1,533 personnel[6] in the Directorate of AYUSH (DoA) in the UT, the effective strength was 1,222 (shortage of 20 *per cent*) as of March 2022. There was, however, variation in the sanctioned and effective strength in respect of data provided by the DoA and information provided by the District AYUSH Officers and concerned Medical Superintendents as detailed in **Table 2.4.**

Table 2.4: Variation in sanctioned and effective strength of staff

Particulars	Sanctioned strength of staff		Variation	Effective strength of staff		Variation
	as provided by DoA	as compiled by Audit		as provided by DoA	as compiled by Audit	
Medical Officers, Pharmacists, Nurses and Nursing Orderlies	1,423	1,409	14	1,137	1,141	4
Other staff[7]	110	110	Nil	85	85	Nil
Total	**1,533**	**1,519**	**14**	**1,222**	**1,226**	**4**

(Source: Information provided by the DoA and concerned HIs)

Reasons for variation in sanctioned and effective strength of staff between data furnished by DoA and data furnished by District AYUSH Officers and concerned Medical Superintendents were not furnished by DoA.

(A) AYUSH Dispensaries (ADs) are the independent basic/ primary healthcare institutions in AYUSH sector providing preventive, promotive and curative AYUSH healthcare services whereas AYUSH Units[8] (AU) are secondary level AYUSH institutions. The AUs also provide specialised procedures like

6 Includes Medical Officers, Pharmacists, Nursing staff, Administrative staff etc.
7 Includes Director AYUSH, Dy. Directors, Assistant Directors, Accounts Officer, A&B Grade Specialists, Junior/Senior Assistants etc.
8 AYUSH units are typically smaller and offer more limited range of services.

Ksharsutra/ Panchkarma/ Regimenal therapies[9] in addition to the preventive, promotive, curative and rehabilitative services. The AYUSH units are functioning on co-location basis within the Allopathic HIs.

The structure of manpower in an AYUSH Dispensary (AD) is one Medical Officer (MO), one Pharmacist and one Nursing Orderly (NO). The manpower requirement is at least one MO for AYUSH units (AUs).

The position of sanctioned and effective strength as on March 2022 of MOs, Pharmacists and NOs in 602 (ADs: 571 and AYUSH units: 31) HIs is given in **Table 2.5**.

Table 2.5: Position of Manpower in ADs, AUs and AYUSH Hospitals

Category	Sanctioned strength			Effective strength			Shortage (-)/Excess (+)		
	AD	AU	AYUSH Hospitals	AD	AU	AYUSH Hospitals	AD	AU	AYUSH Hospitals
Medical Officers (MO)	578	68	18	540	56	18	(-) 38 (7 *per cent*)	(-) 12 (18 *per cent*)	Nil
Pharmacists	573		2	410		2	(-) 163 (28 *per cent*)		Nil
Nurses	-		3	-		3	-		Nil
Nursing Orderly/ other staff	144		23	98		14	(-) 46 (32 *per cent*)		9
Total	**1,363**		**46**	**1,104**		**37**	**(-) 259 (19 *per cent*)**		**9**

(Source: Information furnished by District AYUSH/Nodal Officers, concerned AYUSH Hospitals)

Audit observed that:

- Adequate number of MOs were posted in ADs, AUs and AYUSH Hospitals. However, out of 602 HIs, MOs in 40 ADs and three AYUSH units were not available.

- In 195 ADs, there was no sanctioned strength of Pharmacists whereas in remaining 376 ADs, 573 posts of Pharmacists were sanctioned against which only 410 Pharmacists were in position. In 79 ADs, no Pharmacist was posted despite having sanctioned posts.

- In two[10] AYUSH Hospitals, there was no shortage of MOs, Nurses and Paramedics against the sanctioned posts. However, against the sanctioned strength of 23 other staff, there was shortage of nine personnel.

[9] *Ksharsutra Therapy*: It is an effective treatment for piles; *Panchkarma Therapy*: The therapy involves five actions that helps in cleansing the body of accumulated toxins; Regimenal Therapy: It is a special technique of treatment to improve the constitution of the body by removing waste materials and improving the defence mechanism of the body.

[10] Govt. Ayurvedic Hospital, Jammu and Govt. Unani Hospital, Shalteng Srinagar

In respect of 38 sampled ADs, Audit noticed that as of March 2022:

- Against the sanctioned strength of 38 Medical Officers, 38 Pharmacists and eight Nursing Orderlies there were 37 Medical Officers, 33 Pharmacists and 5 Nursing Orderlies were available.

- Posts of Pharmacist and Nursing Orderly was not sanctioned in 16 and 30 ADs respectively.

- Although having sanctioned posts three[11] and two[12] ADs were without MOs and Pharmacists respectively, while in three[13]ADs, Nursing Orderly were not posted against the sanctioned posts.

The Chief Accounts Officer, Directorate of AYUSH, J&K stated (January 2025) that 30 Medical Officers selected by JKPSC have been posted in those HIs which were without MOs. Moreover, vacancies of 37 MOs have also been referred to JKPSC for filling up on priority basis. Further, 115 posts of Pharmacists and 59 posts of MTS (Nursing Orderlies) have been referred to JKSSRB. Moreover, Multipurpose Workers and Unskilled Attendants have been hired on outsourcing basis for filling the gap of paramedical staff.

(B) Under Ayushman Bharat scheme, ASHAs were required to be attached with AYUSH Health and Wellness Centres (AH and WCs) at the norm of one per 1,000 population to ensure *Prakriti*[14] analysis of individuals above 18 years of age, regular Yoga at these Centres, referral and follow-up care of patients. Audit observed that against
317 approved AH and WCs, ASHAs were attached with only 141 AH and WCs as of March 2022.

- Yoga Instructors were to be engaged on part-time basis in all AH and WCs. Against the requirement of 317 Yoga Instructors for AH and WCs, the Department had deployed (March 2022) only 216 Yoga Instructors.

The Chief Accounts Officer, Directorate of AYUSH, J&K stated (January 2025) that in 523 AH and WCs, services of 2,401 ASHAs are being utilised. It was further stated that 20 Yoga Instructors have left the job and presently 196 Yoga Instructors are working. However, Yoga trainings have been imparted to Medical Officers and Pharmacists/ support staff for ensuring availability of Yoga services in all AH and WCs.

11 N.P. Grain, Khail Seer Mangla and Mahu
12 Mahu and Khanwdwal
13 Ranipora, Hapatnard, Bamloora
14 *Prakriti* analysis is Ayurveda's unique way of determining a body type for an individual

2.5 Human Resources in Drug and Food Control Organisation

Drug and Food Control Organisation plays a vital role in providing safe and quality drugs to the consumers/ patients and in making safe and hygienic quality food articles available to the public. Audit, however, noticed that against 239 sanctioned posts, only 156 personnel were in position as on March 2022, indicating a shortage of 35 *per cent* in manpower. Significant shortage of 53 *per cent* was noticed in Combined Food and Drug Laboratory, Jammu as detailed in **Table 2.6.**

Table 2.6: Position of manpower in Drug and Food Control Organisation

Name of the DDO	Sanctioned strength	Effective strength	Shortage (-)/Excess (+)
Controller, Drug and Food Control Organisation	31	22	(-) 9 (29 *per cent*)
Dy. Controller, Jammu	61	41	(-) 20 (33 *per cent*)
Dy. Controller, Kashmir	65	51	(-) 14 (22 *per cent*)
Combined Food and Drug Laboratory, Jammu	38	18	(-) 20 (53 *per cent*)
Drug Laboratory, Kashmir	44	24	(-) 20 (45 *per cent*)
Total	**239**	**156**	(-) 83 (35 *per cent*)

(Source: Information furnished by State Drugs Controller, J&K)

Shortage of staff in Drug and Food Control Organisation adversely affected the functioning of the organisation in discharging its duties as discussed in **Chapter VIII** of this report.

The State Drugs Controller, Drug and Food Control Organisation Jammu and Kashmir stated (January 2025) that all the direct quota vacancies of various category of posts have been referred to Administrative Department from time to time for further referral to the respective recruiting agencies.

2.6 Human Resources in Jammu Kashmir Medical Supplies Corporation Limited

Jammu and Kashmir Medical Supplies Corporation Ltd. (JKMSCL) was established (May 2013) to improve the health scenario in J&K by facilitating purchase and distribution of quality and affordable medicines and equipment through a rigorous procurement process. The position of availability of manpower in JKMSCL as of March 2022 is given in **Table 2.7**.

Table 2.7: Availability of manpower in JKMSCL

Number of employees posted in JKMSCL	Employees whose salary drawn on sanctioned strength of JKMSCL	Employees deployed from sister offices on temporary basis	Outsourced Employees
188	22	70	96

(Source: information furnished by JKMSCL)

A total of 188 personnel were deployed in various offices of the company. Out of these employees, 70 employees were temporarily deployed from various Departments/ HIs from where they were drawing their salary and 96 employees were outsourced.

On the recommendations (October 2014) of the Establishment Committee for creation of 48 additional posts viz, Company Secretary, Programmer/ System Administrator, Deputy General Managers, Data Entry Operators/ Computer Assistants etc. for JKMSCL, the Board of Directors of JKMSCL authorised (October 2018) the Managing Director of JKMSCL to get the proposal vetted by the Finance Department.

The Department stated (November 2023) that the matter regarding seeking concurrence of the Finance Department regarding creation of 48 posts was taken up with the Administrative Department from time to time, however no response was received till date.

The Financial Advisor/ CAO, JKMSCL stated (January 2025) that no response was received from the concerned Department of creation of 48 posts.

2.7 Human Resources under NHM

To overcome shortage of staff, supplementary manpower was also engaged under NHM for implementation of several schemes. The availability of staff under NHM including AYUSH staff in J&K during the period 2016-22 is given in **Table 2.8**.

Table 2.8: Availability of staff under NHM in J&K

Year	Medical Officers		Staff Nurses		Paramedical staff		Other staff	
	Permissibility	In-position (percentage shortfall)	Permissibility	In-position (percentage shortfall)	Permissibility	In-position (percentage shortfall)	Permissibility	In-position (percentage shortfall)
2016-17	1,626	1,429 (12)	1,103	901 (18)	5,414	4,630 (14)	631	655 (0)
2017-18	1,524	1,423 (7)	1,129	941 (17)	5,414	4,759 (12)	637	550 (14)
2018-19	1,533	1,331 (13)	1,640	966 (41)	5,415	4,821 (11)	634	549 (13)
2019-20	1,617	1,343 (17)	1,862	911 (51)	5,021	4,538 (10)	570	487 (15)
2020-21	1,614	1,309 (19)	1,958	1,620 (17)	5,038	4,867 (3)	584	496 (15)
2021-22	1,739	1,403 (19)	2,312	1,931 (16)	7,123	6,540 (8)	815	724 (11)

(Source: Information furnished by NHM, J&K)

The position depicted in the T**able 2.8** indicates that shortage of Medical Officers was ranging between 12 *per cent* and 19 *per cent* during 2016-17 to 2021-22. However, shortage of paramedical staff had significantly reduced from 14 *per cent* in 2016-17 to 08 *per cent* in 2021-22. Shortage of nurses had reduced from 18 *per cent* in 2016-17 to 16 *per cent* in 2021-22. Shortage of other staff was also reduced from 14 *per cent* in 2017-18 to 11 *per cent* in 2021-22.

2.8 Human Resources in the sampled Districts

Position of sanctioned and available doctors, nurses and paramedical staff as of March 2022 in the six sampled Districts in all HIs is given in **Table 2.9**.

Table 2.9: Availability of staff in the sampled Districts

Category	Position	District					
		Anantnag	Ganderbal	Jammu	Kupwara	Ramban	Udhampur
Doctors	Sanctioned	559	176	1,569	349	156	241
	Available	472	162	976	238	84	135
	Shortage (*per cent*)	87(16)	14 (8)	593 (38)	111 (32)	72 (46)	106 (44)
Nurses	Sanctioned	227	59	1,606	164	62	100
	Available	152	47	1,102	119	42	70
	Shortage (*per cent*)	75 (33)	12 (20)	504 (31)	45 (27)	20 (32)	30 (30)
Paramedical staff	Sanctioned	653	299	1,826	598	289	403
	Available	489	196	1,174	388	202	337
	Shortage (*per cent*)	164 (25)	103 (34)	652 (36)	210 (35)	87 (30)	66 (16)
Others	Sanctioned	897	299	3,184	550	241	502
	Available	671	225	1,876	268	168	326
	Shortage (*per cent*)	226 (25)	74 (25)	1,308 (41)	282 (51)	73(30)	176 (35)

(Source: Information furnished by concerned CMOs)

Audit observed that:

- Shortfall in respect of doctors ranged between 8 *per cent* (District Ganderbal) and 46 *per cent* (District Ramban).
- Shortfall in respect of nurses ranged between 20 *per cent* (District Ganderbal) and 33 *per cent* (District Anantnag).
- Shortfall in respect of paramedical staff ranged between 16 *per cent* (District Udhampur) and 36 *per cent* (District Jammu).
- Shortfall in respect of other staff ranged between 25 *per cent* (Districts Anantnag and Ganderbal) and 51 *per cent* (District Kupwara).

The Chief Accounts Officer, Directorate of Health Services Jammu stated (January 2025) that proposal for creation of posts as per IPHS norms has been submitted to the Administrative Department.

2.9 Human Resources in selected Tertiary Level Health Institutions

The details of available manpower in major categories in the selected tertiary level health institutions are shown in **Table 2.10**.

Table 2.10: The position of manpower as of March 2022

Cadre	Major Category	Government Medical College Jammu[15]			Government Medical College Srinagar[16]		
		SS	PIP	Shortfall *per cent*	SS	PIP	Shortfall *per cent*
Doctors	Professor	87	50	37 (43)	124	89	35 (28)
	Associate Professor	94	39	55 (59)	131	64	67 (51)
	Assistant Professor	97	55	42 (43)	178	78	100 (56)
	Lecturers	170	88	82 (48)	285	73	212 (74)
	Other Specialists	312	211	101 (32)	521	344	177 (34)
	MOs/other doctors	78	39	39 (50)	264	146	118 (45)
	Total	**838**	**482**	**356 (42)**	**1,503**	**794**	**709 (47)**
Supporting staff	Staff Nurses	1,306	927	379 (29)	1,094	933	161 (15)
	Paramedical staff	748	459	289 (39)	843	593	250 (30)
	Other staff	1,941	1,132	809 (42)	2,724	1,837	887 (33)
	Total	**3,995**	**2,518**	**1,479 (37)**	**4,661**	**3,363**	**1,298 (28)**
Grand Total		**4,833**	**3,000**	**1,835 (38)**	**6,164**	**4,157**	**2,007 (33)**

(Source: Information furnished by the Principals and Medical Superintendents concerned)

As seen from the **Table 2.10**, when compared with the sanctioned strength, there were shortages across above mentioned categories with overall shortage of 38 and 33 *per cent* in GMC Jammu and GMC Srinagar respectively.

2.9.1 Government Medical College, Jammu

- There was overall shortage of 356 doctors in GMC Jammu (including the sampled Associated Hospitals) as of March 2022 (Professor: 43 *per cent*, Associate Professor: 59 *per cent,* Assistant Professor: 43 *per cent* and Lecturers: 48 *per cent*) against the sanctioned strength of 838.

- Against the sanctioned post of 78 MOs/ other doctors, 39 were posted as of March 2022.

- There was an overall shortage of 29 *per cent* of staff nurses when compared with the sanctioned strength as of March 2022. Similarly, 39 *per cent* shortage was also noticed in paramedical staff.

- There was an overall shortage of 42 *per cent* of other staff.

[15] Including the sampled TLHs GMC & Hospital Jammu, SMGS Hospital Jammu and Super Specialty Hospital, Jammu

[16] Including the sampled TLHs SMHS Hospital Srinagar, Lalla Ded Hospital Srinagar, G.B. Pant Hospital Srinagar and Super Specialty Hospital Srinagar

2.9.2 Government Medical College, Srinagar

- There was overall shortage of 709 doctors in GMC Srinagar (including the sampled Associated Hospitals) as of March 2022 (Professor: 28 *per cent*, Associate Professor: 51 *per cent,* Assistant Professor: 56 *per cent* and Lecturers: 74 *per cent*) against the sanctioned strength of 1,503.

- Against the sanctioned post of 264 Medical Officers (MOs)/ other doctors, 146 were posted as of March 2022.

- There was an overall shortage of 15 *per cent* of staff nurses when compared with the sanctioned strength as of March 2022. Similarly, 30 *per cent* shortage was also noticed in paramedical staff.

- There was an overall shortage of 33 *per cent* of other staff.

2.10 Norms for allocation of Human Resources

Indian Public Health Standards (IPHS) 2012 guidelines prescribe minimum number of doctors, nurses, paramedical staff and support staff to be available in different Hospitals from DHs up to the Sub-Centre level according to the number of sanctioned beds. Details of IPHS 2012 norms are given in **Table 2.11**.

Table 2.11: IPHS 2012 norms for allocation of Human Resources

Sl. No.	Type of Health Institution	Bed capacity	IPHS 2012 norms for manpower (essential + desirable)
1.	Sub-Centre (Type A)	1	03 (ANM:2 and Health Worker:1)
2.	Primary Health Centre	4 to 6	18 (Doctors:2, Nurses:4, Paramedics and Others:12)
3.	Community Health Centre	30	52 (Doctors:11, Nurses:11, Paramedics:14 and Others:16)
4.	Sub-District Hospital	31 to 50	83 (Doctors:23, Nurses:20, Paramedics:28 and Others:12)
		51 to 100	121 (Doctors:31, Nurses:30, Paramedics:45 and Others:15)
5.	District Hospital	100	120 (Doctors:32, Nurses:45, Paramedics:31 and Others:12)
		200	184 (Doctors:37, Nurses:90, Paramedics:42 and Others:15)
		300	272 (Doctors:50, Nurses:135, Paramedics:66 and Others:21)
		400	345 (Doctors:58, Nurses:180, Paramedics:81 and Others:26)
		500	422 (Doctors:68, Nurses:225, Paramedics:100 and Others:29)

(Source: IPHS Guidelines 2012)

2.11 Manpower in District Hospitals

Shortage/ excess of doctors, nurses and paramedics against the IPHS 2012 norms and sanctioned strength in the sampled DHs is detailed in **Table 2.12**.

Table 2.12: Position of manpower in the sampled District Hospitals as of March 2022

District Hospital	Cadre	IPHS 2012 norms	Sanctioned Strength(SS)	Available	Shortage (-)/ Excess (+) as per IPHS 2012 norms	Shortage/ Excess as per SS
DH Anantnag including MCCH (Beds: 410)	Doctors	68	61	45	(-)23	(-)16
	Nurses	225	42	22	(-)203	(-)20
	Paramedics	100	69	33	(-)67	(-)36
	Others	29	65	63	(+)34	(-)2
DH Ganderbal (Beds: 130)	Doctors	37	26	21	(-)16	(-)5
	Nurses	90	14	9	(-)81	(-)5
	Paramedics	42	55	38	(-)4	(-)17
	Others	15	7	3	(-)12	(-)4
DH Jammu (Beds: 160)	Doctors	37	55	44	(+)7	(-)11
	Nurses	90	36	34	(-)56	(-)2
	Paramedics	42	49	35	(-)7	(-)14
	Others	15	70	28	(+)13	(-)42
DH Handwara (Beds: 73)	Doctors	32	50	30	(-)2	(-)20
	Nurses	45	22	11	(-)34	(-)11
	Paramedics	31	28	23	(-)8	(-)5
	Others	12	6	5	(-)7	(-)1
DH Ramban (Beds: 50)	Doctors	32	34	20	(-)12	(-)14
	Nurses	45	24	14	(-)31	(-)10
	Paramedics	31	32	20	(-)11	(-)12
	Others	12	11	7	(-)5	(-)4
DH Udhampur (Beds: 200)	Doctors	37	58	37	0	(-)21
	Nurses	90	32	21	(-)69	(-)11
	Paramedics	42	36	34	(-)8	(-)2
	Others	15	52	32	(+)17	(-)20

(Source: Figures furnished by the sampled DHs)

Data in the **Table 2.12** indicates that there was shortage of 02 to 23 doctors against the IPHS norms in four[17] out of six sampled DHs and shortage of 05 to 21 doctors against the sanctioned strength in all the six test-checked DHs. Effective strength of doctors in DH Jammu was more than the IPHS norms.

In nursing cadre, the shortage was 31 to 203 and 02 to 20 against the IPHS norms and sanctioned strength respectively in six sampled DHs.

In paramedics cadre, there was shortage of four to 67 paramedics against the IPHS norms whereas shortage of two to 36 paramedics was noticed against the sanctioned strength in six DHs.

2.11.1 Shortage of specialists in District Hospitals

DHs provide specialised medical services including Medicine, Surgery, Radiology, Orthopaedics, Paediatrics, Ophthalmology, ENT etc. IPHS 2012 norms provides for 16 types of Departments/ specialties in a DH. Audit analysed the availability of specialists in respect of 14 Departments/ specialties. The Department/ Specialty-wise availability of doctors in the DHs of UT of J&K as of March 2022 is given in the **Table 2.13**.

[17] DHs Anantnag, Ganderbal, Handwara and Ramban

Table 2.13: Availability of doctors in specialist cadre in DHs of UT of J&K

Sl. No.	Department	Sanctioned Strength	Availability of specialists	Shortfall	Percentage shortfall
1.	General Medicine	43	31	12	28
2.	General Surgery	43	30	13	30
3.	Obstetrics and Gynaecology	43	38	5	12
4.	Paediatrics	26	20	6	23
5.	Anaesthesia	43	29	14	33
6.	Ophthalmology	19	13	6	32
7.	Orthopaedics	27	18	9	33
8.	Radiology	11	6	5	45
9.	Pathology	11	7	4	36
10.	ENT	19	10	9	47
11.	Dental	47	41	6	13
12.	Dermatology and Venereology	7	3	4	57
13.	Psychiatry	7	4	3	43
14.	AYUSH	19	15	4	21
Total		**365**	**265**	**100**	**27**

(Source: Information furnished by the concerned DHs)

In terms of IPHS 2012 norms, there was a shortage of critical specialists such as Dermatologists, ENT specialists followed by Radiologists and Psychiatrists. However, the least shortage was noticed in case of Obstetrician and Gynaecologist (12 *per cent).*

Further, the availability of doctors in the specialist cadre in the sampled DHs as of March 2022 is detailed in **Table 2.14**.

Table 2.14: Availability of doctors in specialist cadre in the sampled DHs as of March 2022

Sl. No.	Department	Anantnag			Ganderbal			Handwara			Jammu			Ramban			Udhampur			Total		
		IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP
1.	General Medicine	5	4	2	2	2	1	2	4	3	2	3	2	2	0	0	2	3	1	**15**	**16**	**9**
2.	General Surgery	4	3	2	2	2	1	2	4	2	2	2	2	2	1	0	2	3	1	**14**	**15**	**8**
3.	Obstetrics and Gynaecology	6	3	3	3	2	2	2	3	2	3	3	3	2	2	2	3	5	3	**19**	**18**	**15**
4.	Paediatrics	5	2	1	3	1	1	2	1	1	3	1	1	2	1	1	3	3	2	**18**	**9**	**7**
5.	Anaesthesia	4	4	2	2	2	2	2	3	1	2	4	3	2	2	1	2	3	1	**14**	**18**	**10**
6.	Ophthalmology	2	2	2	1	1	1	1	0	0	1	4	3	1	1	0	1	2	1	**7**	**10**	**7**
7.	Orthopaedics	2	2	1	1	1	1	1	2	0	1	2	2	1	2	1	1	3	2	**7**	**12**	**7**
8.	Radiology	2	2	2	1	0	0	1	0	0	1	1	1	1	1	0	1	3	1	**7**	**7**	**4**
9.	Pathology	4	1	1	2	0	0	1	1	0	2	1	1	1	1	1	2	1	1	**12**	**5**	**4**
10.	ENT	2	2	2	1	1	1	1	1	1	1	2	2	1	1	0	1	1	1	**7**	**8**	**7**
11.	Dental	3	2	2	1	3	3	1	3	3	1	2	2	1	3	3	1	3	2	**8**	**16**	**15**

Sl. No.	Department	Anantnag			Ganderbal			Handwara			Jammu			Ramban			Udhampur			Total		
		IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP	IPHS	SS	PIP
12.	Dermatology	1	0	0	1	1	1	1	0	0	1	1	0	1	1	0	1	1	1	**6**	**4**	**2**
13.	Psychiatry	1	1	1	1	0	0	1	1	1	1	1	0	1	0	0	1	0	0	**6**	**3**	**2**
14.	AYUSH	2	1	1	1	0	0	1	2	2	1	2	2	1	0	0	1	2	2	**7**	**7**	**7**
Total		**43**	**29**	**22**	**22**	**16**	**14**	**19**	**25**	**16**	**22**	**29**	**24**	**19**	**16**	**9**	**22**	**33**	**19**	**147**	**148**	**104**

(Source: Information furnished by the sampled DHs)

****IPHS 2012 norms, SS: Sanctioned Strength, PIP: Person-in-position***

- The data in **Table 2.14** indicates that there was shortfall of 44 doctors as per the sanctioned strength for six sampled DHs. In percentage terms, the availability of doctors in specialist cadre was highest in Ganderbal District (88 *per cent*) and lowest in Ramban District (56 *per cent*) against the sanctioned strength.

- Audit noticed that there was shortfall of 50 specialists (45 *per cent*) against IPHS norms in the Departments of General Medicine (06), General Surgery (06), O and G (04), Paediatrics (11), Anaesthesia (04), Radiology (03), Pathology (08), Dermatology and Venereology (04) and Psychiatry (04). There was shortfall of 44 specialists (46 *per cent*) against posts sanctioned by GoJ&K for these Departments. However, the availability of Dental specialists in the sampled DHs was seven more than the IPHS 2012 norms.

- The post of specialists for Forensic and Microbiology was not sanctioned for any of the six sampled DHs.

Although GoJ&K had sanctioned posts for many Departments, it did not provide the manpower as per sanctioned strength. As a result, there was shortage of specialists in all Departments except AYUSH. Shortage of manpower in DHs affects delivery of medical services resulting in either the patients having to wait in queues outside the OPDs for a long time or compelling them to approach other hospitals having such facility.

2.12 Manpower in Sub-District Hospitals

In the UT of J&K, there were 47 Sub-District Hospitals as of March 2022. Sub-District Hospitals being below DH level but above block hospital level (CHC) require specialist services to be provided to patients. Manpower availability in the cadre of doctors, nurses, paramedical and other staff in the 18 sampled SDHs as of March 2022 is detailed in **Table 2.15**.

Table 2.15: Availability of Manpower in the sampled SDHs as of March 2022

Sl. No.	Name of the SDH	No. of Beds	IPHS 2012 Norms				Doctors		Nurses		Paramedics		Other Staff	
			Doctors	Nurses	Paramedics	Others	SS	PIP	SS	PIP	SS	PIP	SS	PIP
1	Bijbehara	30	23	20	28	12	17	17	7	4	17	14	9	8
2	Dooru	30					16	15	2	2	37	31	4	4
3	Kokernag	30					16	15	8	8	50	42	3	3

Sl. No.	Name of the SDH	No. of Beds	IPHS 2012 Norms				Doctors		Nurses		Paramedics		Other Staff	
			Doctors	Nurses	Paramedics	Others	SS	PIP	SS	PIP	SS	PIP	SS	PIP
4	Seer Hamdan	30					28	25	9	5	28	16	13	9
5	Shangus	20					9	3	7	5	15	10	3	2
6	Kangan	30					28	25	11	4	26	16	35	21
7	Bishnah	50					16	16	7	7	33	29	15	9
8	Jagti	34					20	11	15	2	35	3	3	1
9	Marh	20					9	9	7	4	25	21	7	4
10	R.S Pura	30					13	9	7	7	45	33	37	25
11	Sarwal	50					43	34	19	13	54	33	10	8
12	Langate	30					2	2	7	5	10	9	2	2
13	Sogam	33					18	11	4	2	12	11	2	2
14	Tangdar	30					12	7	4	2	12	7	2	1
15	Ramnagar	30					13	10	7	7	34	30	12	6
16	Akhnoor	60					33	23	15	12	82	52	14	11
17	Kot Bhalwal	75	31	30	45	15	19	12	6	1	18	16	20	8
18	Kupwara	150					53	37	73	66	42	35	17	17
Total		**762**	**438**	**390**	**555**	**225**	**365**	**281**	**215**	**156**	**575**	**408**	**208**	**141**

(Source: Information furnished by the sampled SDHs)
(SS: Sanctioned Strength; PIP: Person-in-Position)

The data in **Table 2.15** indicates that there was shortage of 84 (23 *per cent*) doctors, 59 (27 *per cent*) nurses, 167 (29 *per cent*) paramedics and 67 (32 *per cent*) other staff in the sampled SDHs against the sanctioned strength. When compared with IPHS 2012 norms, there was shortage of 157 (36 *per cent*) doctors, 234 (60 *per cent*) nurses, 147 (26 *per cent*) paramedics and 84 (37 *per cent*) other staff. However, in SDHs Bijbehara, Bishnah, Marh and Langate the availability of doctors was as per the sanctioned strength. In SDHs Dooru, Kokernag, Bishnah, R.S. Pura and Ramnagar the availability of nurses was as per the sanctioned strength.

2.12.1 Shortage of Specialists in Sub-District Hospitals

The availability of Specialists in the SDHs of UT of J&K as of March 2022 is given in **Table 2.16**.

Table 2.16: Availability of doctors in specialist cadre in SDHs of J&K as of March 2022

Sl. No.	Department	Sanctioned Strength	Availability of specialists	Shortfall
1.	General Medicine	53	31	22
2.	General Surgery	60	37	23
3.	Obstetrics and Gynaecology	61	45	16
4.	Dermatology	2	1	1
5.	Paediatrics	49	34	15
6.	Anaesthesia	51	38	13
7.	ENT	14	10	4
8.	Ophthalmology	12	11	1
9.	Orthopaedics	19	11	8
10.	Radiology	7	4	3
11.	Dental	61	58	3
12.	Pathology	6	5	1
13.	Psychiatry	2	2	0
Total		**397**	**287**	**110**

(Source: Information furnished by the concerned SDHs)

The data in **Table 2.16** indicates that against the sanctioned strength of 397 posts of specialists, only 287 (72 *per cent*) were available. The shortfall was higher in General Surgery, General Medicine and Obstetrics and Gynaecology as compared to other Departments.

Audit further observed that in the sampled SDHs, the specialist posts were either not sanctioned for the SDHs or if sanctioned, there was non-availability of specialists as detailed in **Table 2.17**.

Table 2.17: Non-availability of specialists in the sampled SDHs as of March 2022

Sl. No.	Name of the Department	SDHs lacking sanctioned post of specialist (Numbers)	SDHs without specialist against the sanctioned post (Numbers)
1.	Medicine	Kokernag, Langate, Marh, Tangdar (4)	Shangus, Ramnagar (2)
2.	Surgery	Langate, Marh (2)	Shangus, Sogam, Ramnagar (3)
3.	Obstetrics and Gynaecology	Langate, Marh (2)	Shangus, Tangdar (2)
4.	Paediatrics	Langate, Marh, Tangdar (3)	Seer Hamdan, Shangus, Jagti, Kot-Bhalwal, Sogam (5)
5.	Anaesthesia	Bijbehara, Dooru, Bishnah, Marh, Langate (5)	Shangus, Sogam, Tangdar (3)
6.	ENT	Bijbehara, Dooru, Bishnah, Marh, R.S.Pura, Langate, Sogam, Tangdar, Ramnagar (9)	Kokernag, Kangan, Kupwara (3)
7.	Ophthalmology	Bijbehara, Dooru, Kokernag, Kot-Bhalwal, Marh, R.S.Pura, Langate, Sogam, Tangdar, Ramnagar (10)	Jagti (1)
8.	Orthopaedics	Bijbehara, Dooru, Kokernag, Kot-Bhalwal, Marh, R.S.Pura, Langate, Sogam, Tangdar, Ramnagar (10)	Shangus (1)
9.	Radiology	Bijbehara, Kokernag, Kangan, Bishnah, Kot-Bhalwal, Marh, R.S.Pura, Langate, Sogam, Tangdar, Ramnagar (11)	Jagti (1)
10.	Dental	Langate (1)	Nil

Due to non-availability of specialists in the SDHs, the patients either approached the DHs or private health centres for specialised treatment.

2.12.2 Non-sanctioning of specialist post of doctors in SDH Marh

Audit noticed that PHC Marh was upgraded (August 2002) to SDH. There were eight Casualty Doctors/ General Duty Medical Officers but no posts of specialist doctors were sanctioned even after lapse of more than 19 years as of March 2022. During the period 2016-22, 2,95,195 patients visited the SDH Marh for treatment. Non-sanctioning of specialist post of doctors resulted in deprival of specialised healthcare facilities to the local population.

Picture 2.1: Sub-District Hospital, Marh

The Block Medical Officer, Marh stated (December 2024) that no post of specialist has been sanctioned.

2.13 Human Resources in Community Health Centres

CHC is a 30-bedded hospital providing specialist care in Medicine, Obstetrics and Gynecology, Surgery, Paediatrics, Dental and AYUSH. In the UT of J&K, there were 30 CHCs as of March 2022. The manpower availability for CHC as per IPHS 2012 norms (essential and desirable) is 52 (Doctors:11, Nurses:11, Paramedics:14 and Other staff:16). Manpower availability in the cadre of doctors, nurses, paramedical and other staff in the 10 sampled CHCs as of March 2022 is detailed in **Table 2.18**.

Table 2.18: Availability of Manpower in the sampled CHCs

Sl. No.	Name of the CHC	No. of beds	Doctors		Nurses		Paramedics		Other staff	
			SS	PIP	SS	PIP	SS	PIP	SS	PIP
1.	Sohanjana	17	17	13	6	6	38	30	8	5
2.	Jourian	10	20	14	8	2	37	10	9	4
3.	Khour	30	15	8	7	1	15	8	8	6
4.	Gool	20	14	6	8	6	21	14	5	3
5.	Banihal	30	14	13	8	7	32	22	24	15
6.	Batote	20	14	7	10	6	30	17	24	11
7.	Kralpora	30	19	11	8	7	19	18	6	5
8.	Zachaldara	10	4	4	6	0	6	4	12	7
9	Kralgund	10	3	3	2	0	10	9	6	4
10.	Chenani	110	16	12	7	5	19	16	20	14
Total		-	**136**	**91**	**70**	**40**	**227**	**148**	**122**	**74**

(Source: Information furnished by the sampled CHCs)
(SS: Sanctioned Strength; PIP: Person-in-Position)

It is evident from the **Table 2.18** that out of 10 sampled CHCs, 05 CHCs have adequate strength of doctors as per IPHS norms. However, against the sanctioned strength there was a shortage of 45 (33 *per cent*) doctors, 30 (43 *per cent*) nurses, 79 (35 *per cent*) paramedics and 48 (39 *per cent*) other staff in the sampled CHCs.

2.13.1 Shortage of Specialists in Community Health Centres

The availability of Specialists as of March 2022 in the CHCs of UT of J&K is given in **Table 2.19.**

Table 2.19: Availability of doctors in specialist cadre in CHCs of UT of J&K

Sl. No.	Department	Sanctioned Strength	Availability of specialists	Shortfall
1.	General Medicine	73	51	22
2.	Paediatrics	24	13	11
3.	General Surgery	25	14	11
4.	Dental	36	32	4
5.	Obstetrics and Gynaecology	25	19	6
6.	AYUSH	4	4	0
Total		**187**	**133**	**54**

(Source: Information furnished by the concerned SDHs)

The **Table 2.19** indicates that against the sanctioned strength of 187 posts of specialists, only 133 (71 *per cent*) were available. The shortfall was higher in General Medicine (22 Specialists) followed by Paediatrics and General Surgery (11 Specialists each). There was no shortage of AYUSH doctors against the sanctioned strength.

Further, the Specialist posts were either not sanctioned for the CHCs or if sanctioned, there was non-availability of specialists in the sampled CHCs as detailed in **Table 2.20**.

Table 2.20: Non-availability of Specialists in the sampled CHCs as of March 2022

Sl. No.	Name of the Department	CHCs lacking sanctioned post of specialist	CHCs without specialist against the sanctioned post
1.	Medicine	Banihal, Batote, Kralgund, Zachaldara	Gool, Jourian, Khour, Sohanjana, Chenani
2.	Surgery	Kralgund, Zachaldara	Batote, Chenani, Gool, Khour, Sohanjana
3.	Obstetrics and Gynaecology	Batote, Gool, Kralgund, Zachaldara	Khour
4.	Paediatrics	Kralgund, Zachaldara	Batote, Chenani, Gool, Khour, Kralpora
5.	Dental	Nil	Gool

The **Table 2.20** shows that in nine CHCs, there were no specialists in the Department of Medicine and in seven CHCs, there were no specialists of Surgery and Paediatrics.

Thus, sanctioned strength of the CHCs was not based on any objective criteria. Non-availability of specialist manpower in the sampled CHCs had resulted in non-delivery of medical services to patients who were compelled to take services of higher level health institutions.

2.14 Human Resources in Primary Health Centres

As per IPHS 2012, a PHC has to be manned by a Medical Officer, three staff nurses and nine paramedical and other staff. In the UT of J&K, out of 975 PHCs, there were no doctors in 301 PHCs, no nurses in 669 PHCs, no paramedical staff in 149 PHCs and no other supporting staff in 351 PHCs.

Status of manpower in 52 sampled PHCs in six sampled Districts as of March 2022 is given in **Table 2.21**.

Table 2.21: Status of manpower in the sampled PHCs as of March 2022

Sl. No.	Name of District	No. of PHCs test-checked	PHCs functioning without							
			MO	Nurses	Laboratory Technician	Pharmacist	Accountant cum Data Entry Operator	Health Worker (Female)	Health Assistant (Male)	Health Assistant (Female)
1.	Anantnag	9	1	6	4	1	9	1	9	7
2.	Ganderbal	6	0	4	4	5	6	1	3	6
3.	Jammu	10	3	8	8	1	10	4	10	10
4.	Kupwara	10	4	8	6	5	9	3	7	8
5.	Ramban	7	4	2	7	4	7	7	7	7
6.	Udhampur	10	3	8	1	9	2	7	8	8
Total		**52**	**15**	**36**	**30**	**25**	**43**	**23**	**44**	**46**

(Source: Information furnished by the concerned CMOs/BMOs)

The data in the **Table 2.21** shows that MOs were not available in 15 PHCs (29 *per cent*). Nurses were not available in 36 PHCs (69 *per cent*). Lab Technicians were not available in 30 PHCs (58 *per cent*) while Pharmacists were not available in 25 PHCs (48 *per cent*). There was non-availability of Health Workers (Female) in 23 PHCs (44 *per cent*), Health Assistants (Male) in 44 PHCs (85 *per cent*) and Health Assistants (Female) in 46 PHCs (88 *per cent*). Further, Accountant cum Data Entry Operator was not available in 43 out of 52 test-checked PHCs.

Audit also observed that the PHC Alinbass had sanctioned strength of one Medical Officer, one Laboratory Technician, one Pharmacist, one Health Assistant (Male) and one Staff Nurse as of March 2022. However, all the sanctioned posts remained vacant and one Pharmacist was working in the PHC on attachment basis for vaccination and other routine hospital work (February 2023). Due to non-posting of required staff, the people of the area were deprived of health services; besides, the building of PHC Alinbass completed (January 2015) at a cost of ₹ 232.80 lakh could not be made fully functional (March 2022).

2.15 Human Resources in Sub-Centres

As per IPHS 2012 norms, one Auxiliary Nurse and Midwife (ANM)/ Health Worker (Female) and one Health Worker (Male) are required for functioning of a Sub-Centre (SC). The status of manpower availability in 55 sampled SCs is given in **Table 2.22**.

Table 2.22: Status of manpower in the sampled SCs as of March 2022

Sl. No.	Name of District	Number of SCs sampled	Number of SCs where no ANM/Health Worker (Female) posted	Number of SCs where no Health worker (Male) posted
1.	Anantnag	10	2	9
2.	Ganderbal	6	0	6
3.	Jammu	10	0	8
4.	Kupwara	10	2	7
5.	Ramban	9	4	4
6.	Udhampur	10	1	3
Total		**55**	**9**	**37**

(Source: Information provided by SCs)

The **Table 2.22** shows that in 55 sampled SCs in six test-checked Districts, no ANM/ Health Worker (Female) and Health Worker (Male) were posted in nine and 37 SCs respectively. This was indicative of the fact that these SCs were not working with their optimal strength.

2.16 Non-availability of staff in Trauma Care Centres

Accidental trauma is considered as a leading cause of mortality and morbidity in India. An accepted strategy of Trauma Care Centre (TCC) is that if basic life support, first aid and placement of fluids can be arranged within the first hour of injury, lives of many of the accident victims can be saved. As per Digest of Statistics 2020-21, GoJ&K, 699 people died and 5,951 people sustained injuries in 4,903 road accidents during the year 2020 in the UT. Out of these, 106 persons[18] died and 725 persons[19] were injured in the sampled Districts of Udhampur and Ramban which recorded 553 accidents.

Ministry of Health and Family Welfare, GoI signed a Memorandum of Understanding (MoU) with the GoJ&K for upgradation and strengthening of emergency facilities of seven hospitals in the State/ UT including one each in the sampled DHs of Udhampur and Ramban for providing Trauma Care Services. Audit observed that:

- The TCC with necessary equipment was established (February 2016) in DH Udhampur at a cost of ₹ 4.58 crore[20] but it could not be made functional due to non-availability of technical staff and doctors despite sanctioning of manpower (34 posts) for TCC Udhampur. Non-availability of manpower had not only resulted in idle investment of ₹ 4.58 crore on construction of TCC but also deprived the patients of envisaged facilities.

Picture 2.2: Idle machinery and equipment in Trauma Centre Udhampur

Picture 2.3: Non-functional OT in Trauma Centre Udhampur

The Medical Superintendent, Associated Hospital GMC, Udhampur stated (January 2025) that the Trauma Care Centre could not be made functional due to non-availability of staff and space.

18 Udhampur: 60 and Ramban: 46
19 Udhampur: 487 and Ramban: 238
20 Civil works: ₹ 0.90 crore; equipment: ₹ 3.68 crore

- Sanction was accorded (October 2019) for creation of 34 posts for Trauma Centre Ramban established in the old building of DH Ramban. However, as of November 2023, against the sanctioned strength of 35 (Specialist doctors:eight, MOs:six, Nurses: seven and Other staff: 14) staff, only six (Consultant Paediatric: one, MOs: three, Nurse: one and Other staff: one) staff were posted. Some equipment were received and were functional. However, in absence of required staff, the Trauma Care Centre was being used as Maternal ward, Dialysis unit, District Early Intervention Centre (DEIC) unit and operation theatre.

2.17 Conclusion

Human resources, an essential resource for health management, witnessed persistent shortages in all the cadres in the health institutions. Government had not ensured availability of posts in the health sector considering that the sanctioned posts were not in keeping with the population to be served, thereby adversely affecting health services. This shortage was quite high in several key posts such as Doctors, Staff Nurses, Paramedics, etc. who play a very important role in delivering comprehensive healthcare to the beneficiaries. Moreover, available manpower including the crucial manpower has not been distributed uniformly across the districts.

2.18 Recommendations

In light of the audit findings, GoJ&K may consider:

- ***Revising the sanctioned strength of Health Department at par with the IPHS norms, posting of staff in health institutions at par with the sanctioned strength in the primary, secondary and tertiary healthcare institutions. Government should bring out a long-term strategy and policy to reduce variations in doctor-population ratio across districts; and***
- ***Allocating human resources in the health institutions throughout the UT in a uniform manner in order to minimise skewed distribution of manpower across the districts. Availability of infrastructure and other crucial components should also be considered during such rationalisation.***

CHAPTER-III
HEALTHCARE SERVICES

CHAPTER-III

Healthcare Services

Introduction

High-quality healthcare services involve the right care at the right time and responding to the users' needs and preferences, while minimising harm and wastage of resources. Quality healthcare increases the likelihood of desired health outcomes.

The availability of line and support services in the DHs as on March 2022 is given in **Table 3.1**

Table 3.1: Availability of line and support services in DHs of UT of J&K

Name of the HI	Availability of the service												
	Emergency	Imaging Diagnostic	Pathology	Ambulance	Blood Bank	Bio-Medical Waste Management	Mortuary	ICU	Oxygen service	Dietary service for normal patient other than JSSK (Maternity)	Dietary Service for JSSK (Maternity)	Laundry service within the institution	Laundry service outsourced
DH Anantnag	A	A	A	A	A	A	A	A	A	NA	A	NA	A
DH Kulgam	A	A	NA	A	A	A	NA	A	A	NA	A	NA	A
DH Shopian	A	A	NA	A	A	A	A	A	A	NA	A	A	NA
DH Pulwama	A	A	A	A	A	A	A	A	A	NA	A	A	NA
DH Bandipora	A	A	NA	A	A	A	A	A	A	NA	A	A	NA
DH Handwara	A	A	A	A	A	A	A	A	A	NA	A	A	NA
DH Budgam	A	A	A	A	A	A	A	NA	A	NA	A	A	NA
DH Ganderbal	A	A	A	A	A	A	NA	NA	A	NA	A	A	NA
DH Srinagar	A	A	A	A	A	A	NA	A	A	NA	A	NA	A
DH Ramban	A	A	A	A	A	A	A	NA	A	NA	A	A	NA
DH Jammu	A	A	A	A	A	A	NA	A	A	Yes	A	NA	A
DH Reasi	A	A	A	A	A	A	A	A	A	Yes	A	NA	NA
DH Poonch	A	A	A	A	A	A	A	A	A	Yes	A	A	NA
DH Samba	A	A	NA	A	A	A	A	A	A	NA	A	A	NA
DH Kishtwar	A	A	A	A	A	A	A	A	A	NA	NA	NA	NA
DH Udhampur	A	A	A	A	A	A	A	NA	A	NA	A	A	NA

(Source: Information furnished by the District Hospital concerned)
Available: A; Not Available: NA

It is evident from the **Table 3.1** that services such as Emergency, Imaging Diagnostics, Ambulance, Blood Bank, Bio-Medical Waste Management and Oxygen were available in DHs in UT. Dietary service was provided to *Janani Shishu Suraksha*

Karyakaram (JSSK) patients in all DHs except DH Kishtwar. Dietary service for regular patients other than maternity patients admitted under JSSK was available in only three[1] DHs. Laundry service, either institutional or outsourced, was available in all DHs except DH Kishtwar and DH Reasi.

Audit observations on delivery of timely and quality healthcare services in Outpatient Department (OPD), In-patient Department (IPD), Intensive Care Unit (ICU), Operation Theatre (OT), Emergency and Diagnostic services are discussed in the succeeding paragraphs.

3.1 Outpatient Department

The specific objectives of IPHS 2012 norms for DHs, SDHs and CHCs are to provide comprehensive and optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. As per IPHS norms, Essential (Minimum Assured Services)/ Desirable (which should be aspired to be achieved) services of General Medicine (GM), General Surgery, Orthopaedics, Obstetrics and Gynaecology (O and G), Ophthalmology, Paediatrics, ENT[2], Skin and VD[3], Dental etc. were required to be available in the OPDs of HIs.

3.1.1 Availability of OPD services in DHs

Details of availability/ non-availability of OPD services in DHs of the UT of J&K as of March 2022 are given in **Table 3.2**

Table 3.2: Availability of OPD services in DHs of UT of J&K

Sl. No.	Name of the DH	Availability of OPD services									
		ENT	GM	Paed.	GS	Oph.	Dental	O & G	Psy.	Ortho	Skin &VD
1.	DH Anantnag/ MCCH Anantnag	A	A	A	A	A	A	A	A	A	NA
2.	DH Bandipora	NA	A	A	A	A	A	A	NA	A	NA
3.	DH Budgam	A	A	A	A	NA	A	A	NA	A	NA
4.	DH Ganderbal	A	A	A	A	A	A	A	A	A	A
5.	DH Handwara	A	A	A	A	NA	A	A	A	NA	NA
6.	DH Jammu	A	A	A	A	A	A	A	NA	A	NA
7.	DH Kishtwar	NA	A	A	A	A	A	A	NA	A	NA
8.	DH Kulgam	NA	A	A	A	A	A	A	NA	A	NA
9.	DH Poonch	NA	A	A	A	NA	A	A	NA	A	NA
10.	DH Pulwama	A	A	A	A	NA	A	A	A	A	NA
11.	DH Ramban	NA	NA	A	NA*	NA	A	A	NA	A	NA
12.	DH Reasi	NA	A	A	A	NA	A	A	A	A	NA
13.	DH Samba	NA	A	A	A	A	A	A	NA	A	NA
14.	DH Shopian	NA	A	A	A	A	A	A	NA	NA	NA
15.	DH Srinagar	A	A	A	A	A	A	A	A	A	A
16.	DH Udhampur	A	A	A	A	A	A	A	A	A	A

(Source: Information furnished by the DHs)
(GM: General Medicine; Paed.: Paediatrics; GS: General Surgery; Oph.: Ophthalmology; O&G: Obstetrics & Gynaecology; Psy.: Psychiatry; Ortho: Orthopaedics)
A: Available; NA: Not available, *: consultant surgeon was available on deputation (regular surgeon was not available)

[1] DH Jammu, DH Reasi and DH Poonch
[2] Ear, Nose and Throat
[3] Venereal Diseases

It is evident from the **Table 3.2** that services of Paediatrics, Dental and O and G were available in all DHs. However, services of ENT, Psychiatry, Ophthalmology, Skin and VD were not available in eight, nine, six and thirteen DHs respectively. The service was not available mainly due to non-availability of specialist in the respective categories.

The shortage of manpower is discussed in **Paragraph 2.2**.

3.1.2 Availability of essential OPD services in SDHs

Specialist services are provided through SDHs. As per IPHS 2012 norms, the SDH is expected to provide minimum assured services (essential). In the sampled 18 SDHs, status of availability of essential OPD services is given in **Table 3.3**.

Table 3.3: Availability of essential OPD services in SDHs

Sl. No.	Name of the SDH	General Medicine	Surgery	O & G	Paediatrics	ENT	Ophthalmology	Orthopaedics	Dentistry	AYUSH
1.	R.S. Pura	A	A	A	A	A	A	A	A	NA
2.	Jagti	A	A	A	NA	A	NA	A	A	NA
3.	Kot-Bhalwal	A	A	A	NA	NA	NA	NA	A	NA
4.	Marh	A	NA	A	NA	NA	A	NA	A	NA
5.	Bishnah	A	A	A	A	NA	A	A	A	NA
6.	Akhnoor	A	A	A	A	A	A	A	A	NA
7.	Sarwal	A	A	A	A	A	A	A	A	NA
8.	Kangan	A	A	A	A	NA	A	A	A	NA
9.	Sogam	A	NA	A	NA	NA	NA	NA	A	NA
10.	Kupwara	A	A	A	A	NA	A	A	A	NA
11.	Langate	A	NA	NA	NA	NA	NA	NA	NA	NA
12.	Tangdar	NA	A	A	NA	NA	NA	NA	A	NA
13.	Ramnagar	A	NA	A	A	NA	NA	NA	A	NA
14.	Seer Hamdan	A	A	A	NA	A	A	A	A	NA
15.	Bijbehara	A	A	A	A	NA	NA	A	A	NA
16.	Dooru	A	A	A	A	NA	NA	NA	A	NA
17.	Shangus	A	NA	NA	NA	NA	NA	NA	A	NA
18.	Kokernag	NA	A	A	A	NA	NA	NA	A	NA

(Source: Information furnished by the sampled SDHs)
(A: Available; NA: Not available)

From the **Table 3.3**, it may be seen that Dentistry was available in all SDHs except SDH Langate. However, AYUSH service was not available in any of the selected SDHs. Apart from AYUSH, all other essential services were available in three SDHs. Out of the nine services discussed above, only one service was available in SDH Langate, two services in SDH Shangus and three services were available in SDH Tangdar. The service was not available due to non-availability of specialist in the respective categories as discussed in **Paragraph 2.12**.

3.1.3 Availability of OPD services in CHCs

As per IPHS 2012 norms, General Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Dental and AYUSH Services should be available in CHCs.

In the 10 sampled CHCs, status of availability of OPD services is given in **Table 3.4.**

Table 3.4: Availability of OPD services in CHCs

Sl. No.	Name of the CHC	General Medicine	Surgery	O and G	Paediatrics	Dentistry	AYUSH
1.	Sohanjana	A	A	A	A	A	NA
2.	Jourian	A	A	A	A	A	NA
3.	Khour	A	NA	A	NA	A	A
4.	Gool	A	NA	NA	NA	NA	NA
5.	Banihal	A	A	A	A	A	NA
6.	Batote	NA	NA	NA	NA	A	NA
7.	Kralpora	A	A	A	NA	A	NA
8.	Zachaldara	A	NA	NA	NA	A	NA
9	Kralgund	A	NA	NA	NA	A	NA
10.	Chenani	A	A	A	A	A	NA

(Source: Information furnished by the sampled CHCs)
AA: Available; NA: Not available)

The **Table 3.4** indicates that out of the ten sampled CHCs, all prescribed services except AYUSH were available in four CHCs. However, Surgery, AYUSH and Paediatrics OPD were not available in five, nine and six CHCs respectively. While essential services of General Medicine and O and G were not available in one and four CHCs respectively. The non-availability of services could be ascribed to non-sanctioning of post of specialists or non-availability of specialists against the sanctioned posts which has been discussed in **Paragraph 2.13.**

The Chief Accounts Officer, Directorate of Health Services Jammu stated (January 2025) that sanctioning of Consultant/ Specialist posts and posting of Consultant/Specialist is DHs/ SDHs/ CHCs is within the purview of Administrative Department.

3.1.4 Availability of OPD services in PHCs

As per IPHS 2012 norms, six hours of OPD services (four hours in the morning and two hours in the afternoon) are required for six days in a week at PHC level. No specific OPD services are prescribed in IPHS for PHCs. OPD services were available in all the test-checked PHCs as per physical survey.

3.1.5 Availability of basic facilities in OPD area

According to IPHS 2012 norms, HIs should provide adequate seating arrangement in the waiting area, potable drinking water and functional/ clean toilets to waiting patients/ attendants. Availability of basic facilities in the sampled HIs is detailed in **Table 3.5.**

Table 3.5: Availability of basic facilities in sampled HIs

Sl. No.	Facility	Number of HIs having basic facilities in OPD		
		TLH (7)	DH (6)	SDH/CHCs (28)
1	Seating facility in OPD premises	7	5	21
2	Toilets in OPD premises	7	6	24
3	Drinking water facility in OPD area	6	5	17

(Source: Information provided by the Department)

The data in the **Table 3.5** shows that basic facilities were available in all sampled DHs except drinking water facility in DH Handwara. Out of the sampled 28 SDHs/ CHCs, seven SDHs/ CHCs lacked seating facility, four lacked toilets and drinking water was not available in the OPD area in 11 SDHs/ CHCs. Similarly, out of seven TLHs, basic facilities were available except drinking water facility in SMHS Srinagar.

3.1.6 Patient satisfaction survey for outdoor patients

NHM Assessor's Guidebook for Quality Assurance provides for conducting Patient Satisfaction survey at periodic intervals. Audit noticed that no outpatient satisfaction survey had been conducted by the sampled HIs during 2016-22 except DH Ramban which received patient feedback in 2021-22 through the app *Mera Aspataal*. However, results of patient survey of 1,545 outpatients[4] of sampled HIs carried out by Audit are detailed in **Table 3.6**

Table 3.6: Availability of facilities as per patient satisfaction survey

Availability of facility	Tertiary level HIs (210 patients)	DHs (120 patients)	SDHs/CHCs (420 patients)	PHCs (520 patients)	SCs (275 patients)
Adequate seating arrangement	112 (53)	69 (58)	188 (45)	253 (49)	96 (35)
Drinking water	81 (39)	60 (50)	143 (34)	88 (17)	55 (20)
Neat and clean toilet	95 (45)	45 (38)	193 (46)	220 (42)	74 (27)
Adequacy of registration counters	123 (59)	74 (62)	256 (61)	238 (46)	30 (11)
Availability of staff at registration counter	208 (99)	120 (100)	419 (100)	305 (59)	75 (27)
Cleanliness of OPD area	207 (99)	117 (98)	391 (93)	419 (81)	221 (80)
Patient calling system	144 (69)	110 (92)	228 (54)	333 (64)	168 (61)
Doctor explained the nature of ailment in an understandable way	197 (94)	119 (99)	416 (99)	419 (81)	240 (87)
Availability of prescribed medicines in the pharmacy	03 (1)	63 (53)	113 (27)	282 (54)	173 (63)
Recommended pathological tests done in the hospital	183 (87)	45 (38)	115 (27)	50 (10)	0
Recommended radiological tests done in the hospital	183 (87)	49 (41)	122 (29)	22 (4)	0

(Source: Patient's satisfaction survey)

[4] 30 outpatients per tertiary level hospital (seven hospitals), 20 outpatients per DH (six DHs); 15 outpatients per SDH/ CHC (28 SDHs/CHCs), 10 outpatients per PHC (52 PHCs) and five outpatients per SC (55 SCs)

Out of 330 patients surveyed in the TLHs and DHs:

- 63 (53 *per cent*) patients stated that they were provided with prescribed medicines in DHs whereas about one *per cent* patients were provided with prescribed medicines in TLHs.

- 141 (43 *per cent*) and 181 (55 *per cent*) patients were satisfied with the availability of drinking water and seating arrangements respectively whereas 190 (58 *per cent*) patients mentioned lack of clean toilets in TLHs and DHs.

- 76 (23 *per cent*) patients were not satisfied with the patient calling system.

Out of 420 patients surveyed in the test checked SDHs/ CHCs:

- Only 113 (27 *per cent*) patients stated that they were provided with the prescribed medicines.

- 143 (34 *per cent*) and 188 (45 *per cent*) patients were satisfied with the availability of facilities of drinking water and seating arrangements respectively whereas 227 (54 *per cent*) patients pointed out lack of clean toilets and 164 (39 *per cent*) patients stated the inadequacy of registration counters.

- 192 (46 *per cent*) patients were not satisfied with the patient calling system.

Similarly, in PHCs and SCs combined, about 57 *per cent* patients (455 out of 795) were provided prescribed medicines. 652 (82 *per cent*) and 446 (56 *per cent*) patients complained of non-availability of drinking water and seating arrangements respectively.

3.1.7 Flow of patients in OPD

To avail outpatient services in the hospitals, outpatients first register at the Outdoor Patient Department (OPD). After registration, the doctors examine the patients and either prescribe diagnostic tests for evidence based diagnosis or prescribe drugs as per their own diagnosis during consultation.

3.1.7.1 Registration of Outpatients

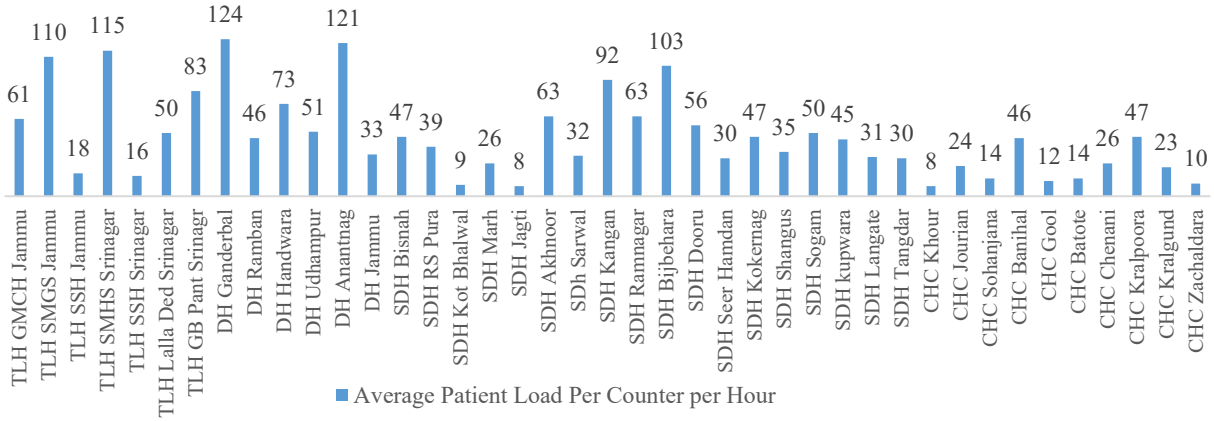
Registration is a process by which a patient's name and identity are enrolled into the records of the hospital in order to provide services of the hospital to the patient and to keep a track of various services that are availed by each patient.

Audit observed that there was no computerised system for registration and patient management in the test checked primary and secondary level hospitals.

Deputy Director (HQ), Health Services Kashmir admitted (January 2023) that there was no computerised system for registration and patient management in primary and secondary level HIs.

Assessor Guidebook for Quality Assurance in District Hospitals (Vol-1) estimates the average time required for registration to be 3-5 minutes per patient, which roughly works out to about 12-20 patients/ hour per counter. Audit examined the number of patients registered during 2016-22 in seven sampled TLHs, six DHs and 28 CHCs/ SDHs along with availability of registration counters and observed that adequate number of registration counters were not available as detailed in **Chart 3.1.**

Chart 3.1 Average Patient load per counter per hour during 2016-22, in seven sampled TLH[5]s, six sampled DHs, 18 SDHs and 10 CHCs



(Source: Information provided by the HIs)

The average patient load per counter per hour varied from 16 (SSH, Srinagar) to 115 (SMHS, Srinagar) in TLHs , 33 (DH Jammu) to 124 (DH, Ganderbal) in DHs, 08 (SDH Jagti) to 103 (SDH Bijbehara) in SDHs and 08 (CHC Khour) to 47 (CHC Kralpoora) in CHCs. The HIs having higher patient load against the norms should consider increasing the number of counters. The result of higher number of patients was visible in long queues in the hospitals as depicted in the photographs below:

OPD patients at registration counters in SDH Akhnoor (18.07.2022)	**OPD patients waiting at registration counters in SDH R.S.Pura (08.06.2022)**

[5] 310 OPD working days were taken in respect of TLHs for the purpose of calculation of Avg. Patient load/counter/hour

3.1.7.2 Waiting Time for Outpatients

Audit surveyed patients for determining waiting time for registration of patients at the registration counters, waiting time between registration and consultation with the doctor and time taken by the doctor for evaluation of patients. The response of the patients in the test checked HIs is detailed in **Table 3.7.**

Table 3.7: Average turnaround time

Type of HI		Tertiary level HIs (7)	DH (6)	SDHs (18)	CHCs (10)	Total
No. of outpatients surveyed per HI		30	20	15	15	
Total no. of outpatients surveyed		210	120	270	150	750
Waiting time for registration (in minutes)	**Up to 5**	17	38	113	157	325
	6-10	75	18	7	41	141
	11-15	52	18	4	41	115
	More than 15	66	46	26	31	169
Waiting time between registration and consultation (in minutes)	**Up to 15**	31	38	91	197	357
	16-30	48	49	36	63	196
	31-60	90	27	21	7	145
	More than 60	41	6	2	3	52
Time taken by doctor (in minutes)	**Up to 5**	129	73	88	146	436
	6-10	67	35	54	106	262
	11-15	9	9	7	14	39
	More than 15	5	3	1	4	13

(Source: Patient's survey)

- Out of 750 outpatients surveyed at various health institutions, 325 (43 *per cent*) patients stated that they were able to get themselves registered within five minutes. However, for the same category the percentage was 32 *per cent* in respect of patients surveyed at DHs and only eight *per cent* in respect of TLHs.

- 34 *per cent* patients at TLHs and DHs took over 15 minutes for registration.

- In TLHs, 62 *per cent* patients waited for more than 30 minutes to consult the doctor after registration.

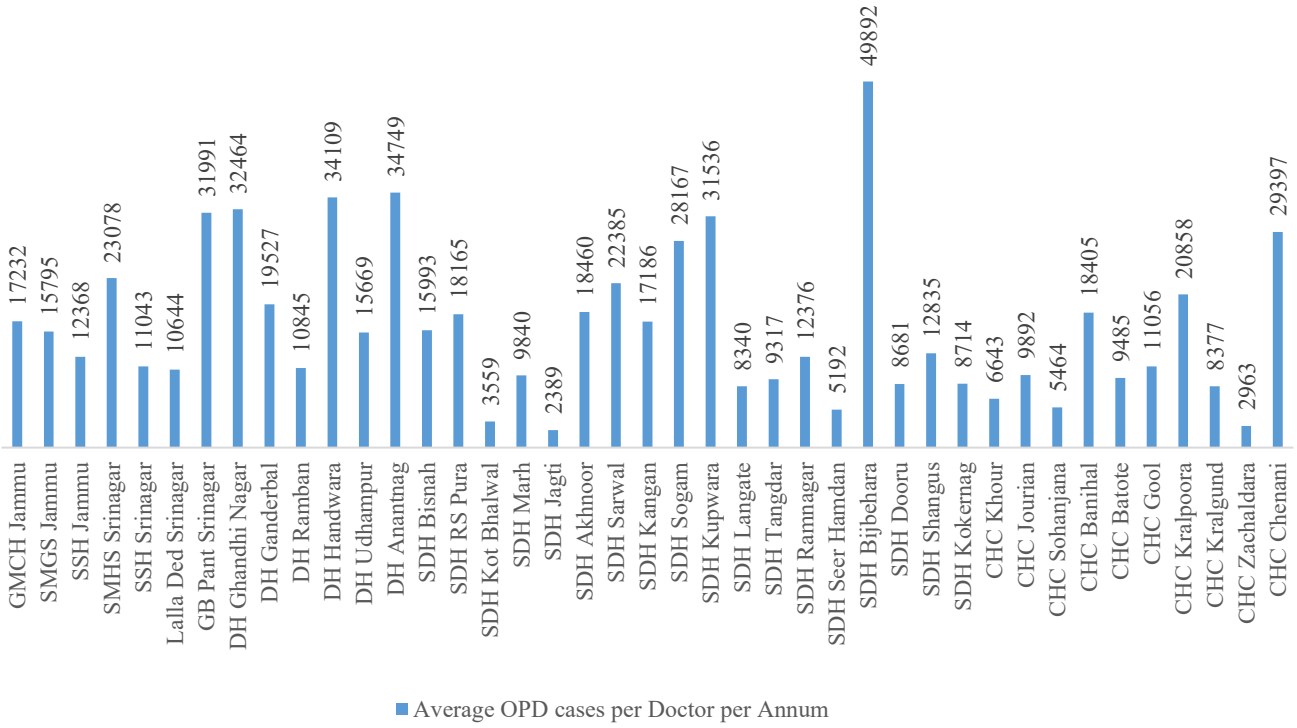
- In DHs/ SDHs/ CHCs, 40 *per cent* patients waited for more than 15 minutes to consult the doctor after registration.

Doctors examined 58 *per cent* patients for only five minutes in all HIs and only 13 (less than two *per cent*) patients stated that the doctors had examined them for over 15 minutes.

3.1.7.3 OPD cases per doctor per annum and consultation time per patient in OPD

OPD cases per day per doctor is an indicator for measuring efficiency of OPD services in a hospital. Average OPD cases per doctor per annum of each individual HI for the period 2016-22 is detailed in **Chart 3.2.**

Chart 3.2: Details of average OPD cases per doctor per annum during 2016-22



(Source: Information furnished by the Department)

The average OPD cases per doctor per annum was highest in SDH Bijbehara (49,892) and lowest in SDH Jagti (2,389).This shows that the availability of doctors is required to be ensured as per the patient load in the health institutions. Such analysis could form the basis for the creation of posts for doctors as well as their deployment.

Overall average consultation time available to patients in TLHs, DHs and SDHs[6]/ CHCs during 2016-22 is detailed in **Table 3.8**.

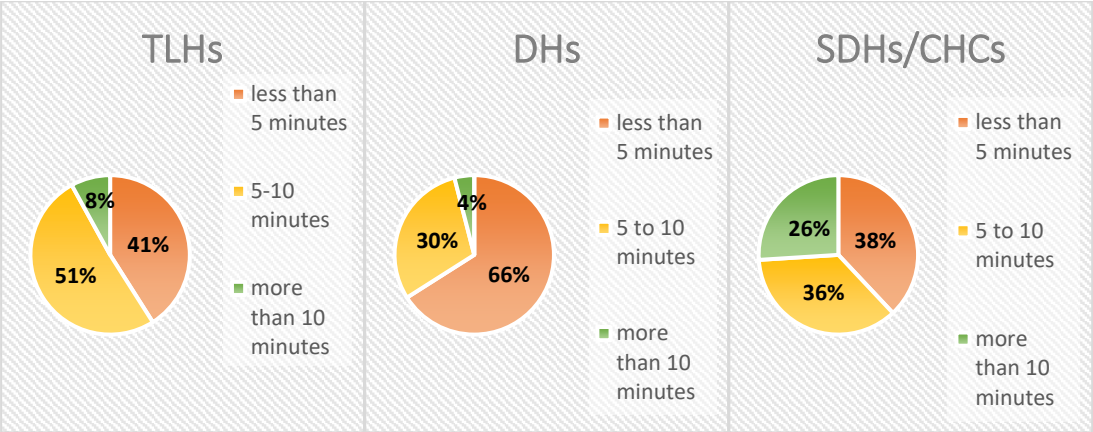
Table 3.8: Average consultation time available to patients in HIs during 2016-22

Consultation time	Number of patients during 2016-22 (in lakh)		
	Tertiary level HIs	DHs	SDHs/CHCs
Less than 5 minutes	59.69	65.24	55.81
5 to 10 minutes	73.35	29.06	52.32
More than 10 minutes	11.22	3.71	37.86

(Source: Information furnished by the Department)

[6] PHC Kot-Bhalwal and Government Hospital Jagti were upgraded as SDH in June 2018 and June 2019 respectively. Accordingly, the period as PHC was not considered for calculation

Percentage of average consultation time given to patients



3.1.7.4 Prescription Audit

Regulations 1.4 and 1.5 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 provide that every physician shall display the registration number accorded to him/ her by the State Medical Council/ Medical Council of India in all his/ her prescriptions and should as far as possible prescribe drugs with generic names.

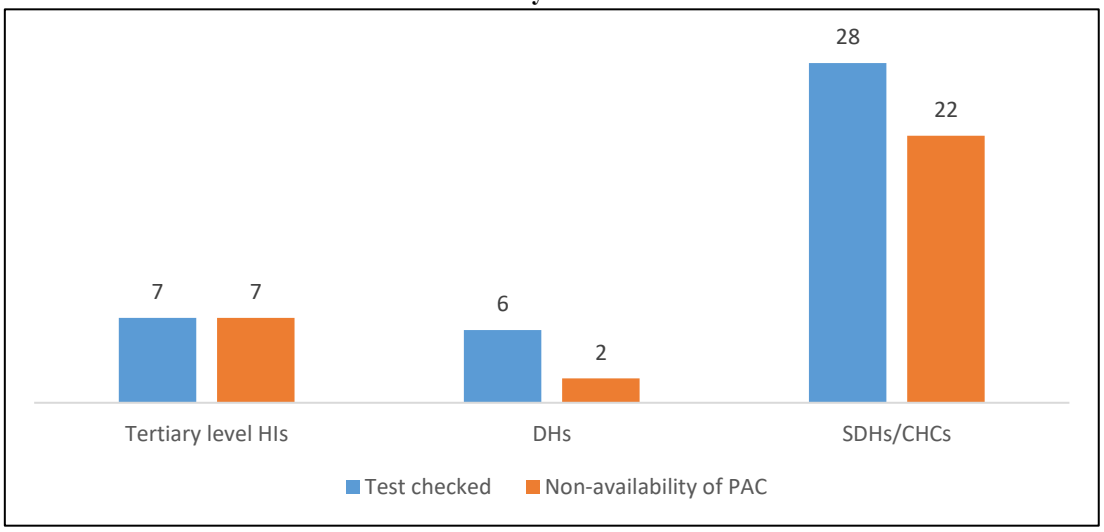
GoJ&K accorded (February 2020) sanction for constitution of Prescription Audit Committees (PAC) for Secondary and Tertiary level hospitals. The PAC shall prepare and submit fortnightly reports to the respective Heads of Departments (HODs). According to the sanction a Nodal Officer was to be nominated for collection of at least one *per cent* of prescriptions written by the Government doctors in OPDs on daily basis at random. The prescriptions collected by the Nodal Officer shall be scrutinised by the PAC to see whether:

- Prescriptions have name of doctor with registration number and are written legibly in capital letters over his/ her signature.
- Generic drugs are prescribed with preference given to drugs which are available free in the hospital.
- Unnecessary diagnostic tests/ procedures are prescribed, and patients are referred to private clinics/ specialists without requirement.
- Drugs are prescribed in contravention to the provisions of the Drugs and Cosmetics Act and regulations.

Audit observed that as of March 2022, PACs had not been constituted in any of the seven sampled TLHs, two[7] out of six sampled DHs and 22 out of 28 sampled CHCs/ SDHs as depicted in **Chart 3.3**.

[7] DH Ganderbal and DH Handwara

Chart 3.3: Non-availability of PACs in test checked HIs



Though PACs were framed in four DHs and six SDHs/CHCs, the purpose thereof was not fulfilled, as discussed in **Table 3.9**.

Table 3.9: Non-fulfillment of objectives of PACs in four DHs and six SDHs/CHCs

Sl. No.	Name of the HIs	Remarks
1.	DH Gandhi Nagar, Jammu	The prescription audit was conducted during January 2021 but it was discontinued after DH, Gandhi Nagar was designated as COVID dedicated hospital. The process was again started w.e.f. April 2022. It was noticed (April 2022) by the committee that only 66 *per cent* drugs were prescribed by generic names, in 77 *per cent* prescriptions date of next visit was not written and 50 *per cent* prescription are not signed legibly by the doctor.
2.	DH, Ramban	The PAC was framed in June 2021 and the prescription audit was conducted twice during the month of June 2021.
3.	DH Anantnag	Though PAC was set up in October 2020, nothing was on record about prescription audit undertaken.
4.	DH Udhampur	The prescription audit was conducted during January 2021 to August 2021 and thereafter stopped due to COVID-19 pandemic.
5.	SDH, Sarwal	The PAC was constituted in January 2021 and prescription audit started from May 2021 and the reports were submitted to the DHS Jammu on monthly basis instead of fortnightly basis..
6.	SDH, Akhnoor	The PAC was constituted in February 2020. Due to spread of COVID-19 in March 2020, no report was furnished to higher authorities.
7.	SDH, Marh	The PAC was constituted in March 2021. No prescription audit was conducted.
8.	SDH, Jagti	The PAC was set up in February 2021. The reports for the months of September-November 2021 only were made available to audit.
9.	SDH Ramnagar	The PAC was constituted in December 2020. No prescription audit was conducted.
10.	CHC Chenani	The PAC was constituted in October 2021. No prescription audit was conducted.

(Source: Information furnished by the concerned sampled HIs)

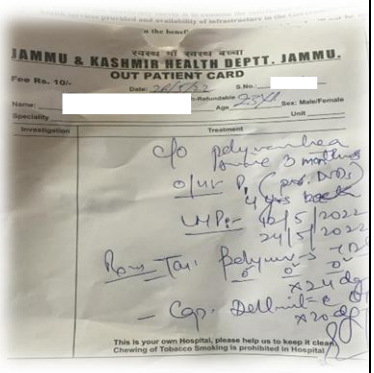
Audit collected prescriptions on the spot from the outpatients and found shortcomings in them as detailed in **Table 3.10.**

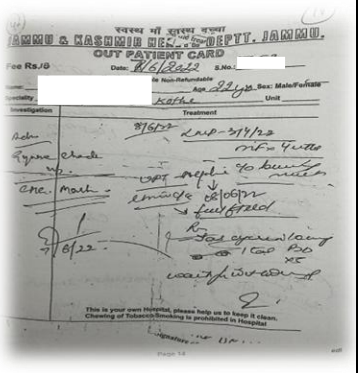
Table 3.10: Shortcomings in prescriptions given to outpatients

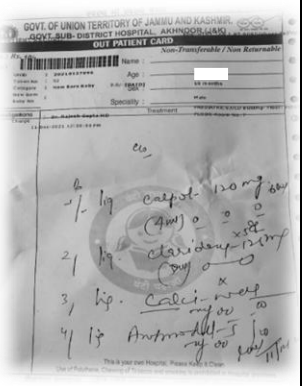
Number of prescriptions	Tertiary level Hospitals (5)	DHs (6)	SDHs/CHCs (28)
Test checked	183	111	300
Of which not written legibly	14	46	84
Of which not written in capital letters	182	111	299
Of which without name of doctor	129	82	277
Of which without signature of doctor	102	48	136
Of which not having registration number of doctor	183	95	284
Of which generic medicines not prescribed	157	67	194

(Source: Patient's satisfaction survey from concerned sampled HIs)

From the table above it is evident that the norms relating to prescriptions had not been adhered to by the HIs.







Prescriptions not written legibly, not written in capital letters and without name and registration number of doctor.

The Medical Superintendent, Associated Hospital GMC, Udhampur stated (January 2025) that the Prescription Audit Committee will be instructed to activate Prescription Audit. The Medical Superintendent, Govt. Hospital Gandhi Nagar, Jammu stated (January 2025) the Prescription Audit is conducted on regular basis. The Chief Medical Officer, Jammu stated (January 2025) that all the Block Medical Officers are conducting the Prescription Audit. The Chief Medical Officer, Udhampur stated (January 2025) that the SDH/ CHC will be instructed to activate Prescription Audit Committee.

3.2 In-patient Department (IPD)

In-patient Department (IPD) refers to the areas of the hospital where patients are admitted on the basis of the doctor's assessment carried out in the OPD, Emergency Services or Ambulatory Care.

3.2.1 Availability of IPD services in sampled DHs/ SDHs/ CHCs

IPHS 2012 norms provides for availability of specialist in-patient services pertaining to General Medicine, General Surgery, Ophthalmology, Paediatrics etc. in the DH, SDH and CHC.

Availability of required in-patient services in the test-checked DHs as of March 2022 is detailed in **Table 3.11.**

Table 3.11: Availability of in-patient services in test checked DHs

Sl. No.	Name of the DH	GM	GS	Oph	Ortho	Phy	Psy	Gyane	Paed	Dental
1.	Anantnag	A	A	A	A	NA	NA	A	A	NA
2.	Ganderbal	A	A	A	A	A	A	A	A	A
3.	Jammu	A	A	A	A	A	A	NA	A	A
4.	Handwara	A	A	A	A	A	A	A	A	A
5.	Ramban	A	A	A	A	A	NA	A	A	A
6.	Udhampur	A	A	A	A	A	A	A	A	A
GM: General Medicine, GS: General surgery, Oph: Ophthalmology, Orth: Orthopedics, Phy: Physiotherapy, Psy: Psychiatry, Gynae: Gynaecology, Paed: Paediatric										

(Source: Information provided by the Department)
(A: Available; NA: Not available)

General Medicine, General Surgery, Ophthalmology, Orthopedic and Paediatric services were available in all six test-checked DHs while Gynaecology service was not available in DH Jammu only. There was lack of Physiotherapy, Psychiatry and Dental services in DH Anantnag and Psychiatry service in DH Ramban.

Availability of IPD services in CHCs/ SDHs is detailed in **Table 3.12.**

Table 3.12: Availability of IPD services in CHCs/ SDHs

Sl. No.	Name of SDH/CHC	General Medicine	Obstetrics and Gynaecology	General Surgery	Ophthalmology	Paediatric
1.	R.S. Pura	A	A	A	A	A
2.	Jagti	A	A	A	NA	NA
3.	Kot-Bhalwal	A	A	A	NA	NA
4.	Marh	A	A	A	NA	NA
5.	Bishnah	A	A	A	A	A
6.	Akhnoor	A	A	A	A	A
7.	Sarwal	A	A	A	A	A
8.	Kangan	A	A	A	A	A
9.	Sogam	A	A	NA	NA	NA
10.	Kupwara	A	A	A	A	A
11.	Langate	A	A	NA	NA	A
12.	Tangdar	A	A	A	NA	NA
13.	Ramnagar	A	A	NA	A	A
14.	Seer Hamdan	A	A	A	A	A
15.	Bijbehara	A	A	A	NA	A
16.	Dooru	A	A	A	NA	NA
17.	Shangus	A	A	NA	NA	NA
18.	Kokernag	A	A	A	NA	NA
19.	Sohanjana	A	A	NA	NA	NA
20.	Jourian	NA	NA	NA	NA	NA
21.	Khour	A	A	NA	NA	NA

Sl. No.	Name of SDH/CHC	General Medicine	Obstetrics and Gynaecology	General Surgery	Ophthalmology	Paediatric
22.	Gool	A	A	NA	NA	NA
23.	Banihal	A	A	A	A	A
24.	Batote	NA	NA	NA	NA	A
25.	Kralpora	A	A	NA	NA	NA
26.	Zachaldara	A	A	NA	NA	NA
27.	Kralgund	A	A	NA	NA	NA
28.	Chenani	A	NA	A	NA	NA
	Total -28	**26**	**25**	**16**	**9**	**12**

(Source: Information provided by the Department)
(A: Available; NA: Not available)

The data in **Table 3.1.2** indicates that all IPD services were available in eight SDHs/ CHCs. General Surgery, Ophthalmology and Paediatric services were available in 16 (57 *per cent*), nine (32 *per cent*) and 12 (43 *per cent*) SDHs/ CHCs respectively. The selected IPD services were not available in CHC Jourian. In CHC Batote, only Paediatric service was available. Non-availability or shortage of these IPD services indicated that patients were either referred to TLHs/ DHs or had to opt for private hospitals resulting in additional financial burden on the patients.

The Chief Accounts Officer, Directorate of Health Services, Jammu stated (January 2025) that regular gap analysis is being done by the concerned BMOs and Medical Superintendents to ensure optimal functioning of IPD services in all respects.

3.2.2 Evaluation of IPD services through Outcome Indicators

The IPD services provided during 2016-22 in the test checked HIs were evaluated through certain Outcome Indicators (OIs) such as Bed Occupancy Rate[8] (BOR), Bed Turnover Rate[9] (BTR), Discharge Rate[10] (DR), Referral Out Rate[11] (ROR), Average Length of Stay[12] (ALoS), Leave Against Medical Advice[13] (LAMA) Rate and Absconding Rate[14].

[8] BOR is an indicator of the productivity of the hospital services and is a measure of verifying whether the available infrastructure and processes are adequate for delivery of health services. As per IPHS, the BOR of hospitals should be at least 80 *per cent.*

[9] BTR is the rate of usage of beds in an In-patient Department in a given period and is a measure of the utilization of the available bed capacity and serves as an indicator of the efficiency of the hospital. High BTR indicates high utilisation of the in-patient beds in a Department while low BTR could be due to fewer patient admissions or longer duration of stay in the Departments.

[10] Discharge rate measures the number of patients leaving a hospital after receiving due health care. High discharge rate denotes that the hospital is providing health care facilities to the patients efficiently, on the other hand low rate of discharge means that the health care facilities were not adequate.

[11] ROR denote refer to higher centres that the facilities for treatments were not available in the hospitals.

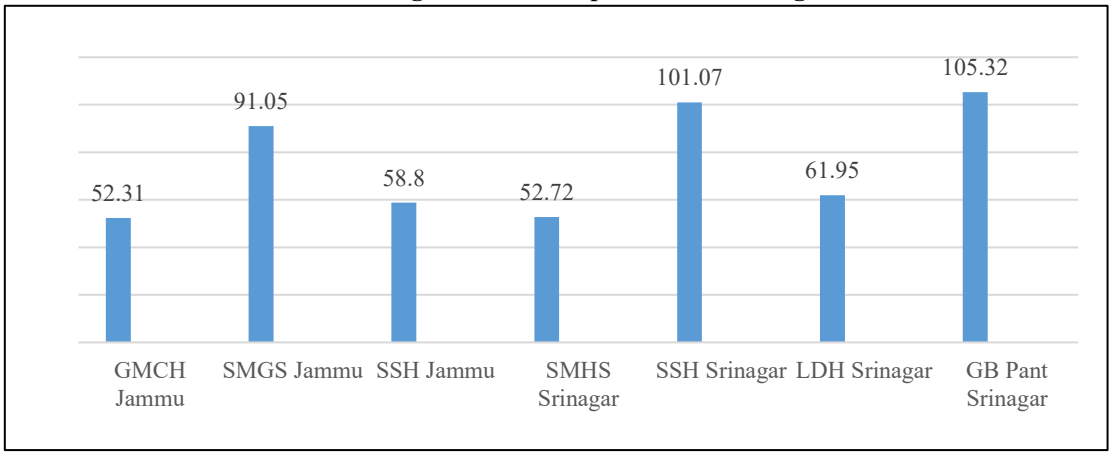
[12] ALoS is an indicator of clinical care capability and to determine effectiveness of interventions. ALoS is the time between the admission and discharge/death of the patient.

[13] LAMA is the term used for a patient who leaves the hospital against the advice of the doctor.

[14] Absconding Rate refers to patients who leave the hospital without informing the hospital authorities.

The average BOR[15] in the seven sampled TLHs during the period 2016-22 is given in **Chart 3.4.**

Chart 3.4: Average BOR in sampled TLHs during 2016-22



It was observed that the average BOR was above 80 *per cent* in case of three TLHs.

Average BOR in respect of six sampled DHs and 28 CHCs/ SDHs was not calculated/relevant information not provided by the concerned HIs.

On being pointed out by Audit, the three[16] CMOs and two[17] Medical Superintendents of District Hospitals concerned stated (December 2023 and January 2024) that in future BOR shall be calculated. The Medical Superintendent, Govt. Hospital Gandhi Nagar stated (January 2024) that BOR of hospital is available w.e.f. April 2022. The reply from three[18] CMOs and three[19] Medical Superintendents of District Hospitals is awaited.

The Bed Turnover Ratio (BTR[20]), Discharge rate[21] and Average Length of Stay[22] (ALoS) for TLH is detailed in **Table 3.13**.

Table 3.13: BTR, Discharge rate and ALoS in Tertiary Level Hospitals

Name of HI	Average BTR (No. of patients per bed in a year)	Discharge rate *per cent*	Average length of stay (No. of days)
GMCH, Jammu	42.43	93	4.19
SMGS Hospital, Jammu	70.96	98	4.61
SSH Jammu	19.15	95	10.61
SMHS Hospital Srinagar	100.57	97	1.86
SSH Srinagar	89.84	99	4.06
Lal Ded Hospital Srinagar	52.88	99	4.23
G.B. Pant Hospital Srinagar	92.99	96	3.97

(Source: Information furnished by the HIs)

15 BOR= (Total Patient bed days / 100)/Available Patient bed days
16 Jammu, Ramban and Udhampur
17 Ramban and Udhampur
18 Anantnag, Ganderbal and Kupwara
19 Anantnag, Ganderbal and Handwara
20 BTR= Total number of discharges/Availability of functional beds
21 Discharge rate = Total Number of discharges*100/total number of admission
22 AloS= Total patient bed days/Total number of admission

The average referral out rate[23], LAMA[24] rate and Absconding rate[25] could not be worked out either due to non-providing or partial providing of data by the concerned HIs or there were no such cases. It was observed that:

- Average BTR of SMHS Hospital, Srinagar was 100.57 during 2016-22, which shows that one bed catered to the needs of more than 100 patients. On the other hand, BTR of SSH Jammu was quite low as compared to other HIs.
- Discharge rate in respect of all the seven sampled TLHs was more than 90 *per cent,* which indicated that the hospitals are providing healthcare facility to the patients efficiently.

The outcome indicators in the sampled DHs is detailed in **Table 3.14.**

Table 3.14: Outcome indicators of IPD services in District Hospitals

Name of HI	Average BTR (No. of patients per bed in a year)	Discharge rate *per cent*	Referral out rate *per cent*	LAMA rate *per cent*	Absconding rate *per cent*
DH Anantnag	154.28	94	6.00	0	0
DH Ganderbal	71.80	91	9.20	0	0
DH Handwara	184.92	90	9.47	0.46	0
DH Jammu	92.41	93	6.58	NA	NA
DH Ramban	132.59	84	16.19	0.01	NA
DH Udhampur	95.54	90	9.58	0	0

(Source: Information furnished by the HIs)

It can be observed that:

- Average BTR in three sampled DHs was more than 100 during 2016-22 which indicated high utilisation of beds whereas in respect of DH Ganderbal it was quite low which indicated fewer patient admission or longer duration of stay of patients in the hospital as compared to other HIs.

- The DR was more than 90 *per cent* in five out of six sampled DHs (except DH Ramban) which indicated that the hospitals are providing healthcare facility to the patients efficiently.

- The referral out rate in respect of five out of six sampled DHs was less than 10 *per cent* whereas the referral out rate in respect of DH Ramban was higher as compared to other HIs. It was also observed in case of DH Ramban that there was shortage of doctors (discussed in **Paragraph 2.8**), non-availability of essential drugs (discussed in **Paragraph 4.1.1**) and poor availability of equipment (discussed in **Paragraph 4.3**). This indicated that healthcare facilities were not adequate in DH Ramban.

[23] ROR= Total number of cases referred*100/Total number of admission
[24] LAMA rate= Total number of LAMA*100/Total number of admission
[25] Absconding rate= Total number of absconding*100/Total number of admission

- The LAMA and absconding rate was either nil or negligible in respect of sampled DHs.

- In absence of data on average patient bed days, the average length of stay in respect of sampled DHs could not be worked out.

Similarly, the outcome indicators (OIs) of sampled SDHs/ CHCs are given in **Table 3.15.**

Table 3.15: Outcome Indicators of sampled SDHs/ CHCs

Name of District	Name of SDH/CHC	Average BTR (No. of patients per bed in a year)	Discharge rate *per cent*	Referral out rate *per cent*	LAMA rate *per cent*	Absconding rate *per cent*
Anantnag	Bijbehara	300.72	96	6.6	0	0
	Dooru	134.88	93	6.99	0	0
	Kokernag	178.09	88	11.82	0	0
	Seer Hamdan	153.79	100	0.22	0	0
	Shangus	196.43	95	5.21	0.05	0
Ganderbal	Kangan	178.63	88	12.02	0	0
Jammu	Akhnoor	162	98	13.82	0	0
	Bishnah	114.79	87	12.77	0	0
	Jagti	9.50	98	2.00	0	0
	Jourian	125.72	86	13.93	0	0
	Khour	20.45	98	7.69	0	0
	Kot-Bhalwal	18.30	94	10.36	0	0
	Marh	73.74	98	14.21	0	0
	R.S.Pura	128.81	95	12.33	0	0
	Sarwal	140.46	96	3.88	0	0
	Sohanjana	61.61	98	10.08	0	0
Kupwara	Kralgund	98.38	97	2.54	0	0
	Kralpora	253.05	86	13.55	0	0
	Kupwara	157.99	87	15.62	3.5	0
	Langate	200.71	99	0.51	0	0
	Sogam	175.15	90	10.29	0	0
	Tangdar	203.38	98	2.23	0.06	0
	Zachaldara	101.48	79	21.21	0	0
Ramban	Banihal	105.76	80	19.73	0.02	0
	Batote	67.42	92	7.79	0	0
	Gool	76.17	90	10.3	0	0
Udhampur	Chenani	29.35	99	9.74	0	0
	Ramnagar	158.68	93	7.14	0	0

(Source: Information furnished by HIs)

The **Table 3.15** indicates that:

- Average BTR in respect of 19 SDH/ CHCs was more than 100, which indicated high utilisation of beds, while in SDH/ CHCs Jagti, Khour, Kot-Bhalwal, Marh, Sohanjana, Batote and Chenani BTR was comparatively low.

- Discharge rate in all the sampled SDHs/ CHCs ranged from 79 to 99 *per cent*, which indicated efficient healthcare facility.

- The referral out rate was more than 15 *per cent* in SDHs/ CHCs Kupwara, Zachaldara and Banihal whereas in 12 SDHs/ CHCs, it was between 10 and 15 *per cent.*

3.2.3 Patient Satisfaction Survey of indoor patients

NHM Assessor's Guidebook for Quality Assurance provides for conducting of monthly Patient Satisfaction survey.

Audit observed that no in-patient Satisfaction Survey had been conducted by the hospital authorities during 2016-21 except in LD Hospital Srinagar, SDH Langate and CHC Kralgund. In-patient Satisfaction Survey was conducted during 2018-19 and 2019-20 in DH Jammu. The level of patient satisfaction revealed by a survey of 574 in-patients by audit is indicated in **Table 3.16.**

Table 3.16: Level of patient satisfaction revealed during survey of 574 in-patients

Particulars	TLHs (140 patients surveyed)	DHs (90 patients surveyed)	SDHs/CHCs (267 patients surveyed)	PHCs (77 patients surveyed)
	No. of patients satisfied			
Promptness of response of nurses in the ward	140 (100)	90 (100)	267 (100)	67 (87)
Prescribed drugs made available at Pharmacy and wards	101 (72)	70 (78)	170 (64)	35 (45)
Availability of prescribed investigations (lab/radiology)	131 (94)	87 (97)	173 (65)	26 (34)
Expenditure incurred by the in-patients out of own pocket on medicines/ diagnostic tests	33 (24)	21 (23)	114 (43)	33 (43)
Informed consent taken from family member/ attendant before treatment and procedures	138 (99)	63 (70)	170 (64)	45 (58)
Promptness in attending to complaints	138 (99)	90 (100)	179 (67)	57 (74)
Availability of manpower during day and night	139 (99)	90 (100)	202 (76)	42 (55)
Behaviour of the staff being good	140 (100)	90 (100)	266 (100)	67 (87)
Effective security system in place at patient care areas	139 (99)	49 (54)	87 (33)	2 (3)
Providing of sufficient food	125 (89)	32 (36)	40 (15)	2 (3)
Providing of food as per the diet prescribed by the doctor	0	15 (17)	19 (7)	2 (3)
Clean and adequate toilet facility available for male and female patients	93 (66)	56 (62)	179 (67)	16 (21)
Garbage removed from patient care area regularly	140 (100)	72 (80)	223 (84)	49(64)

(Source: Patient's Satisfaction Survey)

- In all sampled TLHs, DHs and SDHs/ CHCs, 100 *per cent of* patients were satisfied with the promptness of response of nurses in wards and behaviour of staff.

- In the sampled TLHs, out of 140 patients surveyed 24 *per cent* in-patients incurred out of pocket expenditure for drugs/ diagnostic tests etc. while 72 *per cent* patients were provided drugs in the institutions and 89 *per cent* patients were provided

sufficient food. However, all in-patients stated that diet was not provided as prescribed by the doctor as uniform diet was provided to all patients.

- One-third of the patients were not satisfied with the toilet facilities in DHs and SDHs/ CHCs.
- 22 *per cent* and 36 *per cent* in-patients respectively in DHs and SDHs/ CHCs stated that they were not provided prescribed drugs in the HIs.
- 23 *per cent* and 43 *per cent* in-patients respectively in DHs and SDHs/ CHCs had incurred expenditure on drugs/ diagnostics out of own pocket.
- 46 *per cent* and 67 *per cent* in-patients were not satisfied with the security system at IPD of secondary level Hospitals in DHs and SDHs/ CHCs respectively.
- 64 *per cent* and 85 *per cent* of in-patients were not satisfied with the availability of sufficient food whereas 83 *per cent* and 93 *per cent* stated that food provided was not as prescribed by the doctor in the DHs and SDHs/ CHCs respectively.

In PHCs;

- 55 *per cent* patients stated that they were not provided prescribed drugs through pharmacy.
- 79 *per cent* patients were not satisfied with the availability of toilet facility.
- 97 *per cent* patients stated that they were not satisfied with the security system in place at patient care areas, availability of sufficient food and providing of food as per diet plan.

Thus, due to non-conducting of patient satisfaction survey in most of the sampled HIs, the HI authorities were unable to develop an effective action plan for quality improvement in health facilities by identifying gaps on the basis of feedback from patients.

3.2.4 Operation Theatre services

Operation Theatre (OT) is an essential service that is to be provided to the patients. IPHS norms 2012 for DHs prescribe OTs for elective major surgery, emergency surgeries and ophthalmology/ ENT (ear, nose and throat) surgeries.

The status of availability of OTs in the DHs as of March 2022 is given in **Table 3.17**.

Table 3.17: Availability of Operation Theatres in District Hospitals

Availability of OTs	District Hospitals					
	Anantnag	Ganderbal	Handwara	Jammu	Ramban	Udhampur
Elective major surgery	A	A	A	A	A	A
Emergency surgeries	A	A	A	A	A	A
Ophthalmology/ENT surgeries	A	A	A	A	A	A

(Source: Information furnished by the HIs)
(A: Available; NA: Not available)

The table above indicates that the OTs for elective major surgeries, emergency services and Ophthalmology/ ENT surgeries were available in all the sampled DHs as of March 2022.

IPHS 2012 guidelines also prescribe OTs for elective major surgeries and emergency surgeries in SDHs. The status of availability of OTs in the sampled 18 SDHs as of March 2022 is given in **Table 3.18.**

Table 3.18: Availability of Operation Theatres in sampled SDHs

Sl. No.	Name of the SDH	OT for Elective major surgery	OT Emergency surgeries
1.	R.S. Pura (30)	NR	A
2.	Jagti (34)	NR	NA
3.	Kot-Bhalwal (75)	A	NA
4.	Marh (20)	NR	NA
5.	Bishnah (50)	NR	A
6.	Akhnoor (60)	A	A
7.	Sarwal (50)	NR	A
8.	Kangan (30)	NR	NA
9.	Sogam (33)	NR	A
10.	Kupwara (150)	A	A
11.	Langate (30)	NR	A
12.	Tangdar (30)	NR	A
13.	Ramnagar (30)	NR	A
14.	Seer Hamdan (30)	NR	NA
15.	Bijbehara (30)	NR	A
16.	Dooru (30)	NR	NA
17.	Shangus (20)	NR	NA
18.	Kokernag (30)	NR	NA

(Source: Information furnished by HIs)
(A: Available; NA: Not Available; NR: Not Required)

Data in the **Table 3.18** indicates that OT for emergency service was available in 10 out of 18 test-checked SDHs.

IPHS norms 2012 prescribe OT facility at CHC level but the same was not available in seven[26] out of 10 test-checked CHCs. However in three[27] CHCs minor OT was available.

IPHS norms 2012 for PHCs prescribe optional OT services in PHCs for performing selected surgical procedures such as Vasectomy, Tubectomy and Hydrocelectomy. Out of 52 sampled PHCs, only PHC Majalta (District Udhampur) and PHC Achabal (District Anantnag) had OT facility for these surgical procedures.

3.2.5 Physical verification of OT area

Availability of facilities as revealed during physical verification by Audit of the OT area of six selected DHs is detailed in **Table 3.19.**

[26] Batote, Gool, Khour, Jourian, Kralpora, Kralgund and Zachaldara
[27] Gool, Batote, Kralpoora,

Table 3.19: Availability of facilities revealed during physical verification

Facilities	DHs					
	Anantnag	Ganderbal	Handwara	Jammu	Ramban	Udhampur
Piped suction	Yes	Yes	No	Yes	Yes	Yes
Adequate oxygen supply	Yes	Yes	Yes	Yes	Yes	Yes
Uninterrupted electric supply with power backup	Yes	Yes	Yes	Yes	Yes	Yes
Heating system	Yes	Yes	Yes	No	Yes	Yes
Air-conditioning	Yes	Yes	Yes	Yes	Yes	Yes
Proper ventilation	Yes	Yes	Yes	No	No	Yes
Accessible to surgical ward	Yes	Yes	Yes	Yes	Yes	Yes
Accessible to Pathology	No	No	Yes	Yes	Yes	Yes
Accessible to blood bank	No	Yes	Yes	Yes	Yes	Yes
Changing room	Yes	Yes	Yes	No	Yes	Yes
Pre-operative room	Yes	Yes	Yes	Yes	No	Yes
Post –operative room	Yes	Yes	Yes	Yes	Yes	Yes
Regularly fumigated	Yes	Yes	Yes	Yes	Yes	Yes

(Source: Information provided by concerned HIs)

The data in **Table 3.19** indicates that almost all the necessary facilities were available in the OTs in the DHs except that piped suction in DH Handwara, heating system and proper ventilation in DH Jammu and pre-operative room and proper ventilation in DH Ramban were not available.

3.2.6 Surgeries performed per surgeon

As per NHM Assessor's Guidebook, surgeries performed per surgeon are an indicator to measure efficiency of hospitals.

Analysis of selected sample of surgeries performed in the test-checked DHs during the last quarter of 2021-22 indicated substantial variation in the number of major and minor surgeries performed per surgeon as detailed in **Table 3.20.**

Table 3.20: Major and minor surgeries per surgeon in the last quarter of 2021-22

Name of District Hospital	Surgeries performed per surgeon			Eye surgeries performed per surgeon
	General	ENT	Ortho	
Anantnag	25	32	19	37
Ganderbal	84	66	39	63
Handwara	57	52	117	32
Jammu	400	89	643	283
Ramban	95	0	96	0
Udhampur	120	44	140	71

(Source: Information provided by the sampled DHs)

As can be seen from the **Table 3.20**, general surgeries performed per surgeon were maximum in DH Jammu while these were minimum in DH Anantnag. No ENT and Eye surgeries were performed in DH Ramban due to non-availability of specialists.

3.2.7 Availability of equipment and drugs for OTs

Against essential drugs and equipment prescribed in NHM Assessor's Guidebook for OTs, Audit checked availability of 23 types of drugs and 29 equipment in the six test-checked DHs during the selected months[28] for the period 2016-17 to 2020-21. Significant shortages were observed as detailed in **Table 3.21**

Table 3.21: Availability of essential drugs and equipment in OTs

Sl. No.	Name of the District Hospital	Percentage shortage of	
		Essential drugs	Essential equipment
1.	Anantnag	65-74	34-45
2.	Ganderbal	35-65	59
3.	Handwara	30-61	76-86
4.	Jammu	30-48	45
5.	Ramban	61-70	55 -66
6.	Udhampur	39 -65	41

(Source: Records of test-checked hospitals)

- Shortage of essential drugs in OTs of all selected DHs ranged between 30 *per cent* and 74 *per cent*.
- Shortage of equipment was 76 to 86 *per cent* in DH Handwara, 59 *per cent* in DH Ganderbal, 45 *per cent* in DH Jammu and in DH Ramban shortage ranged between 55 *per cent* and 66 *per cent*.

In absence of required drugs and equipment, the patients may have to avail this facility from other sources.

3.2.8 Intensive Care Unit

3.2.8.1 Availability of ICU services in District Hospitals

As per IPHS 2012 norms, critically ill patients suffering from head injuries, severe haemorrhage, acute coronary occlusion, kidney and respiratory catastrophe, poisoning etc. are to be provided with lifesaving medical aid and nursing care by highly specialised staff in Intensive Care Unit (ICU) of District Hospital. The number of patients requiring intensive care may be about 05 to 10 *per cent* of total medical and surgical patients in a hospital.

Audit observed that four (Anantnag, Handwara Jammu and Udhampur) out of six DHs had Intensive Care Unit (ICU) and two (Ganderbal and Ramban) DHs were without ICU as of March 2022. However, ICU in DH Udhampur was non-functional due to non-availability of required manpower.

[28] November-2016, May-2017, April-2018, January-2020 and February-2021

ICU equipment lying idle in DH, Udhampur (27.06.2022)

Thus, in absence of ICU, patients in serious condition in need of ICU services were likely to be referred to other hospitals.

The Chief Accounts Officer, Directorate of Health Services, Jammu stated (January 2025) that ICU in DH Udhampur is non-functional due to non-availability of staff and space while as ICU service is available in DH Ramban.

3.2.8.2 Availability of essential equipment in ICU

IPHS 2012 norms prescribe a minimum of four beds in ICU of a DH. Audit observed that the availability of ICU beds in the sampled DHs[29] having availability of ICU services were more than those prescribed in the IPHS norms.

IPHS norms also envisage each bed in the ICU to be equipped with essential equipment such as High-end Monitor, Ventilator, Oxygen therapy devices, Deep vein thrombosis prevention devices, suction and Infusion pumps. Defibrillator, Ultrasound for invasive procedures and Arterial Blood Gas Analysis Machine should be available in the ICU as common facilities. The requirement and availability of ICU equipment in three test checked DHs where ICUs were functional as of March 2022 are detailed in **Table 3.22.**

Table 3.22: Requirement and availability of ICU equipment in District Hospitals

Name of the equipment	DH Anantnag (12 ICU beds)		Handwara (11 ICU beds)		Jammu (8 ICU beds)	
	Required	Available	Required	Available	Required	Available
High end monitor	12	12	11	3	8	6
Ventilator	12	15	11	5	8	18
Oxygen therapy devices	12	6	11	Nil	8	7
Deep vein thrombosis prevention suction devices	12	3	11	Nil	8	Nil

[29] DH Anantnag: 12 ICU beds; DH Handwara: 11 ICU beds; DH Jammu: 08 ICU beds

Name of the equipment	DH Anantnag (12 ICU beds)		Handwara (11 ICU beds)		Jammu (8 ICU beds)	
	Required	Available	Required	Available	Required	Available
Infusion pumps	12	12	11	Nil	8	Nil
Ultrasound	1	1	1	Nil	1	1
Defibrillator	1	5	1	1	1	1
Arterial Blood Gas (ABG) Analysis Machine	1	2	1	Nil	1	1

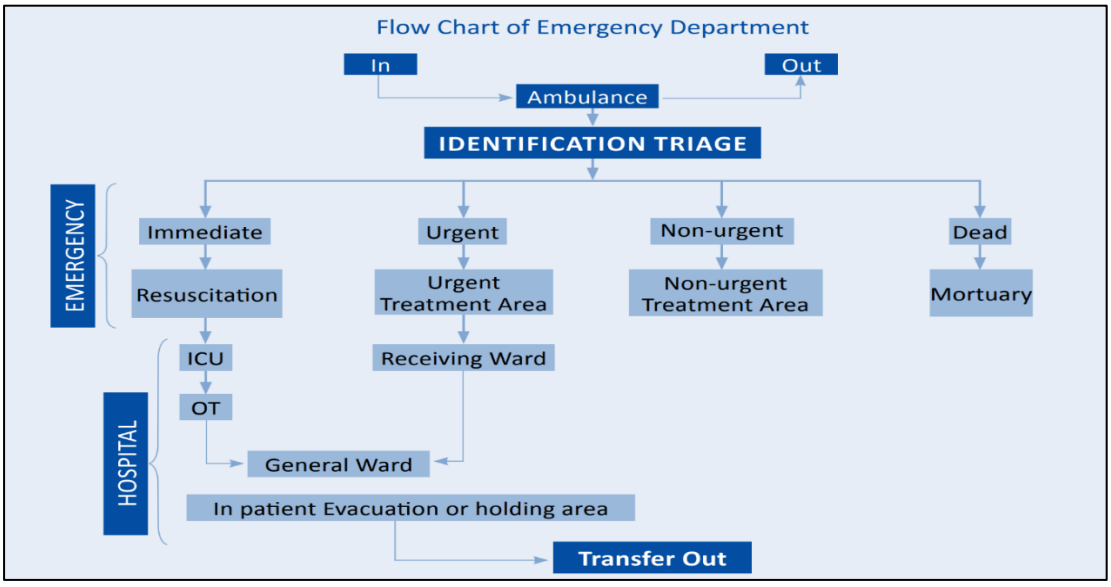
(Source: Information provided by the test checked hospitals)

It can be seen from the **Table 3.22** that ICUs in DH Anantnag and DH Jammu had adequate equipment, while Oxygen therapy devices, Deep vein thrombosis prevention suction devices, Infusion pumps, Ultrasound and ABG analysis machine were not available in DH Handwara. The facility of deep vein thrombosis prevention devices suction and infusion pumps was not available in DH Jammu.

3.2.9 Emergency Department

Emergency Department is the first point of contact for any critically ill patient needing immediate medical attention. Flow chart of Emergency Department is given in **Chart 3.5**.

Chart 3.5: Flow chart of Emergency Department



3.2.9.1 Availability of emergency services in DHs and SDHs

As per IPHS 2012 norms for DHs and SDHs, 24x7 operational emergency with dedicated emergency room shall be available with adequate manpower. Emergency shall have dedicated triage, resuscitation and observation area. Separate provision for examination of rape/ sexual assault victims should be made available in the emergency as per the guidelines of the Supreme Court.

Emergency should have mobile X-ray, laboratory, side labs, plaster room and minor OT facilities. Sufficient separate waiting areas and public amenities for patients and relatives should be located in such a way that these do not disturb functioning of emergency services. Further, procedures under emergency services required for Assault injuries/ Bowel injuries/ Head injuries/ Stab injuries/ Multiple injuries/ Perforation/ Intestinal obstruction should be available.

As per NHM Assessors' Guidebook 2013, emergency protocols should be defined and implemented for head injury, snake bite, poisoning, drawing etc. The facility should have a disaster management plan in place. The status of emergency services available in the sampled hospitals is given in **Table 3.23**.

Table 3.23: Availability of emergency services in sampled DHs

Particulars	DH Anantnag	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban	DH Udhampur
Availability of Emergency OT	Yes	Yes	No	Yes	Yes	Yes
Availability of infrastructure in the hospital Emergency ward	Yes	Yes	No	Yes	Yes	Yes
Availability of infrastructure relating to Trauma Ward such as bed capacity, machinery and equipment etc.	Yes	Yes	No	No	Yes	Yes
Availability of surgical facilities for Emergency Appendectomy	Yes	Yes	Yes	Yes	Yes	Yes
Availability of facilities to diagnose and to treat for Hypoglycemia, Ketosis and Coma	Yes	Yes	Yes	Yes	Yes	No
Availability of Assault injuries/Bowel injuries/Head injuries/Stab injuries/Multiple injuries/Perforation/Intestinal obstruction	Yes	No	Yes	Yes	Yes	Yes
Availability of Emergency laboratory services	Yes	Yes	Yes	Yes	Yes	Yes
Availability of Blood Bank in close proximity to Emergency Department	Yes	Yes	Yes	Yes	Yes	Yes
Availability of mobile X-ray/ laboratory, side labs/plaster room	Yes	Yes	Yes	No	Yes	Yes
Availability of Emergency Operation Theatre for Maternity/Orthopaedic Emergency/Burns and Plastic and neurosurgery cases round the clock.	Yes	Only Maternity OT	No	No	Yes	Yes
Availability of facilities for accidents and emergency services including poisoning and trauma care	Yes	Yes	Yes	Yes	Yes	Yes
Availability of separate emergency ward for examination of rape/sexual assault victim	Yes	No	No	No	Yes	Yes

Particulars	DH Anantnag	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban	DH Udhampur
Availability of sufficient separate waiting areas and public amenities in emergency ward for patients and relatives.	Yes	Yes	No	Yes	No	Yes
Availability of emergency protocols in emergency ward	Yes	Yes	No	Yes	Yes	Yes
Availability of disaster management plan in emergency ward.	Yes	Yes	No	Yes	Yes	Yes

(Source: Information furnished by sampled hospitals)

It is evident from the table above that most of the emergency services were available in all the sampled HIs except DH Handwara.

Availability of emergency services in sampled SDHs is given in **Table 3.24.**

Table 3.24: Availability of emergency services in sampled SDHs

Availability of facilities in test checked SDHs	Anantnag District (out of test checked 05 SDHs)	Ganderbal District (out of test checked 01 SDH)	Jammu District (out of test checked 07 SDHs)	Kupwara District (out of test checked 04 SDHs)	Udhampur District (out of test checked 01 SDH)
Emergency OT	1	0	6	3	1
Infrastructure in the hospital Emergency ward	4	1	6	4	1
Infrastructure relating to trauma ward such as Bed capacity, machinery and equipment etc.	3	1	5	4	0
Surgical facilities for Emergency Appendectomy	2	0	4	3	0
To diagnose and to treat for Hypoglycemia, Ketosis and Coma	2	0	3	4	1 (Only for hypoglycemia
To treat Assault injuries/Bowel injuries/Head injuries/Stab injuries/Multiple injuries/Perforation/Intestinal obstruction	4	0	4	3	0
Emergency laboratory services	3	1	7	4	1
Blood bank/blood storage unit in close proximity to Emergency Department	0 (Blood bank not available in 4)	0 (Blood bank not available in 1)	0 (Blood bank not available in 4)	0 (Blood bank not available in 1)	0
Mobile X-ray/laboratory, side labs/plaster room	0	0	4	2	0
Emergency Operation Theatre for Maternity/Orthopaedic Emergency/Burns and Plastic and neurosurgery cases round the clock.	0	0	5 (only for maternity)	3	1 (Only for maternity)

Availability of facilities in test checked SDHs	Anantnag District (out of test checked 05 SDHs)	Ganderbal District (out of test checked 01 SDH)	Jammu District (out of test checked 07 SDHs)	Kupwara District (out of test checked 04 SDHs)	Udhampur District (out of test checked 01 SDH)
Facilities for accidents and emergency services including poisoning and trauma care	4	1	7	4	0
Separate provision emergency ward for examination of rape/sexual assault victim	1	1	7	2	1
Sufficient separate waiting areas and public amenities in emergency ward for patients and relatives.	4	1	7	4	1
Emergency protocols in emergency ward	4	1	7	3	1
Disaster management plan in emergency ward.	4	1	7	3	1

(Source: Information furnished by sampled hospitals)

Data in the **Table 3.24** indicates that:

- The facility of Emergency OT was not available in seven SDHs out of 18 sampled SDHs/ CHCs.
- The surgical facilities for Emergency Appendectomy and Assault injuries/ Bowel injuries/ Head injuries/ Stab injuries/ Multiple injuries/ Perforation/ Intestinal obstruction were not available in nine and seven SDHs respectively out of sampled 18 SDHs/ CHCs.
- Blood Bank/ blood storage unit was not available in 10 out of 18 SDHs whereas in seven SDHs, it was not in close proximity to the Emergency Department.

The Chief Accounts Officer, Directorate of Health Services, Jammu stated (January 2025) that availability of emergency services in DHs and SDHs are in tune with IPHS norms except wherever there is shortage of staff.

3.2.9.2 Availability of routine and emergency care in CHCs

IPHS 2012 norms for CHCs provide for care of routine and emergency cases. Specific mention is made of handling of emergencies like Dengue Haemorrhagic Fever, Cerebral Malaria and others like dog and snake bite cases, Poisoning, Congestive heart failure, Left Ventricular failure, Pneumonias, meningoencephalitis, acute respiratory conditions, status epilepticus, burns, shock, acute dehydration etc. Availability of care of routine and emergency cases in CHCs is given in **Table 3.25.**

Table 3.25 Availability of routine and emergency cases in 10 sampled CHCs

Availability of routine and Emergency care service	Name of CHC									
	Sohanjana	Jourian	Khour	Batote	Gool	Banihal	Chenani	Zachaldara	Kralpora	Kralgund
Dengue Haemorrhagic fever	No	No	No	No	No	Yes	No	No	No	No
Cerebral malaria	Yes	No	Yes	No	No	Yes	No	No	No	No
Dog and snake bite cases	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Poisonings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Congestive Heart Failure	No	No	No	No	No	Yes	No	No	Yes	Yes
Left Ventricular Failure	No	No	No	No	No	No	No	No	Yes	No
Pneumonia	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Meningo-encephaltis	No	No	No	No	No	No	No	No	No	No
Acute respiratory conditions	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Status Epilepticus	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No
Burns	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Shock	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Acute dehydration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Obstetric care including surgical interventions like Caesarean section and other medical interventions	Yes	No	No	No C-Section	No	Yes	Yes	No	No	No

(Source: Information furnished by sampled hospitals)

It is evident from the **Table 3.25** that out of 10 test checked CHCs:

- Treatment of Dengue Haemorrhagic fever was only available in CHC Banihal.
- Treatment of Celebral Malaria was not available in seven CHCs except in CHC Sohanjana, CHC Khour and CHC Banihal.
- Treatment of dog and snake bite cases, poisoning, acute respiratory conditions, acute dehydration was available in all the sampled CHCs.

3.2.9.3 Management of Emergency cases in PHCs

As per IPHS 2012 norms for PHCs, 24-hour emergency services such as appropriate management of injuries and accident, First Aid, stitching of wounds, incision and drainage of abscess, stabilisation of the condition of the patient before referral, treatment of dog bite/ snake bite/ scorpion bite cases and other emergency services should be provided in PHCs. These services are to be provided primarily by the nursing

staff. However, in case of need, Medical Officer may be available to attend the emergencies on call basis. 24-hour delivery services-both normal and assisted including appropriate and prompt referral for cases needing specialist care should be ensured.

Availability of emergency services in PHCs of the six sampled Districts is detailed in **Table 3.26.**

Table 3.26: Availability of emergency services in PHCs

Sl. No.	Name of District	Number of test checked PHCs/NTPHCs/UPHCs	24-hours management of selected emergency services	Emergency on call basis, 24-hour normal delivery services and referral services
			Availability of services in no. of PHCs	
1.	Anantnag	9	4	4
2.	Ganderbal	6	2	1
3.	Jammu	10	0	0
4.	Kupwara	10	3	3
5.	Ramban	7	2	1
6.	Udhampur	10[30]	2	3
	Total	**52**	**13**	**12**

(Source: Information furnished by the sampled HIs)

It is evident from the **Table 3.26** that out of the sampled 52 PHCs, 24-hour management of selected emergency services and emergency on call basis, 24-hour normal delivery services and referral were available in 13 and 12 PHCs respectively.

3.2.9.4 Emergency Management of Covid-19

Coronavirus disease (COVID-19) is an infectious disease caused by SARS-CoV-2[31] virus. The COVID-19 pandemic in India was part of the worldwide pandemic that started at the beginning of December 2019. Symptoms of COVID-19 include fever, cough, headache, fatigue, breathing difficulties, loss of smell and taste etc. The surge of COVID cases put the healthcare infrastructure in the whole country including J&K under huge stress. Audit reviewed the emergency response of the public healthcare system of J&K to derive important lessons for future preparedness.

i) COVID-19 cases in J&K

The details of COVID-19 cases as of March 2022 are given in **Table 3.27**

Table 3.27: COVID-19 cases during 2019-22

Year	Active positive cases of previous year	COVID cases during the year	Total cases
2019-20	0	55	55
2020-21	51	1,30,905	1,30,956
2021-22	2,531	3,22,777	3,25,308
Total		**4,53,737**	

(Source: Figures furnished by State Health Society)

[30] NTPHC Latyar is not 24*7

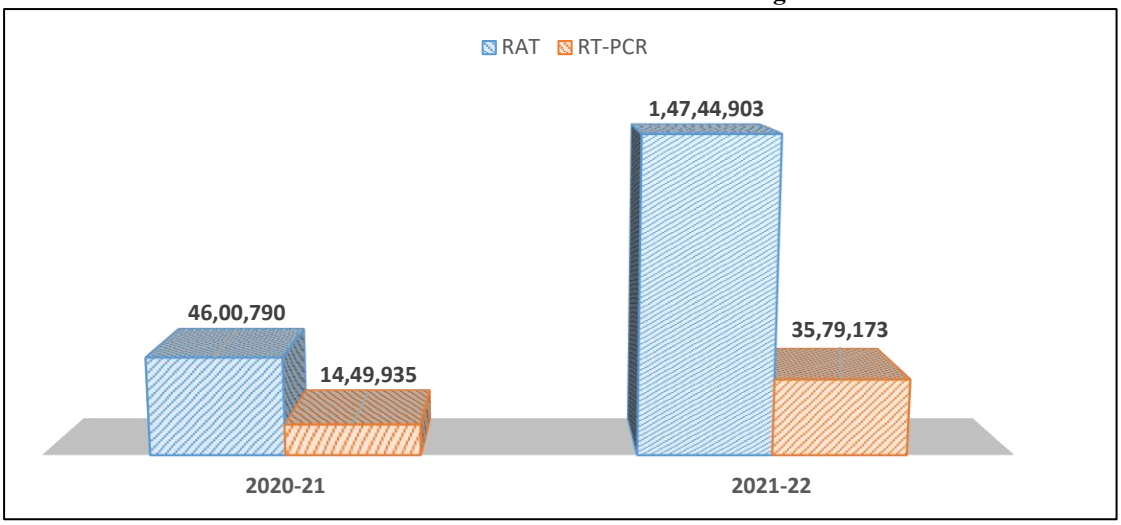
[31] Severe acute respiratory syndrome coronavirus 2

ii) COVID-19 tests

RT-PCR[32] and Rapid Antigen Test (RAT) [33] were commonly used to trace COVID-19 infection cases.

As of March 2022, a total of 243.75 lakh COVID-19 tests were conducted in the UT of J&K as detailed in the following Chart:

Chart 3.6: Covid-19 tests conducted in the UT of J&K during 2020-21 and 2021-22



(Source: Figures furnished by State Health Society)

iii) Emergency Response and Health Systems Preparedness Package (COVID Package)

The Emergency COVID Response Plan (ECRP) 2020-21 under Emergency Response and Health Systems Preparedness Package (COVID Package) was approved (November 2020) by GoI for the UT of J&K for ₹ 171.70 crore. The main components were testing and lab strengthening, procurement (excluding central supply), engagement of additional human resources, incentive to human resources, IEC activities for COVID etc.

Out of ₹ 43.74 crore received under ECRP by the Principal, GMC, Srinagar, funds of ₹1.84 crore were advanced to various Departments/Associated Hospitals[34] by the Principal, GMC, Srinagar during July 2020 and December 2021 for implementation of various activities. However, neither the adjustment accounts nor the utilisation certificates were furnished by the concerned institution in absence of which actual utilisation of ₹ 1.84 crore could not be ascertained.

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[32] Real time Reverse Transcription-Polymerase Chain Reaction test is a method of testing to directly detect the presence of virus in the sample.

[33] RAT is a rapid diagnostic test that gives result faster than RT-PCR test but it had a higher chance of missing active infection

[34] Executive Engineer, MHCH Division, Srinagar (₹ 0.54 crore), Executive Engineer, R&B Division 2nd Srinagar (₹ 0.10 crore), Medical Superintendent, G.B.Pant Hospital, Srinagar (₹ 0.12 crore), Medical Superintendent, SMHS Hospital Srinagar (₹ 0.80 crore) and Medical Superintendent, CD Hospital, Srinagar (₹0.26 crore)

iv) Emergency COVID Response Package-II

The proposal for Emergency COVID Response Package-II (ECRP-II) under "COVID-19 Emergency Response and Health System Preparedness Package Phase-II" was approved (August 2021) by GoI for ₹ 211.04 crore for implementation from July 2021 to March 2022. As per the laid-down condition, all the approved activities were to be completed well before March 2022.

The key deliverables to be achieved under ECRP-II and outcome as of March 2022 in respect of selected HIs is given in **Table 3.28.**

Table 3.28: Key deliverables under ECRP-II in respect of selected HIs

Sl. No.	Milestones to be achieved by March 2022	Actual achievement
1.	Establishment of RT-PCR Labs in 10 DHs	No RT PCR Labs was established (June 2022) in 10 DHs including in selected DHs Handwara and Ramban.
2.	Establishment of Paediatric Centre of Excellence (PCoE) in SMGS Hospital Jammu and in New 500 bedded Paediatric Hospital Bemina, Srinagar.	Not established as of December 2023 due to non-installation of software[35] set up in SMGS Hospital Jammu and in New 500 bedded Paediatric Hospital Bemina.
3.	Establishment of 12 bedded ICU at District Hospitals Ganderbal, Udhampur, Ramban, Anantnag and Govt. Hospital Gandhi Nagar Jammu, Handwara	Work in progress in DH Udhampur and DH Handwara (February 2023). The work in respect of DH Ganderbal, DH Ramban, DH Anantnag and DH Jammu has been completed.
4.	Establishment of 30-bedded Paediatric ward at DHs Anantnag, Ganderbal and Udhampur.	Work in progress in GMC Anantnag (February 2023). 24 bedded ward established in DH Ganderbal instead of approved 30-bedded ward and work in DH Udhampur completed.

(Source: Information provided by concerned HIs)

No reasons were furnished (February 2023) by the Mission Director, NHM, J&K for non-achievement of milestones.

v) Supply of ventilators and oxygen concentrators

• Ventilators

A ventilator is a device that supports or takes over the breathing process by pumping air into the lungs. People including those with severe COVID-19 symptoms, who stay in Intensive Care Units (ICU) may need the support of a ventilator.

During the period from March 2020 to March 2021 (March 10, 2021), 1,056 ventilators were received in the State/UT either by procurement (105) or donation (40) or under PM Cares (911). The details of ventilators received in the UT of J&K during 2021-22 were not furnished to audit. 219 ventilators were received in 18 out of 34 sampled secondary level HIs and 408 ventilators were received in seven TLHs during 2019-22.

[35] Tele-ICU is a combination of telemonitoring software and hardware integration. It is a web based solution that will facilitate monitoring of vital health parameters of patients connecting through web app and mobile app over network to view at Nursing station and patient at TELEICU.

Audit noticed that out of 219 ventilators received in 18 secondary level HIs, 17 ventilators in four[36] HIs were not being used due to non-availability of trained manpower, oxygen generation plant and delay in installation by the engineering staff. This indicated that the ventilators were issued without ascertaining the availability of required infrastructure and manpower in these HIs. The audit contention is substantiated by the fact that 26 ventilators were shifted (May 2021) to GMC Hospital, Jammu from six[37] secondary level HIs of Jammu District due to non-availability of trained manpower and oxygen plant in these HIs.

The Block Medical Officer, Akhnoor stated (January 2025) that all the four ventilators are installed and functional in the new building of SDH Akhnoor.

Out of 408 ventilators received in seven TLHs, four[38] ventilators were kept (December 2023) as reserve for pandemic exigencies, the rest were installed.

Ventilators lying idle at SDH, Akhnoor (23.12.2021)	**Ventilators lying unused in SDH, Ramnagar (20.05.2022)**

- **Oxygen Concentrators**

An oxygen concentrator (OC) is a medical grade machine which is used to deliver oxygen to patients with breathing related disorders. Surge in COVID-19 infection had resulted in an alarming increase in the number of active cases which led to spike in demand for OCs.

In the six selected Districts and six[39] Tertiary Level Hospitals, 5,616 Oxygen Concentrators (OCs) were received by the HIs by March 2022.

Audit noticed that out of these 5,616 OCs, 4,322 OCs were stated to be installed (as on March 2022) leaving a balance of 1,294 OCs which were yet to be put to use.

[36] DH Ganderbal (6), SDH, Akhnoor (4), SDH Kupwara (2), SDH Ramnagar (5)
[37] SDH Akhnoor (6), CHC Jourian (5), SDH R.S.Pura (2), CHC Khour (4), CHC Sohanjana (5) and SDH Sarwal (4)
[38] SMHS, Srinagar (2) and SSH, Srinagar (2)
[39] SSH Jammu, GMCH Jammu, SMGS Jammu, SMHS Srinagar, SSH Srinagar and Lalla Ded Hospital, Srinagar

OCs lying in sealed covers in store at CHC, Jourian (28.12.2021)	**OCs lying packed in store of SDH, Ramnagar (20.05.2022)**

The Block Medical Officer, Akhnoor stated (January 2025) that the Oxygen Concentrators are kept as buffer stock and are being used as and when necessity arises.

Supply of ventilators and OCs to the HIs without actual requirement had led to non-utilisation of machinery.

3.2.10 Blood Bank

IPHS 2012 norms provides for establishment of Blood Bank in DHs and blood storage unit (BSU) in the SDHs/ CHCs. All relevant guidelines and requirements of various Acts should be followed in setting up of a Blood Bank. Blood Bank was available in all the six sampled DHs. Availability of facilities in Blood Banks in six DHs and adherence to connected norms therein are detailed in **Table 3.29**.

Table 3.29: Availability of facilities in Blood Banks in six sampled DHs

Sl. No.	Facilities	Anantnag	Ganderbal	Handwara	Jammu	Ramban	Udhampur
1.	Separate reporting room for doctors	Yes	Yes	Yes	Yes	Yes	Yes
2.	Blood Bank validates the test results from external labs on regular basis.	Yes	No	Yes	Yes	Yes	Yes
3.	Blood group displayed prominently in the Blood Bank	Yes	Yes	Yes	No	Yes	Yes
4.	Blood Bank adhering to NACO guidelines	Yes	Yes	Yes	Yes	Yes	Yes

Sl. No.	Facilities	Anantnag	Ganderbal	Handwara	Jammu	Ramban	Udhampur
	and Drugs and Cosmetic Act						
5.	Blood Bank practicing first in first out policy for reduction of waste (Blood).	Yes	Yes	Yes	Yes	Yes	Yes
6.	Refrigerator for storing blood	Yes	Yes	Yes	Yes	Yes	Yes
7.	Adequate storage capacity	Yes	Yes	Yes	Yes	Yes	Yes
8.	Records of donor and receiver maintained properly	Yes	Yes	Yes	Yes	Yes	Yes
9.	24 hours power supply with power backup	Yes	Yes	Yes	Yes	Yes	Yes

(Source: Information provided by the concerned HIs)

It is evident from the **Table 3.29** that all norms were being adhered to in four out of six test- checked DHs. DH, Jammu was not displaying blood group and DH, Ganderbal had not got blood test results validated from external labs on a regular basis.

Out of 28 test-checked SDHs/ CHCs, BSUs were available in nine[40] SDHs/ CHCs. The license to operate blood storage units in SDH, Ramnagar and CHC, Chenani, had expired in January 2020 and September 2020 respectively but had not been renewed.

Further, 13[41] BSUs were approved for establishment in SDHs/ CHCs under NHM in 2018-19. The Directors Health Services, Jammu/ Kashmir were directed (December 2019) to establish the BSUs on priority by March 2020. Audit noticed that despite the lapse of over three years as of December 2023 eight[42] BSUs had been established.

3.2.11 Diagnostic Services

Efficient and effective Radiological and Pathological diagnostic services are amongst the most essential health care facilities for delivering quality treatment to the public based on accurate diagnosis. Many of the important Radiology and Pathology tests were not performed in the sampled HIs due to lack of required equipment and skilled manpower. Significant audit findings are discussed in the succeeding paragraphs:

[40] SDHs Akhnoor, Bijbehara, Bishnah, Kupwara, Ramnagar, Sarwal, Sogam, Tangdar and CHC Chenani

[41] R.S.Pura, Banihal, Ramgarh, Sohanjana, Vijaypur, Mendhar, Bishnah, Kangan, Zainpora, Qazigund, Nagam, Beerwah, Pattan

[42] CHCs Qazigund, Beerwah, Nagam, Pattan, Banihal, Mendhar, Vijaypur and SDH Bishnah.

3.2.11.1 Radiology and other major Diagnostic Services

i) Availability of Radiology and other major diagnostic services in sampled DHs

Radiology is a branch of medicine that uses imaging technology to diagnose and treat disease. Availability of adequate functional radiology equipment with consumables and skilled human resources are key requirements for delivery of quality radiology services.

IPHS 2012 norms prescribe availability of radiology diagnostic services of X-ray, dental X-ray, Ultrasonography, CT Scan etc. in DHs. IPHS also prescribe diagnostic services under cardiac investigation, ENT, Ophthalmology, Endoscopy and Respiratory in DHs.

Availability of various diagnostic services in the test checked DHs is detailed in **Table 3.30.**

Table 3.30: Availability of Radiology Diagnostic services in sampled DHs

Name of Service	Name of Test/Diagnostic Service	DH Anantnag	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban	DH Udhampur
Radiology	X-ray for chest, Skull, Spine, Abdomen, bones	Yes	Yes	Yes	Yes	Yes	Yes
	Dental X-ray	Yes	Yes	Yes	Yes	Yes	Yes
	Ultrasonography	Yes	Yes	Yes	Yes	Yes	Yes
	CT Scan	Yes	No	Yes	Yes	Yes	Yes
	Barium Swallow, Barium meal, Barium enema, IVP	Yes	Yes	Yes	No	Yes	No
	MMR (Chest)	Yes	No	No	No	No	No
	HSG	Yes	Yes	No	No	No	No
Cardiac Investigation	ECG	Yes	Yes	Yes	Yes	Yes	Yes
	Stress Tests	Yes	No	No	No	No	No
	ECHO	Yes	Yes	No	Yes	No	Yes
ENT	Audiometry	Yes	Yes	No	Yes	Yes	Yes
	Endoscopy for ENT	Yes	Yes	Yes	Yes	No	No
Ophthalmology	Refraction by using Snellen's chart	Yes	Yes	Yes	Yes	Yes	Yes
	Retinoscopy	Yes	Yes	Yes	Yes	Yes	Yes
	Ophthalmoscopy	Yes	Yes	Yes	Yes	Yes	Yes
Endoscopy	Laparoscopic (diagnostic)	Yes	Yes	No	Yes	No	Yes
	Oesophagus	Yes	Yes	No	Yes	No	Yes
	Stomach	Yes	Yes	No	Yes	No	Yes
	Colonoscopy	Yes	Yes	No	Yes	No	No
	Bronchoscopy	Yes	No	No	No	No	No
	Arthroscopy	Yes	No	No	Yes	No	No
	Hysteroscopy	Yes	Yes	No	No	No	Yes
Respiratory	Pulmonary function tests	Yes	No	No	Yes	Yes	Yes

(Source: Information furnished by the sampled HIs)

It can be observed from the **Table 3.30** that:

- CT Scan services were available in five out of six test checked DHs except DH, Ganderbal.

- Facility of Barium swallow, Barium meal, Barium enema, IVP was not available in DH, Jammu and DH, Udhampur.

- Endoscopy for ENT was not available in DH, Ramban and DH, Udhampur.

ii) Availability of Radiology Diagnostic Services in sampled SDHs

IPHS 2012 norms provide that facilities of X-ray for Chest, Skull, Spine, Abdomen, bones, Dental X-ray and Ultrasonography with Colour Doppler should be available in an SDH. Availability of these imaging services in the sampled SDHs is detailed in **Table 3.31.**

Table 3.31: Availability of Radiology Diagnostic services in sampled SDHs

Sl. No.	Name of the SDH	X-ray for Chest, Skull, Spine, Abdomen, bones	Dental X-ray	Ultrasonography with Colour Doppler
1.	R.S. Pura	Yes	Yes	Yes
2.	Jagti	Yes	No	Yes
3.	Kot-Bhalwal	Yes	Yes	Yes
4.	Marh	Yes	Yes	Yes
5.	Bishnah	Yes	No	Yes
6.	Akhnoor	Yes	Yes	Yes
7.	Sarwal	Yes	Yes	Yes
8.	Kangan	Yes	Yes	Yes
9.	Sogam	Yes	Yes	No
10.	Kupwara	Yes	Yes	Yes
11.	Langate	Yes	Yes	Yes
12.	Tangdar	Yes	Yes	Yes
13.	Ramnagar	Yes	No	Yes
14.	Seer Hamdan	Yes	Yes	Yes
15.	Bijbehara	Yes	Yes	Yes
16.	Dooru	Yes	Yes	Yes
17.	Shangus	Yes	Yes	Yes
18	Kokernag	Yes	Yes	Yes

(Source: Information furnished by the sampled SDHs)

The data in **Table 3.31** indicates that major shortages in availability of imaging services were not there at SDH level. However, Dental X-ray was not available in three SDHs and Ultrasonography facility was not available in SDH, Sogam.

iii) Availability of Radiology Diagnostic Services in sampled CHCs

IPHS 2012 norms provide that X-ray for Chest, Skull, Spine, Abdomen, bones, Dental X-ray and Ultrasonography (desirable) facilities should be available in a CHC. Availability of these imaging services in the sampled CHCs is detailed in **Table 3.32.**

Table 3.32: Availability of Radiology Diagnostic services in sampled CHCs

Sl. No.	Name of the CHC	X-ray for Chest, Skull, Spine, Abdomen, bones	Dental X-ray	Ultrasonography (desirable)
1.	Sohanjana	Yes	Yes	Yes
2.	Jourian	Yes	Yes	Yes
3.	Khour	Yes	No	Yes
4.	Gool	Yes	Yes	Yes
5.	Banihal	Yes	Yes	Yes
6.	Batote	Yes	Yes	No
7.	Kralpora	Yes	Yes	Yes
8.	Zachaldara	Yes	Yes	Yes
9.	Kralgund	Yes	Yes	Yes
10.	Chenani	Yes	Yes (but not installed as of March -2021)	Yes

(Source: Information furnished by the sampled CHCs)

The data in **Table 3.32** indicates that the imaging services were available in all the sampled CHCs except that Dental X-ray was not available in CHC, Khour.

Further, the Minimum Standard Requirements for the Medical Colleges for (150 admissions) prescribe radiological equipment in the Department of Radio-Diagnosis. Availability of radiological equipment in the sampled TLHs is detailed in **Table 3.33.**

Table 3.33: Availability of radiological services in sampled TLHs

Name of radiological equipment	GMCH Jammu	SMGS Jammu	SSH Jammu	SMHS Srinagar	Lal Ded Srinagar	SSH Srinagar	G.B.Pant Srinagar
X-ray	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ultrasonography	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CT Scan	Yes	Yes	Yes	Yes	No	Yes	Yes
Mammography	Yes	No	No	Yes	No	No	No
MRI	Yes	No	No	Yes	No	No	No

(Source: Information furnished by the sampled TLHs)

MRI and Mammography facility were available only in GMCH Jammu and SMHS Srinagar.

3.2.11.2 Laboratory Services

HIs should be able to perform all tests required to diagnose epidemics or important diseases from public health point of view. IPHS 2012 norms prescribe 70, 39 and 29 types of laboratory investigations under five categories of Clinical Pathology, Pathology, Microbiology, Serology and Biochemistry to be carried out in the DHs, SDHs and CHCs respectively. Audit observations regarding these services are discussed in the succeeding paragraphs.

i) Availability of Laboratory Services in District Hospitals

The laboratory services were being provided through in-house laboratories in HIs. Availability of laboratory services in the sampled DHs is detailed in **Table 3.34.**

Table 3.34: Availability of laboratory investigations in sampled DHs

Sl. No.	Name of HI	Clinical Pathology (29)	Pathology (8)	Microbiology (7)	Serology (7)	Biochemistry (19)
1.	DH Anantnag	21	2	1	2	12
2.	DH Ganderbal	19	2	7	2	10
3.	DH Handwara	19	0	0	4	12
4.	DH Jammu	22	0	0	2	11
5.	DH Ramban	20	1	1	4	11
6.	DH Udhampur	22	3	0	6	10

(Source: Information furnished by sampled DHs)

76-100 *per cent*	51-75 *per cent*	26-50 *per cent*	Upto 25 *per cent*

The maximum laboratory investigations among six sampled DHs were available in DH Udhampur while DH Handwara and DH Jammu had maximum shortfall in laboratory services. Availability of investigations under Pathology were not available in DH Handwara and DH Jammu while Microbiology investigations were not available in DHs, Handwara, Jammu and Udhampur.

ii) Availability of Laboratory Services in SDHs

Against 39 types of laboratory investigations prescribed in IPHS 2012 norms for SDHs, availability in sampled SDHs is detailed in **Table 3.35.**

Table 3.35: Availability of laboratory services in sampled SDHs

Sl. No.	Name of SDH	Clinical Pathology (24)	Pathology (1)	Microbiology (4)	Serology (4)	Biochemistry (6)
1.	R.S. Pura	21	1	1	4	4
2.	Jagti	10	0	0	3	2
3.	Kot-Bhalwal	11	0	2	4	4
4.	Marh	12	0	1	4	4
5.	Bishnah	14	0	1	4	4
6.	Akhnoor	19	1	1	4	4
7.	Sarwal	20	1	1	2	3
8.	Kangan	16	0	1	4	4
9.	Sogam	18	0	1	3	4
10.	Kupwara	18	1	2	4	5
11.	Langate	12	0	1	4	3
12.	Tangdar	18	1	1	4	4
13.	Ramnagar	14	1	1	4	5
14.	Seer Hamdan	12	0	0	4	4
15.	Bijbehara	17	0	1	4	4
16.	Dooru	16	0	1	4	4
17.	Shangus	7	0	1	3	4
18.	Kokernag	0	1	4	4	6

(Source: Information furnished by sampled DHs)

76-100 *per cent*	51-75 *per cent*	26-50 *per cent*	Upto 25 *per cent*

The data in **Table 3.35** above indicates that there was maximum shortfall in pathology services in SDH Jagti, SDH Shangus and SDH Kokernag.

iii) Availability of Laboratory services in sampled CHCs

IPHS 2012 norms prescribe 29 types of laboratory investigations to be available in the CHCs. Availability of laboratory services in sampled CHCs is detailed in **Table 3.36.**

Table 3.36: Availability of laboratory services in sampled CHCs

Sl. No.	Name of HI	Clinical Pathology (18)	Pathology (1)	Microbiology (2)	Serology (3)	Biochemistry (5)
1.	Sohanjana	13	0	1	3	5
2.	Jourian	13	1	1	3	1
3.	Khour	10	1	0	2	1
4.	Gool	11	0	0	3	5
5.	Banihal	10	1	1	3	5
6.	Batote	11	0	1	3	5
7.	Kralpora	14	0	1	3	5
8.	Zachaldara	12	0	1	3	5
9.	Kralgund	11	0	0	3	2
10.	Chenani	14	0	1	3	5

(Source: Information furnished by sampled CHCs)

76-100 *per cent*	51-75 *per cent*	26-50 *per cent*	Upto 25 *per cent*

Information in the **Table 3.26** indicates Serology tests were adequate in all sampled CHCs. Pathology tests were not available in seven out of 10 sampled CHCs and Microbiology tests were not available in three CHCs. In absence of required pathology services the patients had to approach other institutions for availing the required services.

iv) Availability of Laboratory services in sampled TLHs

In seven test-checked TLHs, the position of availability of laboratory services in TLHs is given in **Table 3.37.**

Table 3.37: Availability of laboratory test in TLHs

Sl. No.	Name of the HI	Total number of tests*	Tests available	Shortfall	Percentage shortfall
1.	GMC Hospital Jammu	41	24	17	41
2.	SMGS Hospital Jammu	41	28	13	32
3.	SSH Jammu	41	30	11	27
4.	SMHS Srinagar	41	32	9	22
5.	SSH Srinagar	41	32	9	22
6.	GB Pant Hospital Srinagar	41	18	23	56
7.	LD Hospital Srinagar	41	22	19	46

(Source: Information furnished by the concerned HIs)
****As per Minimum Standard Requirements for the Medical Colleges (for 150 Admissions Annually) Regulations 1999 issued by Medial Council of India.***

The data in the **Table 3.37** indicates that there was shortfall in availability of pathology investigations in all the TLHs and percentage shortfall ranged between 22 *per cent* and 56 *per cent*.

3.2.11.3 Laboratory Equipment

- **Availability of laboratory equipment in sampled DHs**

IPHS 2012 norms prescribe 83 types of laboratory equipment for the DHs. It was, however, observed that the full range of prescribed laboratory equipment was not available as of March 2022 in the test-checked DHs as detailed in **Table 3.38.**

Table 3.38: Availability of laboratory equipment in sampled DHs

Sl. No.	Name of HI	Number of pathological equipment required as per IPHS	Equipment available	Shortfall (*percentage*)
1.	DH Anantnag	83	35	48 (58)
2.	DH Ganderbal	83	43	40 (48)
3.	DH Handwara	83	25	58 (70)
4.	DH Jammu	83	33	50 (60)
5.	DH Ramban	83	51	32 (39)
6.	DH Udhampur	83	41	42 (51)

(Source: Information furnished by the sampled DHs)

Shortfall less than 50 *per cent*	Between 50-60 *per cent*	More than 60 *per cent*

The **Table 3.38** indicates that the shortfall was maximum in DH Handwara (70 *per cent*) of laboratory equipment as compared with the other DHs.

- **Availability of laboratory equipment in sampled SDHs**

IPHS 2012 norms prescribe 33 laboratory equipment for SDHs. There was shortfall in availability of laboratory equipment in sampled SDHs as of March 2022 as detailed in **Table 3.39**.

Table 3.39: Availability of laboratory equipment in sampled SDHs

Sl. No.	Name of SDH	Number of laboratory equipment required as per IPHS	Equipment available	Shortfall (*percentage*)
1.	R.S. Pura	33	16	17 (51)
2.	Jagti	33	12	21 (64)
3.	Kot-Bhalwal	33	14	19 (58)
4.	Marh	33	16	17 (51)
5.	Bishnah	33	15	18 (54)
6.	Akhnoor	33	25	8 (24)
7.	Sarwal	33	18	15 (45)
8.	Kangan	33	15	18 (54)
9.	Sogam	33	32	3 (9)
10.	Kupwara	33	4	29 (88)
11.	Langate	33	19	14 (42)
12.	Tangdar	33	2	31 (94)
13.	Ramnagar	33	16	17 (51)
14.	Seer Hamdan	33	14	19 (58)
15.	Bijbehara	33	13	20 (61)
16.	Dooru	33	18	15 (45)
17.	Shangus	33	12	21 (64)
18.	Kokernag	33	15	18 (54)

(Source: Information furnished by the sampled SDHs)

Shortfall less than 50 *per cent*	Between 50-60 *per cent*	More than 60 *per cent*

The **Table 3.39** indicates that maximum shortfall of laboratory equipment was in SDH Tangdar and SDH Kupwara.

- **Availability of laboratory equipment in sampled CHCs**

IPHS 2012 norms prescribe 25 laboratory equipment for a CHC. However, full range of prescribed laboratory equipment was not available as of March 2022 in the test-checked CHCs as detailed in **Table 3.40.**

Table 3.40: Availability of laboratory equipment in sampled CHCs

Sl. No.	Name of CHC	Number of laboratory equipment required as per IPHS	Equipment available	Shortfall (*percentage*)
1.	Sohanjana	25	17	8 (32)
2.	Jourian	25	13	12 (48)
3.	Khour	25	10	15 (60)
4.	Gool	25	13	12 (48)
5.	Banihal	25	17	8 (32)
6.	Batote	25	14	11 (44)
7.	Kralpora	25	19	6 (24)
8.	Zachaldara	25	12	13 (52)
9.	Kralgund	25	20	5 (20)
10.	Chenani	25	15	10 (40)

(Source: Information furnished by the sampled CHCs)

Shortfall less than 50 *per cent*	Between 50-60 *per cent*	More than 60 *per cent*

The data in **Table 3.40** indicates that maximum shortfall (60 *per cent*) of laboratory equipment was in CHC Khour.

3.2.12 Maternity Services

Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) are important indicators of the quality of maternity services available in HIs. As per the Sample Registration System report by Registrar General of India, against MMR of 97 at the national level, MMR in UT of J&K was 77 during 2018-20. Further, as per National Family Health Survey-5, IMR was 16.3 in the UT during 2019-20 as compared to 35.2 at national level during the year 2019-21.

Antenatal care (ANC), Intrapartum care (IPC) and Postnatal care (PNC) are the major components of maternity services.

3.2.12.1 Antenatal Care

Antenatal care (ANC) is the systematic supervision of women during pregnancy to monitor the progress of foetal growth and to ascertain the well-being of the mother and the foetus. ANC involves general and abdominal examination, laboratory investigations, comprehensive abortion care and management of complications such as Reproductive Tract Infection (RTI) and Sexually Transmitted Infection (STI).

i) ANC checkup of pregnant women

One of the major aims of safe motherhood is to register all pregnant women before they attain 12 weeks of pregnancy and provide them with services such as four antenatal checkups. As per the 'Guidelines for Antenatal Care and Skilled Attendance at Birth', the suggested schedule for antenatal visits is: 1st visit: within 12 weeks preferably as soon as pregnancy is suspected for registration of pregnancy and first antenatal check-up, 2nd visit: between 14 and 26 weeks, 3rd visit: between 28 and 34 weeks and 4th visit between 36 weeks and term.

To prevent anaemia, pregnant women need to be given one tablet of Iron Folic Acid (IFA: 100 mg elemental iron and 0.5 mg folic acid) every day for at least 100 days, starting after the first trimester (14-16 weeks of pregnancy). IFA dose is repeated three months after child birth.

Further, the administration of two doses of Tetanus Toxoid (TT) is an important step in the prevention of maternal and neonatal tetanus (tetanus of the newborn). The first dose of TT should be administered as soon as possible, preferably when the women register for ANC and the second dose is to be given one month after the first, preferably at least one month before the expected date of delivery.

Percentage of pregnant women registered and ANC, TT and IFA tablets provided to them in the UT of J&K as per NFHS-5 is detailed in **Table 3.41.**

Table 3.41: Indicators of Antenatal Care, TT administration and IFA tablets in the UT of J&K

Indicators	2019-20
ANC received in the first trimester *per cent*	86.6
Pregnant women received at least four ANC *per cent*	80.9
TT administration *per cent*	91.9
IFA (180 days) *per cent*	15.9

(Source: NFHS-5 survey report)

Audit observed that six test checked DHs[43] had facilities of specialised ANC. Details of pregnant women registered, check-ups received by them and medicinal doses provided to them during 2016-22 in the test-checked DHs are given in **Table 3.42.**

Table 3.42: Pregnant women registered and checkups/ medicinal doses provided to them

Year	Check-up received at				Women given Tetanus Toxide dose		Women given Iron Folic Acid Tablets
	Registration	14-26 weeks	28-34 weeks	36th week	TT1	TT2	
2016-17	15,341	17,717	17,865	7,714	7,486	5,000	2,499
2017-18	15,079	14,864	11,428	7,047	11,814	11,651	6,024
2018-19	14,267	10,899	8,425	5,401	11,213	10,505	1,091
2019-20	6,547	8,952	7,417	4,729	5,702	5,283	1,206
2020-21	1,600	9,913	7,353	4,315	1,519	1,325	1,379
2021-22	7,256	12,044	9,539	6,193	7,019	5,841	8,252
Total	**60,090**	**74,389**	**62,027**	**35,399**	**44,753**	**39,605**	**20,451**

(Source: Information furnished by sampled DHs,)

[43] Maternity services provided in MCCH, Anantnag instead of DH Anantnag

- The number of pregnant women registering themselves at the DHs had decreased from 15,341 during 2016-17 to 7,256 during 2021-22.

- Number of pregnant women registered for ANC during 2016-22 to the extent of 60,090 had reduced at the time of final ANC after 36th week of pregnancy by 41 *per cent*. This was indicative that pregnant women had shifted to other HIs for delivery.

- Out of 60,090 registered pregnant women, only 39,605 (66 *per cent*) had received 2nd dose of TT and only 34 *per cent* were provided IFA supplementation.

ii) Laboratory investigations

Guidelines for ANC and Skilled Attendance at Birth prescribe conducting six laboratory investigations (Blood group including Rh[44] factor, VDRL[45]/ RPR[46], HIV[47], Rapid Malaria, Blood sugar and HBsAg[48]) during visit by pregnant women at SDHs/ CHCs for ANC to identify pregnancy related complications.

Audit observed that:

- In SDH Jagti, only the facility of pathological investigation of Blood Sugar was available.

- The facility of Rapid Malaria test was not available in 13 SDHs/ CHCs (43 *per cent*) out of the sampled 28 SDHs/ CHCs which was prescribed for detection of Pregnancy Malaria which can lead to cases of maternal anemia, premature delivery, intrauterine growth retardation, and delivery of low birth-weight infants.

iii) Management of RTI/ STI

Reproductive Tract Infections (RTIs) including Sexually Transmitted Infections (STIs) present a huge burden of disease and adversely impacts the reproductive health of people. The consequences of RTI/ STI can be severe and life-threatening, such as Pelvic Inflammatory Disease (PID), Ectopic Pregnancy and adverse pregnancy outcomes including abortion, stillbirth, preterm birth and congenital infections (due to Syphilis, HSV, Hepatitis-B virus and HIV). National Guidelines (July 2014) on prevention, management and control of RTI/ STI provides for 13 essential RTI/ STI drugs.

Details of RTI/ STI patients treated in sampled DHs during 2016-22 and shortfall in availability of drugs in DHs are given in **Table 3.43:**

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44 Rhesus factor
45 Venereal Disease Research Laboratory
46 Rapid Plasma Reagin
47 Human Immuno deficiency Virus
48 Hepatitis B Surface Antigen

Table 3.43: Availability of essential RTI/STI drugs in sampled DHs

Particulars	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban
Number of patients treated for RTI/STI during 2016-22	3,597	7,330	2,572	224
Average availability of drugs out of 13 essential RTI/STI drugs during test checked months (November 2016, May 2017, April 2018, January 2020, February 2021 and August 2021)	4	3	3	5
Percentage shortfall of drugs (out of 13)	69	77	77	62

(Source: Information furnished by the sampled HIs)

It is evident from the **Table 3.43** that there was shortfall in availability of essential RTI/ STI drugs ranging between 62 *per cent* and 77 *per cent* in four out of six sampled DHs during 2016-22. No RTI/ STI patient was treated in DH Udhampur during 2016-21 however during 2021-22, despite 35 patients attended the HI. No RTI/ STI patient attended the MCCH Anantnag during 2016-22.

Similarly, there was also shortfall in availability of essential RTI/ STI drugs in the sampled 28 SDHs/ CHCs as detailed in **Table 3.44.**

Table 3.44: RTI/ STI patients treated and availability of essential RTI/STI drugs in SDHs/ CHCs

Sl. No.	Name of SDH/CHC	Number of patients treated for RTI/STI during 2016-22	Average availability of essential RTI/STI drugs (out of 13 drugs)
1.	R.S. Pura	2,245	2
2.	Jagti	426	5
3.	Kot-Bhalwal	104	4
4.	Marh	2,079	5
5.	Bishnah	357	9
6.	Akhnoor	285	5
7.	Sarwal	14,150	3
8.	Kangan	840	5
9.	Sogam	12,872	1
10.	Kupwara	37,376	13
11.	Langate	44	7
12.	Tangdar	2,200	Nil
13.	Ramnagar	1,094	5
14.	Seer Hamdan	633	Nil
15.	Bijbehara	1,059	2
16.	Dooru	170	4
17.	Shangus	2,468	2
18.	Kokernag	6,244	12
19.	Sohanjana	11,457	5
20.	Jourian	10	7

Sl. No.	Name of SDH/CHC	Number of patients treated for RTI/STI during 2016-22	Average availability of essential RTI/STI drugs (out of 13 drugs)
21.	Khour	352	3
22.	Gool	69	7
23.	Banihal	13,455	2
24.	Batote	360	7
25.	Kralpora	1,226	6
26.	Zachaldara	3,687	5
27.	Kralgund	23	8
28.	Chenani	0	6

(Source: Information furnished by the sampled HIs)

More than 10 drugs	6-10 drugs	1-5 drugs	Nil drugs

The **Table 3.44** indicates that out of 28 sampled SDHs/ CHCs:

- there was non-availability of essential RTI/ STI drugs in two SDHs.
- average one to five drugs were available in 16 SDHs/ CHCs.
- average six to 10 drugs were available in eight SDHs/ CHCs.
- only two SDHs/CHCs had average availability of more than 10 drugs.
- During the period covered in audit, 2,833 RTI/ STI patients were stated to be treated in SDH Tangdar (2,200) and SDH Seer Hamdan (633) despite absence of specific RTI/ STI essential drugs. This indicated that the patients had to arrange the drugs themselves.

3.2.12.2 Intrapartum care (IPC)

Intrapartum is the time period from onset of labor to childbirth. Proper care during labor and childbirth saves not only mothers and their newborn babies, but also prevents stillbirths, neonatal deaths and other complications.

Audit observations on IPC have been discussed in the succeeding paragraphs:

• Preparation of partograph

The partograph is a tool for monitoring maternal and foetal well-being during the active phase of labour, and a decision-making aid when abnormalities are detected. Scrutiny of records of HIs revealed that out of six sampled DHs, three DHs partially used the partograph, whereas partographs were not used during 2016-22 in three DHs. 16 out of 28 test-checked SDHs/ CHCs had not used partographs and 12 SDHs/ CHCs[49] had either fully or partially used them.

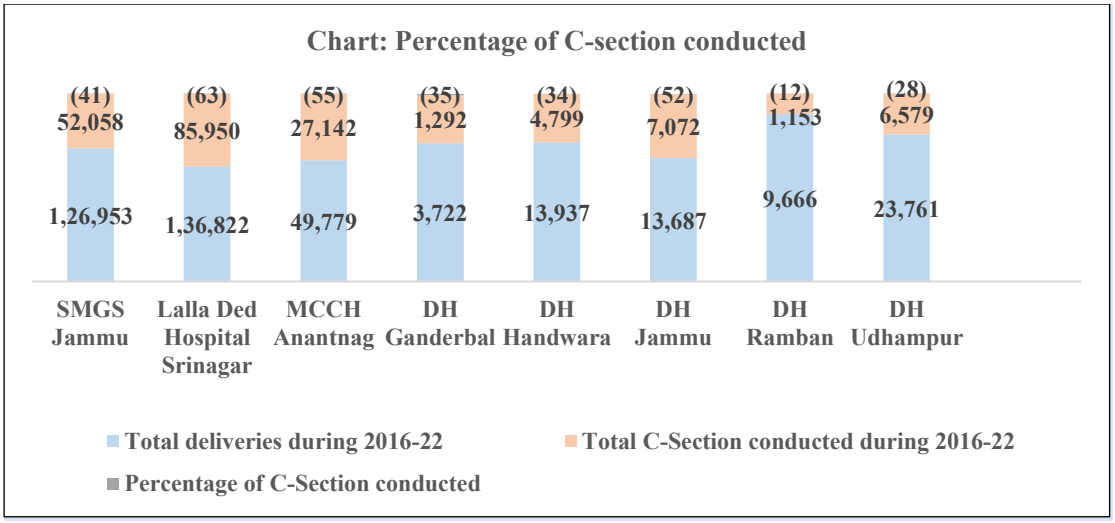
[49] SDHs Sarwal, Kupwara, Langate, Ramnagar, Seer Hamdan, Bijbehara, Dooru, Kokernag, Shangus, Marh and CHCs Kralpora and Kralgund

i) Caesarean Section deliveries

A Caesarean Section (C-Section) delivery is a lifesaving surgical procedure for the mothers and babies when certain complications appear during pregnancy or labour. NHM Guidelines on "Engaging General Surgeons for performing Caesarean Sections and managing Obstetric Complications" envisage that around 8-10 *per cent* of total delivery cases require C-section.

C-Sections conducted out of total deliveries in the selected two TLHs and six DHs are depicted in **Chart 3.7.**

Chart 3.7: Caesarian Sections deliveries conducted in Health Institutions



(Source: Information furnished by the respective HIs)

The data in the **Chart 3.7** shows that:

- A high percentage of total deliveries in two[50] TLHs beyond the percentage envisaged in NHM guidelines was conducted through C-Section.
- During 2016-22, out of 1,14,552 deliveries in sampled DHs, the C-section deliveries were 48,037 (42 *per cent*). The higher percentage of C-section deliveries was in DH Jammu (52 *per cent*) and MCCH Anantnag (55 *per cent*).
- 12 *per cent* C-section deliveries out of total deliveries in DH Ramban were however, close to the norms.

The C-Section deliveries in the sampled SDHs/ CHCs were 24 *per cent* of total deliveries (88,260).

The percentage of C-section deliveries in the HIs of the State/ UT was more than the national average of 14.3 *per cent* as per NFHS-5 (2019-21). The percentage of C-section deliveries as per NFHS-5 stood at 42.7 *per cent.*

[50] SMGS Hospital, Jammu and Lal Ded Hospital, Srinagar

In view of the higher rate of C-Section deliveries, the Mission Director, National Health Mission, J&K directed (February 2022) for conducting of C-Section audit to curb the rising trend of Caesarean births and to ensure judicious use of C-Section in only medically indicated cases.

ii) Postnatal Care

MNH Toolkit provides for Zero day immunisation for four vaccines viz. BCG[51], OPV[52], Hepatitis 'B' and Vitamin 'K' to newborns. The details of birth dose vaccination given to newborns in six test-checked HIs during 2016-22 are given in **Table 3.45.**

Table 3.45: Details of birth dose vaccination to newborns in sampled DHs during 2016-22

Sl. No.	Name of HI	Newborn (Live Birth) in HI	*Per cent* of newborns[53] given the vaccination dose			
			BCG	OPV	Hepatitis-B	Vit-K
1.	MCCH Anantnag	48,748	134	134	109	93
2.	DH Ganderbal	3,713	104	100	97	69
3.	DH Handwara	13,937	99	97	96	97
4.	DH Jammu	13,629	103	103	94	100
5.	DH Ramban	9,442	108	98	98	100
6.	DH Udhampur	23,603	124	119	104	100

(Source: Information furnished by sampled HIs)

From the **Table 3.45** it could be seen that the selected hospitals were fairly regular in administering zero day vaccination.

Details of birth dose vaccination administered to newborns in 28 test-checked SDHs/ CHCs during 2016-22 are given in **Table 3.46.**

Table 3.46: Details of birth dose vaccination to newborns in sampled SDHs/CHCs during 2016-22

Name of sampled District.	Number of SDHs/CHCs	Newborn (Live Birth)	*Per cent* of newborns given the vaccination dose			
			BCG	OPV	Hepatitis-B	Vit-K
Anantnag	5	15,480	100	100	100	100
Ganderbal	1	4,722	101	101	100	101
Jammu	10	23,367	108	108	100	100
Kupwara	7	28,736	105	115	104	81
Ramban	3	9,467	100	100	100	100
Udhampur	2	6,321	101	101	101	101

(Source: Information furnished by sampled HIs)
(Red: Less than 100)

Percentage immunisation given to newborns in the 28 test-checked SDHs/ CHCs was also satisfactory in the sampled Districts. However, the administration of Vitamin-K was 81 *per cent* in District Kupwara due to shortage of Vitamin-K supply during the period.

[51] Bacille Calmette-Guerin
[52] Oral Polio Vaccine
[53] Including newborns not delivered in concerned HI.

The status of immunisation of newborns in two TLHs during 2016-22 is given in **Table 3.47.**

Table 3.47: Status of immunisation of newborns in two TLHs during 2016-22

Name of Hospital	Newborn (Live Birth)	*Per cent* of newborns given vaccination			
		BCG	OPV	Hepatitis-B	Vit-K
SMGS Hospital	1,25,121	92	92	83	65
Lalla Ded Hospital	1,39,129	85	85	77	83[54]

(Source: Records of test checked hospitals)

As can be seen from the **Table 3.47**, during 2016-22 immunisation of newborns in SMGS Hospital Jammu ranged between 65 *per cent* and 92 *per cent* and in Lal Ded Hospital it ranged between 77 *per cent* and 85 *per cent*. In respect of administering of Vitamin-K in SMGS Hospital Jammu, the data was provided for normal deliveries only.

Thus, the mechanism of providing vaccination was better at the secondary level than at the tertiary level.

3.2.13 Doctor Survey

An interaction by Audit with 78 doctors in six DHs (16 doctors) and SDHs/ CHCs (62 doctors) revealed the following:

- About 67 *per cent* doctors were posted in HIs (DHs:13, SDHs/ CHCs: 39) for over two years.
- Out of 78 doctors, 53 doctors were post-graduate (DHs;13, SDHs/ CHCs: 40).
- 26 (33 *per cent*) doctors (DH: 04, SDHs/ CHCs: 22) stated that the required infrastructure was not available in the hospital.
- On an average one doctor was attending 67 patients per day in OPD/ IPD (DH:75, SDH/ CHC:59).
- 15 doctors (DH: 01, SDHs/ CHCs:14) were not aware of medical records kept in the hospital.
- 16 doctors (DHs: 05, SDHs/ CHCs: 11) stated that generic medicines were not available in hospital pharmacy.
- Manual on Standard Treatment Guidelines was not available in the chambers of 56 doctors (DHs: 08, SDHs/ CHCs: 48).
- 71 out of 78 doctors felt the need for improvement in the health care infrastructure by making equipment, machinery, drugs etc. available as per requirements of the patients.

[54] Data was taken for 2018-19 to 2021-22, as in 2016-17 and 2017-18 data was not available.

- 70 doctors confirmed availability of proper monitoring system in the HIs for patients requiring long term/ continuous treatment.

3.2.14 Support services

3.2.14.1 Liquid Medical Oxygen

Liquid Medical Oxygen is high purity oxygen used for medical treatment, and is developed for use in the human body. The oxygen supply is provided in hospitals through centralised oxygen supply, oxygen cylinders and oxygen concentrators.

Audit observed that:

- Centralised oxygen supply was available in four out of six selected DHs. In DH Handwara and DH Jammu, oxygen supply was provided through oxygen cylinders.

- Out of 28 SDHs/ CHCs, centralised oxygen supply was available only in eight[55] SDHs/ CHCs.

- There was adequate buffer stock of oxygen cylinders and oxygen concentrators in all test- checked DHs and SDHs/ CHCs except CHC Batote.

Availability of oxygen generation plants and their capacity in the sampled TLHs is detailed in **Table 3.48.**

Table 3.48: Availability of oxygen generation plants and their capacity in the sampled TLHs

Sl. No.	Name of the HI	Number of oxygen generation plants available	Available capacity (LPM[56])
1.	GMCH Jammu	10	8,700
2.	SSH Jammu	5	3,375
3.	SMGS Hospital Jammu	6	5,400
4.	SMHS Hospital Srinagar	6	5,600
5.	SSH Srinagar	3	2,300
6.	LD Hospital Srinagar	2	1,625
7.	G.B.Pant Hospital Srinagar	3	1,440
	Total	**35**	**28,440**

(Source: Information furnished by Departmental authorities)

One Liquid Medical Oxygen Tank of 20 kilolitre capacity was also installed in the GMC Hospital Jammu to cater to the needs of the patients.

3.3.14.2 Dietary service

IPHS norms 2012 envisage that dietary service of a hospital is an important therapeutic tool. It is, therefore, essential that the quality and quantity of diet provided to patients

[55] SDH Dooru, SDH Kangan, SDH Kot-Bhalwal, SDH Kupwara, SDH Sogam, SDH Tangdar, SDH Sarwal and CHC Banihal

[56] Litre per minute

should be of the requisite standard. Various aspects pertaining to providing diet to patients is detailed in **Table 3.49**.

Table 3.49: Availability of dietary facilities in the sampled HIs

Particulars	Available in number of TLHs (out of 7)	Available in number of DHs (out of 6)	Available in number of SDHs/ CHCs (out of 28)
Institutional mechanism for providing diet to patients	Nil	Nil	Nil
Outsourcing of diet	7	5	8
Availability of diet register	7	5	10
Mechanism for providing various types of diet (normal, dry, semisolid) to patients	1	1	2
Conducting of quality check	5	3	1
Conducting of quantity check	2	3	1
Availability of Dietician	2	Nil	Nil

(Source: Information provided by the concerned HIs)

Audit observed the following points in the sampled HIs.

- In absence of institutional mechanism for providing diet in all sampled HIs, all seven sampled TLHs, five out of six sampled DHs and eight out of 28 sampled SDHs/ CHCs were providing diet to patients through outsourcing. Dietary services were not available in DH Anantnag and in seven SDHs/ CHCs whereas the diet under the scheme JSSK was only being provided by DH Ganderbal and 13 SDHs/ CHCs.

- Diet register was available in all the TLHs, in five DHs and in 10 SDHs/ CHCs.

- There was no mechanism of providing diet to patients as prescribed by the doctors in all the HIs except in SSH Srinagar, DH Udhampur, SDH Kupwara and CHC Khour.

- The quality check of diet was being conducted in five TLHs, three DHs and in SDH Kupwara.

- The quantity check of diet was being conducted in two TLHs, three DHs and in SDH Kupwara.

- Dietician was not available in five TLHs and in none of the six sampled DHs and 28 SDHs/ CHCs.

In view of the above-mentioned observations, Audit could not derive an assurance that quality diet was provided to patients in the test-checked HIs.

3.2.14.3 Laundry services

IPHS 2012 norms provide that hospital laundry should be provided with necessary facilities for segregated collection, drying, pressing and storage of soiled and cleaned linens. It may be outsourced.

Audit observed that as of March 2022, laundry service was available in five[57] out of six test checked DHs except DH Handwara. Out of 28 sampled SDHs/ CHCs, laundry service was available in only four[58] SDHs.

HIs not having laundry facility were getting linen washed by employing someone on call basis or sending linen to a HI having laundry facility. Lack of laundry services poses health risk to both staff and patients.

Linen being washed in the open in SDH Marh (District Jammu) in absence of laundry facility (08.12.2021)

i) Availability of linen in hospital

IPHS 2012 norms prescribe 24 types of linen that are required for patient care services in hospitals. The availability of linen in sampled HIs is detailed in **Table 3.50.**

Table 3.50: Availability of linen in sampled DHs during 2021-22

Sl. No.	Type of linen	Availability of linen					
		DH Anantnag	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban	DH Udhampur
1.	Bed sheets	Yes	Yes	Yes	Yes	Yes	Yes
2.	Bedspreads	No	No	No	No	No	No
3.	Blankets (Red and Blue)	Yes	Yes	Yes	Yes	Yes	Yes
4.	Patna Towels	No	No	Yes	No	No	No
5.	Table cloth	No	No	No	No	No	Yes
6.	Draw sheets	No	Yes	Yes	Yes	Yes	Yes
7.	Doctor's overcoats	Yes	Yes	Yes	Yes	Yes	Yes
8.	Hospital workers' OT coat	No	Yes	No	Yes	Yes	Yes
9.	Patient's house coat (Female)	No	No	No	Yes	No	Yes
10.	Patient's Pyjama Shirt (for male)	No	No	No	Yes	No	Yes
11.	Over-shoes pairs	No	No	No	Yes	Yes	Yes
12.	Pillows	No	Yes	Yes	Yes	Yes	Yes
13.	Pillows cover	No	Yes	Yes	Yes	Yes	Yes
14.	Mattresses (Foam) for adult	Yes	Yes	Yes	Yes	Yes	Yes
15.	Paediatric mattresses	No	No	No	Yes	No	No
16.	Abdominal sheets for OT	No	Yes	Yes	Yes	No	Yes

[57] DH Anantnag, DH Ganderbal, DH Jammu, DH Ramban and DH Udhampur
[58] SDH Bishnah, SDH Akhnoor, SDH Kangan and SDH Sarwal

Sl. No.	Type of linen	Availability of linen					
		DH Anantnag	DH Ganderbal	DH Handwara	DH Jammu	DH Ramban	DH Udhampur
17.	Perineal sheets for OT	No	No	No	Yes	No	Yes
18.	Leggings	No	No	No	Yes	No	No
19.	Curtain cloth windows and doors	No	No	No	Yes	Yes	Yes
20.	Uniform/Apron	Yes	Yes	Yes	Yes	No	Yes
21.	Mortuary sheets	No	No	No	Yes	Yes	Yes
22.	Mats (nylon)	No	No	No	No	No	Yes
23.	Mackintosh sheets	No	Yes	No	Yes	Yes	Yes
24.	Apron for cook	No	No	No	Yes	No	No

(Source: Information furnished by sampled HIs)

It is evident from the **Table 3.50** that:

- The prescribed types of linen were not available in all the sampled HIs.
- The maximum shortfall of linen was in DH Anantnag whereas the minimum shortfall of linen was observed in DH Jammu.

In respect of the 28 sampled SDHs/ CHCs, availability of linen was in the range of four to 24 types. The maximum shortfall of 20 types of linen was observed in SDH Marh whereas in SDH Sogam and Kupwara, there was no shortfall.

ii) Cleanliness of linen

A hospital should provide clean and hygienic linen to patients for preventing infection among patients and hospital staff. The status of cleanliness of linen in the sampled DHs during 2021-22 is given in **Table 3.51**.

Table 3.51: Status of cleanliness of linen in sampled DHs during 2021-22

Particulars	DH Anantnag	DH Ganderbal	DH Jammu	DH Handwara	DH Ramban	DH Udhampur
Bed sheets changed on daily basis (with colour code)	Yes	Yes	Yes	No	Yes	Yes
Daily collection of soiled linen	Yes	Yes	Yes	Yes	Yes	Yes
Daily delivery of cleaned linen	Yes	Yes	Yes	Yes	Yes	Yes
Register of maintenance of linen available	Yes	Yes	Yes	Yes	Yes	Yes
Records of quantity of linen received from laundry available	Yes	Yes	Yes	No	Yes	Yes

(Source: Information furnished by sampled HIs)

The data in the **Table 3.51** indicates that cleanliness of linen was ensured in five out of six sampled DHs. In DH Handwara bed sheets were neither changed on a daily basis nor were records of quantity of linen received from laundry available.

The status of cleanliness of linen in the sampled 28 SDHs/ CHCs is detailed in **Table 3.52.**

Table 3.52: Status of cleanliness of linen in sampled SDHs/CHCs during 2021-22

Name of the District	Number of sampled SDHs/CHCs	Number of HIs where				
		Bed sheets changed on daily basis (with colour code)	Soiled linen collected daily	Cleaned linen delivered daily	Register of maintenance of linen was available	Records of quantity of linen received from laundry available
Anantnag	5	3	4	5	3	3
Ganderbal	1	0	0	1	0	0
Jammu	10	10	10	9	9	9
Kupwara	7	5	6	6	5	5
Ramban	3	3	2	2	2	1
Udhampur	2	2	1	1	2	2

(Source: Information furnished by sampled HIs)

It is evident from the **Table 3.52** that hospitals were not providing hygienic and clean bed linen to patients exposing them to the risk of infection.

3.2.14.4 Ambulance Services

IPHS 2012 norms provide for availability of 24-hour ambulance service in DHs, SDHs and CHCs. It is also desirable to have an ambulance in PHCs to provide emergency services.

Out of 1,263 ambulances under the control of Directorate of Health Services, Jammu & Kashmir, 121 ambulances were off the road (requiring repair: 09; outlived their useful life: 112) and 143 ambulances were beyond economic repair as of March 2022.

It was observed that in the sampled 06 DHs and 28 SDHs/ CHCs, ambulance service was available except in SDH Langate.

Out of 52 test-checked PHCs, ambulance service was not available in 33 (63 *per cent*) PHCs with the result the patients were deprived of ambulance service at the time of emergency.

- **Operationalisation of 102/108 Ambulance Service**

Toll free numbers 102 and 108 dedicated for providing ambulance service to pregnant women and infants and for attending medical emergency calls respectively was launched (March 2020) under JK Emergency Medical Service (JKEMS) in the UT of Jammu and Kashmir. As of March 2023, there was a fleet of 203 Critical Care Ambulances (Advance Life Support: 139; Basic Life Support: 64) and 286 Patient Transport Ambulances under Janani Shishu Suraksha Karyakram (JSSK) which were responding to Toll free numbers 102 and 108 in the UT of J&K. Year wise work done by JKEMS (102-108) Ambulance Service is detailed in **Table 3.53.**

Table 3.53: Patients served by JKEMS as of March 2022

Particulars	Total patients served since launch upto March 2022
Patients served by 102	27,819
Patients served by 108	1,13,515
Total	**1,41,334**

(Source: Information furnished by NHM, J&K)

The data in **Table 3.53** indicates that as of March 2022, on an average 194 patients[59] per day were served by 102-108 Ambulance service. Category wise patients served under 102 and 108 ambulances is detailed in **Table 3.54.**

Table 3.54: Category wise patients served under 102 and 108 ambulances

Total Patients served under 102	Upto March 2022	Total patients served under 108	Up to March 2022
Pregnant Women	5,475	Medical Emergency, Police Emergency, Fire Emergencies	48,396
Infants	396		
Other referral drop back	21,912		
Any other	36	Pregnancy Emergencies	38,056
		COVID	12,144
		Any other	14,919
Total	**27,819**		**1,13,515**

(Source: Information furnished by NHM, J&K)

It can be seen from the **Table 3.54** that 21,912 patients availed the referral drop back facility out of a total of 27,819 patients by 102 ambulances. Further, as many as 86,452 emergency cases (48,396 medical emergencies and 38,056 pregnancy emergencies) were served by 108 ambulances. A total of 12,144 patients related to COVID-19 had also been shifted to nearby dedicated COVID-19 HIs through 108 ambulances.

- **Average Response Time**

The average response time for urban and rural areas is 20 minutes and 30 minutes respectively. It was fixed by agreement (JKMSCL and BVG INDIA LTD) in August 2019.

The average response time in urban and rural areas by 108 ambulances during 2020-21 and 2021-22 is given in **Table 3.55.**

Table 3.55: Average response time in urban and rural areas by 108 ambulance service

Year	Urban area	Rural area
2020-21	17 minutes 53 seconds	22 minutes
2021-22	11 minutes 05 seconds	14 minutes 25 seconds

(Source:- National Health Mission J&K)

The average response time had improved in urban as well as in rural areas during 2021-22 as compared to 2020-21. Data regarding average response time by 102 ambulances was not provided.

[59] 1,41,334 patients / (365 days x 2 years)

- **Average calls per day**

The average calls per day during 2020-21 and 2021-22 under 102 and 108 ambulance services is given in **Table 3.56.**

Table 3.56: Average calls per day and answer time during 2020-22

Year	Average calls per day		Answer time	
	102	108	102	108
2020-21	1,867	1,020	09 seconds	08 seconds
2021-22	1,272	1,079	08 seconds	07 seconds

(Source:- National Health Mission J&K)

The data in **Table 3.56** indicates that the calls received under 102/ 108 were answered within nine seconds.

3.2.14.5 Mortuary

As per IPHS 2012 norms, mortuary provides facilities for keeping dead bodies and conducting autopsy.

Audit observed that mortuary was available in five out of six sampled DHs except DH Gandhi Nagar, Jammu. Out of 28 test-checked SDHs/ CHCs, mortuary was available in 12 SDHs/ CHCs. However, mortuary in eight[60] SDHs/ CHCs was functional and in four[61] SDHs/ CHCs, the mortuary was non-functional due to lack of infrastructure.

3.2.14.6 Patient Safety

i) Infection Control

Infection control in hospitals is vital for maintaining a safe environment for both patients and staff in the hospitals.

NHM Assessor's Guidebook requires that for cleaning and disinfection of patient care areas, standard practices be followed through maintenance of a checklist for hygiene and infection control in a hospital. Also for prevention and measurement of hospital associated infection, a Hospital Infection Control Committee (HICC) should be constituted.

Availability of checklist for hygiene and infection control and status of HICC as of March 2022 in the test checked hospitals is detailed in **Table 3.57.**

Table 3.57: Availability of checklist for infection control and status of constitution of HICCs

Availability of checklist for hygiene and infection control		Constitution of Hospital Infection Control Committee	
DHs (6)	SDHs/CHCs (28)	DHs (6)	SDHs/CHCs (28)
Five	12	05	15

(Source: Information furnished by sampled HIs)

[60] SDH R.S.Pura,, SDH Bishnah, SDH Akhnoor, SDH Kangan, SDH Kupwara, SDH Tangdar, SDH Ramnagar, and CHC Chenani.

[61] SDH Kot-Bhalwal, SDH Dooru, CHC Khour and CHC Sohanjana

It was observed that checklist for hygiene and infection control was not available in DH Handwara whereas the HICC was not constituted in DH Anantnag.

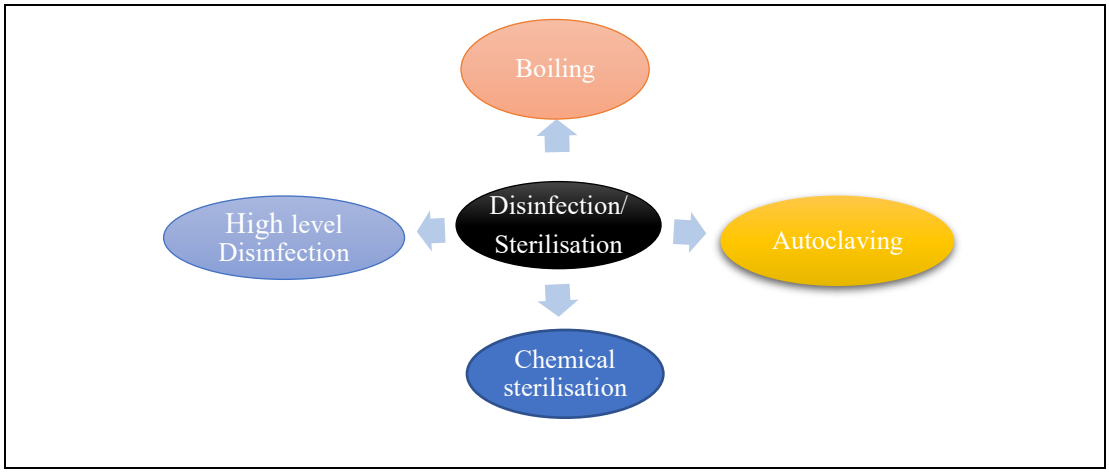
Further, out of 28 sampled SDHs/ CHCs, checklist for hygiene and infection control was available in 12 SDHs/ CHCs. HICC was constituted in 15 SDHs/ CHCs.

In six out of seven test-checked TLHs (except SMHS Hospital, Srinagar), a checklist for hygiene and infection control was maintained and HICC had been set up.

ii) Disinfection and Sterilisation

NHM Assessor's Guidebook recommends Boiling, Autoclaving, High Level Disinfection (HLD) and Chemical Sterilisation process for disinfection/ sterilisation of instruments and equipment in the health facility.

Various methods of disinfection and sterilisation



Status of availability of methods of disinfection and sterilisation in the sampled HIs is given in **Table 3.59.**

Table 3.59: Availability of methods of disinfection and sterilisation

Hospitals	Number of HIs where methods available			
	Boiling	Autoclaving	Chemical Sterilisation	High level disinfection
Tertiary Level Hospitals (7)	07	07	07	07
DHs (6)	05	06	04	04
SDHs/CHCs(28)	27	25	16	08

(Source: Information furnished by sampled HIs)

It is evident from the **Table 3.59** that all the methods of disinfection and sterilisation were not available in most of the sampled HIs.

iii) Disaster management in hospitals

NHM Assessor's Guidebook for Quality Assurance envisages preparation of Disaster Management Plan (DMP) and constitution of Disaster Management Committee.

Audit however observed that DMP was prepared and DMC was constituted by four[62] TLHs. Out of six sampled DHs, DMP was framed by three[63] DHs and DMC was constituted by four[64] DHs. Similarly, out of 28 sampled SDHs/ CHCs, DMP was prepared by 13 SDHs/ CHCs and DMC was constituted by 14 SDHs/ CHCs.

iv) Safety from fire

Fire safety is important and necessary in the workplace in order to prevent and protect against destruction caused by fire. Fire safety reduces the risk of injury and damage to buildings that fires can cause.

IPHS 2012 norms provide for ready availability of fire-fighting equipment such as fire extinguishers (FEs), sand buckets etc. Availability of fire safety equipment in the sampled TLHs is detailed in **Table 3.60.**

Table 3.60: Availability of fire safety equipment in sampled TLHs

Name of the HI	NOC obtained from F&ES Department	Fire extin-guisher	Smoke and heat detector	Smoke alarm	Fire hydrants	Sand bucket	Backup water for fire	Evacuation plan routes for fire exit	Fire extin-guisher at power backup area	Underground static water tank
GMCH Jammu	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
SMGS Jammu	No	30 expired out of 71	Non-functional	No	Yes	Yes	Yes	No	Yes	Yes
SSH Jammu	No	All 116 expired	Non-functional	No	Non-functional	Yes	Yes	No	No	Yes
SMHS Srinagar	Yes	Yes	No	No	No	No	No	Yes	Yes	No
SSH Srinagar	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
LD Srinagar	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
G.B. Pant Srinagar	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes

(Source: Information furnished by the concerned HIs)

Data in the **Table 3.60** indicates that:

- NOC from Fire and Emergency Services (F&ES) Department was obtained by only SMHS Hospital Srinagar.
- FEs were installed in all the HIs. However, FEs were found expired in SMGS Hospital Jammu and SSH Jammu.
- Smoke and heat detectors were available in three HIs, were not available in two HIs and were found non-functional in SMGS Hospital, Jammu and SSH, Jammu.

[62] GMCH Jammu, SMGS Jammu, G.B. Pant Hospital Srinagar and Lal Ded Hospital Srinagar.
[63] DH Ganderbal, DH Jammu and DH Udhampur
[64] DH Ganderbal, DH Jammu, DH Handwara and DH Udhampur.

- Smoke alarms were installed in three HIs.
- Fire hydrants were available in five HIs and were found non-functional in SSH Jammu.
- Sand buckets, the basic fire safety measure were available in five HIs.
- Backup water availability for fire, availability of FEs at power back up area and availability of underground static water tank was available in six HIs.
- Evacuation plan route for fire exit in case of emergency was available in four HIs.

Availability of fire safety equipment in the sampled DHs is given in **Table 3.61**.

Table 3.61: Availability of fire safety equipment in sampled six DHs

Name of the HI	NOC obtained from F&ES Department	Fire extin-guisher (FE)	Smoke and heat detector	Smoke alarm	Fire hydrants	Sand bucket	Backup water for fire	Evacuation plan routes for fire exit	FE at power backup area	Underground static water tank
DH Anantnag	No	Yes	No	No	No	No	No	No	Yes	No
DH Ganderbal	No	Yes	No	No	Yes	No	No	No	No	No
DH Handwara	No	Yes	No	No	No	No	No	No	No	No
DH Jammu	No	Yes	Yes	No	No	Yes	No	No	Yes	No
DH Ramban	No	Yes	Yes	Yes	Yes	No	No	No	No	No
DH Udhampur	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes

(Source: Information furnished by the concerned HIs)

It is evident from the **Table 3.61** that:

- NOC from the F&ES Department had not been obtained by any of the DHs.
- FEs were installed in all the sampled DHs.
- Smoke and heat detectors were installed in three (50 *per cent*) HIs.
- Smoke alarms, fire hydrants, sand buckets and fire extinguishers at power backup area were found installed in four HIs.
- Backup water facility for fire, evacuation plan route for fire exit and underground static water tank was available in five HIs.

Availability of fire safety equipment in 28 sampled SDHs/ CHCs is given in **Table 3.62.**

Table 3.62: Availability of fire safety equipment in sampled 28 SDHs/CHCs

Particulars	Name of the District					
	Anantnag	Ganderbal	Jammu	Kupwara	Ramban	Udhampur
	Number of SDHs/CHCs sampled (5)	Number of SDHs/CHCs sampled (1)	Number of SDHs/CHCs sampled (10)	Number of SDHs/CHCs sampled (7)	Number of SDHs/CHCs sampled (3)	Number of SDHs/CHCs sampled (2)
NOC obtained from F&ES Department	1	0	1	Information not available	0	0
Fire extinguishers	5	1	9 (not available in SDH Jagti)	6 (not available in CHC Kralgund)	3	2
Smoke and hea Detectors	1	0	6	1	2	2
Smoke alarm	0	0	6	1	2	2
Fire Hydrants	2	1	3	0	1	0
Sand buckets	0	0	4	1	0	0
Backup water for fire	3	0	4	0	1	0
Evacuation plan routes for fire exit	0	0	2	0	0	2
Fire extinguisher at power backup area	4	1	3	3	0	0
Underground static water tank	3	0	4	1	0	0

(Source: Information furnished by the concerned HIs)

Available	Partially available	Not available

Audit observed that:

- NOC from F&ES Department was obtained by only SDH Kokernag and SDH Bishnah out of 28 sampled SDHs/ CHCs.
- Fire extinguishers were available in all the sampled SDHs/ CHCs except SDH Jagti and CHC Kralgund.
- Smoke and heat detectors were not installed in all the sampled SDHs/ CHCs of five out of six sampled Districts. Smoke and heat detectors were installed in SDH Ramnagar and CHC Chenani in District Udhampur.
- Fire hydrants were not installed in the sampled SDHs/ CHCs of District Kupwara and District Udhampur.

- Sand buckets were not available in sampled SDHs/ CHCs of District Anantnag, Ganderbal, Ramban and Udhampur.

- Backup water facility for fire was not available in sampled SDHs/ CHCs of District Ganderbal, Kupwara and Udhampur.

- Evacuation plan route for exit in case of fire were not marked in sampled SDHs/ CHCs of District Anantnag, Ganderbal, Kupwara and Ramban.

- FEs at power backup area were not installed in sampled SDHs/ CHCs of Ramban and Udhampur District.

- The facility of underground water static tank was not available in sampled SDHs/ CHCs of District Ganderbal, Ramban and Udhampur.

3.2.15 Grievances/complaints Redressal

For effective redressal of grievances of patients, NHM Assessor's Guidebook provides for a defined and established grievance redressal system. There should be a system of periodic review of patient complaints.

Details of complaints received and disposed of during 2016-22 in seven TLHs are given in **Table 3.63**.

Table 3.63: Number of complaints received and disposed of during 2016-22 in sampled TLHs

Name of the HI	Number of complaints received during 2016-22	Number of complaints disposed during 2016-22	Remarks
GMC Hospital Jammu	1	1	Records not available for the period 2016-20.
SMGS Hospital Jammu	1	1	Records not available for the period 2016-20
SSH Jammu	7	7	There was no mechanism for redressal of grievances during 2016-21
SMHS Srinagar	0	0	Records not maintained for the period 2016-22
SSH Srinagar	0	0	No grievance cell was in place in the hospital during 2016-22
LD Hospital Srinagar	47	47	
G. B. Pant Hospital Srinagar	47	49 (including 2 OB)	

(Source: Information furnished by the concerned HIs)

It is evident from the **Table 3.63** that either the record of complaints was not available or there was no mechanism in place for redressal of patient grievances in the TLHs except LD Hospital, Srinagar and G. B. Pant Hospital, Srinagar. Thus, due to non-maintenance of records of complaints, it could not be verified whether these hospitals had properly attended to the complaints of the patients.

In respect of sampled DHs, the number of complaints received and disposed of during 2016-22 is indicated in **Table 3.64.**

Table 3.64: Number of complaints received and disposed of during 2016-22 in sampled DHs

Name of the HI	Number of complaints received during 2016-22	Number of complaints disposed during 2016-22
DH Anantnag	69	69
DH Ganderbal	3	3
DH Handwara	24	24
DH Jammu	12	12
DH Ramban	Nil	Nil
DH Udhampur	11	11

(Source: Information furnished by the concerned HIs)

The data in the **Table 3.64** indicates that maintenance of data relating to redressal of grievances of patients was better in secondary care HIs as compared to TLHs.

3.3 Conclusion

The OPD services of ENT, Psychiatry, Ophthalmology, Skin and VD were not available in eight, nine, six and 13 DHs respectively. In 18 sampled SDHs, all the 09 essential OPD services were not available, and the shortfall ranged from one to 08 services. Similarly, against the requirement of 06 essential OPD services, there was a shortfall ranging from one to five services in 10 sampled CHCs. AYUSH services were not available in test-checked 18 SDHs and 09 CHCs (except CHC, Khour). Registration counters were also not found adequate in TLHs and DHs leading to long queues. PACs had not been framed in seven TLHs, two DHs and 22 CHCs/ SDHs. All basic facilities were not available in OPD area of all SDH/ CHCs.

All IPD services as per IPHS 2012 norms were available in three DHs out of six test-checked DHs. In respect of 28 sampled SDHs/CHCs, all IPD services were available in only seven SDHs and one CHC. OT services were available in all test-checked DHs. The OT facility was not available in SDHs Jagti, Marh, Kangan, Seer Hamdan, Dooru, Shangus and Kokernag. Out of 52 sampled PHCs, only two PHCs (Majalta and Achabal) had OT facility for surgical procedures such as Vasectomy, Tubectomy and Hydrocelectomy. Therefore, patients had to avail these facilities in other HIs.

Out of seven sampled TLHs, average BOR was above 80 *per cent* in case of three TLHs. While average BOR in respect of six sampled DHs and 28 CHCs/ SDHs was not calculated by the concerned HIs. Referral out rate in DH Ramban was higher as compared to other DHs. The referral out rate was more than 15 *per cent* in SDH Kupwara and CHCs Zachaldara and Banihal.

ICU services were not available in DH Ganderbal and DH Ramban. ICU in DH Udhampur was non-functional due to non-availability of staff. In Emergency services, most of the emergency services were available in all the test-checked DHs except for DH Handwara. It was noticed that the availability of Emergency OT was not available

in seven SDHs. Blood storage unit was not available in 10 out of 18 SDHs. Out of 10 sampled CHCs, treatment of Dengue Haemorrhagic fever was available only in CHC Banihal, treatment of Celebral Malaria was available only in three CHCs (Sohanjana, Khour and Banihal). Treatment of dog and snake bite cases, poisoning, acute respiratory conditions and acute dehydration was available in all the sampled CHCs. Out of 52 sampled PHCs, 24-hour management of selected emergency services was available in 13 PHCs and emergency on call basis, 24-hour normal delivery services and referral was available 12 PHCs.

Out of 219 ventilators received in 18 secondary level HIs, 17 ventilators in four HIs were not being used as of date of Audit due to non-availability of trained manpower, oxygen generation plant and delay in installation by the engineering staff. Out of 5,616 OCs, 4,322 OCs were installed and 1,294 OCs were not put to use.

Out of six sampled DHs, all the prescribed Radio Diagnostic services as per IPHS 2012 norms were available only in DH Anantnag. Endoscopy facility was not available in DH Ramban and DH Handwara. Further, facility of Barium swallow, Barium meal, Barium enema, IVP was not available in DH Jammu and DH Udhampur and DH Ganderbal did not have facility for CT scan.

Out of 18 sampled SDHs, all the three prescribed Radio Diagnostic services as per IPHS 2012 norms were available in 14 SDHs. Similarly, out of 10 CHCs, all the three prescribed/ desirable Radio Diagnostic services as per IPHS 2012 norms were available in eight CHCs. All sampled health institutions were not providing the full quota of prescribed pathology services, which implies that patients had to avail these services outside.

In two sampled TLHs and six sampled DHs, the rate of C-Section deliveries during 2016-22 was beyond the percentage envisaged in NHM guidelines. Percentage of C-section deliveries in HIs of State/ UT (42.70 *per cent*) was more than the national average of 14.3 *per cent* as per NFHS-5 (2019-21).

Among laundry services, the prescribed types of linen were not available in all the sampled HIs. The maximum shortfall of linen was in DH Anantnag whereas the minimum shortfall of linen was observed in DH Jammu. In respect of sampled 28 SDHs/CHCs, availability of linen was in the range of four to 24. The maximum shortfall of 20 types of linen was observed in SDH Marh whereas in SDH Sogam and Kupwara, there was no shortfall.

Ambulance service was available in all test-checked DHs and SDHs/CHCs except SDH Langate. However, ambulance service was available in only 19 out of 52 sampled PHCs. Out of 41 sampled HIs, seven TLHs, five DHs and eight SDHs/CHCs were providing diet to patients through outsourcing. Dietary services were not available in DH Anantnag and seven SDHs/CHCs. Dietary service was being provided by DH Ganderbal and 13 SDHs/CHCs to patients admitted under JSSK.

Out of sampled 41 TLHs/ DHs/ SDHs/ CHCs, NOC from Fire and Emergency Services Department was obtained only in respect of three HIs.

3.4 Recommendations

In the light of the audit findings, GoJ&K may consider the following:

- ***Ensure availability of basic facilities and registration counters in OPDs of each hospital at all levels, and ensure availability of doctors as per the patient load in the health institutions;***
- ***Ensure that all OPD services, IPD services, emergency services, OT services, maternity services and ICU services as prescribed under IPHS norms for different health institutions are made available to the beneficiaries;***
- ***Ensure availability of basic diagnostic services as prescribed under IPHS norms at secondary level health facilities; and***
- ***Take steps to improve and strengthen auxiliary and support services so that the overall healthcare experience is improved.***

CHAPTER-IV

AVAILABILITY OF DRUGS, MEDICINES, EQUIPMENT AND OTHER CONSUMABLES

CHAPTER-IV

Availability of drugs, medicines, equipment and other consumables

Drugs, medicines, equipment and other consumables constitute vital components for delivering comprehensive health services. With a view to relieving the service providers[1] of the additional burden of procurement of medicines, surgical equipment, machinery and vehicles and their distribution to various public health institutions (HIs), the J&K Government approved (May 2013) establishment of Jammu and Kashmir Medical Supplies Corporation Limited (JKMSCL) under the administrative control of the Health and Medical Education Department (H&MED). JKMSCL was incorporated in March 2014 as a Company under the Companies Act, 1956.

Audit findings on various components of drugs and equipment management in the health institutions are discussed in the succeeding paragraphs.

4.1 Availability of Essential Drugs

Essential medicines are those that satisfy the priority health care needs of the population. Essential medicines are intended to be available at all times in adequate amounts and in appropriate dosage forms. H&MED notified (July 2018) an Essential Drug List (EDL) for Government Hospitals of J&K for the period 2016-18 containing 558 drugs (885 formulations). However, the drugs/medicines in the list were not categorised for use in HIs at various levels. A revised EDL was subsequently notified (July 2019) containing 345 drugs (479 formulations) for its implementation in the Government Hospitals of Jammu and Kashmir.

4.1.1 Availability of Essential Drugs in DHs

As per the EDL of July 2019, 266 drug formulations were notified for District Hospitals (DHs). Average availability[2] of essential drug formulations under 28 categories for DHs is given in **Table 4.1**.

Table 4.1: Average availability of essential drug formulations in test-checked DHs

Sl. No.	Category (drugs)	Anantnag	Handwara	Ganderbal	Ramban	Udhampur	Jammu
1.	Anaesthetics (21)	18	5	3	1	10	10
2.	Analgesics, Antipyretics, non-steroidal Anti-Inflammatory medicines (7)	5	4	3	3	3	3
3.	Anti-allergics and medicines used in anaphylaxis (11)	9	5	3	2	7	3
4.	Anti-dotes and other substances in poisoning (5)	3	1	2	0	3	1
5.	Anti-convulsants/Anti-epileptics (13)	12	1	1	1	9	1

[1] Nine Head of Departments (HoDs)/ Doctors

[2] Average availability of drug formulations for two test-checked months of January 2020 and February 2021.

Sl. No.	Category (drugs)	Anantnag	Handwara	Ganderbal	Ramban	Udhampur	Jammu
6.	Anti-infective medicines (27)	22	10	6	6	19	9
7.	Anti-Parkinsonism medicines (1)	0	0	0	0	0	0
8.	Medicines affecting the blood (6)	4	4	1	1	4	2
9.	Cardiovascular medicines (27)	16	13	2	2	9	2
10.	Dermatological medicines (5)	2	1	0	0	1	1
11.	Disinfectants and Antiseptics (13)	10	2	0	0	6	2
12.	Medicines for Urology (3)	2	2	1	1	2	1
13.	Gastrointestinal medicines (9)	8	6	3	4	8	6
14.	Hormones (4)	3	0	0	0	2	1
15.	Immunologicals (6)	3	2	2	1	5	1
16.	Muscle relaxants and Cholinesterase Inhibitors (2)	2	1	0	1	1	2
17.	Ophthalmological Preparations (6)	5	0	0	0	1	0
18.	Oxytocics and Anti- Oxytocics (9)	0	2	2	1	5	2
19.	Psychotherapeutic Medicines (20)	7	0	1	1	4	3
20.	Medicines acting on respiratory tract (5)	3	0	0	0	3	1
21.	Solutions correcting water, electrolyte and acid base disturbances (12)	12	8	4	3	11	6
22.	Vitamins and Minerals (4)	4	0	0	0	2	0
23.	Anti-malarial medicines (1)	1	0	0	0	0	0
24.	RNTCP[3]medicines (21)	0	0	0	0	2	0
25.	Anti- retroviral medicines (13)	0	0	0	0	0	0
26.	Vaccines (5)	0	0	0	0	5	0
27.	Radio Contrasts (7)	1	0	0	0	2	1
28.	Miscellaneous (3)	2	1	1	0	2	0
Total availability (266)		**154**	**68**	**35**	**28**	**126**	**58**
Percentage availability		**58**	**26**	**13**	**11**	**47**	**22**

(Source: Information furnished by test-checked HIs)

Colour Code:	**76-100 *per cent***	**51-75 *per cent***	**25-50 *per cent***	**Below 25 *per cent***

It is evident from the **Table 4.1** that the overall average availability of essential drug formulations was ranging between 11 *per cent* (DH Ramban) and 58 *per cent* (DH Anantnag).

The Financial Advisor/ CAO JKMSCL stated (January 2025) that the procurement procedure involves demand generation, supply management and tendering process to get the quality hospital supplies. It is further stated that out of 28 categories, three[4] formulations are being provided to various healthcare facilities by the Ministry of Health & Family Welfare, GoI and three[5] formulations are available on the active rate contract of JKMSCL at present out of six[6] formulations which were not available in the

[3] Revised National Tobacco Control Programme
[4] (i) RNTCP medicines (ii) Anti-retroviral medicines and (iii) Vaccines
[5] (i) Radio Contrasts (ii) Oxytocics and Anti-Oxytosis and (iii) Anti-Parkinsonism
[6] (i) Anti-Parkinsonism medicines (ii) Oxytocics and Anti-Oxytocics (iii) RNTCP medicines (iv) Anti-retroviral medicines (v) Vaccines and (vi) Radio Contrasts.

active rate contracts of JKMSCL. The reasons for non-availability of essential drugs were non-execution of supplies by suppliers due to meager quantity, COVID pandemic and Not of Standard Quality report of drugs at the time of quality testing.

4.1.2 Availability of Essential Drugs in SDHs/ CHCs

As per the EDL of July 2019, 214 drug formulations were notified for SDHs and CHCs. The average percentage availability[7] of 214 essential drug formulations under 27 categories during the months of January 2020 and February 2021 in respect of sampled SDHs/CHCs is given in **Table 4.2**.

Table 4.2: Average availability of essential drug formulations in test-checked SDHs/ CHCs

Sl. No.	Name of the District	Name of the HI	Number of drug formulations available (out of 214)	Average percentage availability of drug formulations
1.	Anantnag	SDH Seer Hamdan	43	20
2.		SDH Bijbehara	33	15
3.		SDH Shangus	54	25
4.		SDH Kokernag	52	24
5.		SDH Dooru	108	50
6.	Kupwara	SDH Sogam	20	9
7.		SDH Kupwara	19	9
8.		SDH Langate	34	16
9.		SDH Tangdar	37	17
10.	Ganderbal	SDH Kangan	43	20
11.	Jammu	SDH Akhnoor	100	47
12.		SDH Bishnah	80	37
13.		SDH Jagti	23	11
14.		SDH Kot-Bhalwal	43	20
15.		SDH Marh	40	19
16.		SDH R.S.Pura	30	14
17.		SDH Sarwal	43	20
18.	Udhampur	SDH Ramnagar	41	19
19.	Kupwara	CHC Kralpora	71	33
20.		CHC Kralgund	34	16
21.		CHC Zachaldara	109	51
22.	Jammu	CHC Khour	33	15
23.		CHC Jourian	62	29
24.		CHC Sohanjana	51	24
25.	Ramban	CHC Gool	78	36
26.		CHC Banihal	39	18
27.		CHC Batote	72	34
28.	Udhampur	CHC Chenani	58	27

(Source: Information furnished by test-checked HIs)

[7] Average availability of drug formulations for two test-checked months of January 2020 and February 2021.

As evident from the **Table 4.2**, the average availability of essential drug formulations was below 25 *per cent* in respect of 18 out of 28 sampled SDHs/ CHCs whereas in respect of the other nine SDHs/ CHCs, it was ranging between 25 and 50 *per cent*. CHC Zachaldara had availability of more than 50 *per cent* essential drug formulations.

4.2 Availability of AYUSH Essential Medicines

Department of AYUSH, Ministry of Health and Family Welfare (now Ministry of AYUSH) had prescribed (March 2013) 277 essential Ayurveda drugs and 288 essential Unani drugs. Average availability of Ayurvedic and Unani drugs during the period 2016-21 in the sampled Districts[8] is shown in **Table 4.3**.

Table 4.3: Availability of Ayurvedic and Unani essential drugs in test-checked Districts

Sl. No.	Name of the District	Average availability of Ayurvedic drugs during 2016-21 (*per cent*)	Average availability of Unani drugs during 2016-21 (*per cent*)
1	Anantnag	17 (6)	33 (11)
2	Ganderbal	31 (11)	53 (18)
3	Jammu	44 (16)	19 (7)
4	Kupwara	18 (6)	30 (10)
5	Ramban	107 (39)	45 (16)
6	Udhampur	22 (8)	17 (6)

(Source: Information furnished by District AYUSH Officers)

Colour Code:	76-100 *per cent*	51-75 *per cent*	25-50 *per cent*	Below 25 *per cent*

As seen from the **Table 4.3**, the average availability of essential Ayurvedic drugs in Ramban District was 39 *per cent* as compared to other sampled Districts where the average availability ranged between six and 16 *per cent*. In respect of average availability of essential Unani drugs, it ranged between six and 18 *per cent* only in the sampled districts.

Shortage of drugs had adverse impact on the services and there was high possibility that the unavailable drugs were being procured by the patients from the open market incurring expenditure out of own pocket defeating the purpose of free drug policy.

4.3 Availability of equipment in selected DHs

Under IPHS 2012 norms, essential equipment are worked out keeping in mind the assured services recommended for various grades of District Hospitals as per their bed capacity. The equipment required were worked out under 14 different categories and their availability as of March 2021 was checked in the test-checked DHs and the findings have been tabulated in **Table 4.4**.

[8] The essential Ayurvedic and Unani drugs are stored in the drug store at District level for further issuance to dispensaries under the administrative control of District AYUSH Officer.

Table 4.4: Position of availability of equipment in the selected DHs (as on March 2021)

Sl. No.	Type of equipment	101-200 beds	301-500 beds	Anantnag (410)	Handwara (73)	Ganderbal (130)	Ramban (50)	Udhampur (200)	Jammu (160)
1	Imaging	4	7	7	3	3	3	4	3
2	X-Ray Room Accessories	7	7	3	3	5	5	6	7
3	Cardiopulmonary equipment	13	15	13	8	11	11	12	10
4	Labour ward & Neo Natal and special New Born Care Unit equipment	27	27	16	20	15	19	24	21
5	General Equipment for Special New Born care unit	11	11	10	4	9	6	11	11
6	Disinfection of special New Born Care Unit Equipment	11	11	1	3	7	5	10	11
7	Immunisation Equipment	13	13	12	2	13	11	12	12
8	Ear, Nose, Throat equipment	16	18	15	5	6	1	6	11
9	Eye equipment	24	25	17	13	13	9	19	22
10	Dental equipment	42	42	27	24	30	22	29	25
11	Laboratory equipment	51	58	15	21	25	29	34	24
12	Endoscopy equipment	3	7	3	1	1	1	0	1
13	Anesthesia equipment	15	15	14	12	14	14	13	14
14	Post Mortem equipment	8	8	7	5	6	2	4	0
	Total	**245**	**264**	**160**	**124**	**158**	**138**	**184**	**172**
	Percentage			**61**	**51**	**64**	**56**	**75**	**70**

(Source: Information furnished by HIs)
Figures in brackets indicates number of beds in the HI

Colour Code:	**76-100 *per cent***	**51-75 *per cent***	**25-50 *per cent***	**Below 25 *per cent***

It can be observed from the **Table 4.4** that the overall availability of essential equipment was satisfactory in all the sampled DHs and it ranged between 51 *per cent* and 75 *per cent*.

The Financial Advisor/ CAO JKMSCL stated (January 2025) that the procurements are made on the basis of requisitions submitted by the Heads of the Department, subject to budgetary provisions.

4.3.1 Availability of equipment in sampled SDHs

IPHS 2012 norms recommend essential equipment for Sub-District Hospitals under different categories. Availability of essential equipment under 12 different categories were scrutinised in the sampled SDHs. The number of essential equipment available in

sampled SDHs under the recommended categories as of March 2021 is given in **Table 4.5**.

Table 4.5: Availability of equipment in sampled SDHs (as on March 2021)

Type of equipment	No.of equipment required		Seer Hamdan	Bijbehara	Shangus	Kookernag	Dooru	Sogam	Kupwara	Langate	Tangdar	Kangan	Akhnoor	Bisnah	Jagti	Kot Bhalwal	Marh	RS Pura	Sarwal	Ramnagar
	31-50 beds	51-100 beds	30 beds	30 beds	20 beds	30 beds	30 beds	33 beds	150 beds	30 beds	30 beds	30 beds	60 beds	50 beds	34 beds	75 beds	20 beds	30 beds	50 beds	30 beds
Imaging Equipment	3	5	2	2	3	3	2	2	2	3	2	2	3	2	2	4	3	3	2	3
X - Ray Room Services	6	6	5	5	6	6	5	4	3	5	4	1	4	2	5	6	6	5	5	6
Cardio Pulmonary	8	11	8	6	6	8	8	7	11	5	6	8	11	7	5	6	5	6	8	7
Labour ward & Neo Natal	17	20	14	9	14	13	16	17	17	14	14	16	14	13	12	10	12	10	16	14
Immunization Equipment	13	13	8	0	12	9	12	9	7	9	7	9	10	12	12	13	12	11	13	10
Ear,Nose & Throat Equipment	17	17	3	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3	2
Eye Equipment	22	9	6	15	9	13	11	9	3	10	7	16	5	7	5	3	6	12	18	15
Dental Equipment	4	4	4	4	4	4	4	4	3	3	3	3	4	3	3	4	4	4	2	3
Lab Equipment	27	32	21	13	11	17	17	26	2	17	2	13	27	13	11	14	14	15	16	14
Surgical Equipment	27	29	12	11	10	25	17	12	20	7	14	17	25	20	11	11	14	21	25	21
Anesthesia Equipment	15	14	14	15	3	15	13	10	12	9	12	12	13	15	10	3	12	14	15	12
Post Mortem Equipment	10	10	0	0	1	10	5	6	6	2	7	7	2	6	0	0	4	8	2	6
Total	**169**	**170**	**97**	**80**	**79**	**123**	**110**	**106**	**86**	**84**	**78**	**104**	**118**	**100**	**79**	**74**	**92**	**109**	**125**	**113**
Percentage			**57**	**47**	**47**	**73**	**65**	**63**	**51**	**50**	**46**	**62**	**69**	**59**	**47**	**44**	**54**	**64**	**74**	**67**

(Source: Information furnished by HIs)

Colour Code:	**76-100 *per cent***	**51-75 *per cent***	**25-50 *per cent***	**Below 25 *per cent***

The average availability of equipment in the sampled SDH Sarwal was 74 *per cent* followed by SDH Kokernag (73 *per cent*) and SDH Akhnoor (69 *per cent*). However, the availability of equipment in SDH Kot-Bhalwal 44 *per cent*.

4.4 Procurement of drugs/ medicines and machinery/ equipment

To ensure a systematic and uniform approach for procurement of drugs/ medicines and machinery/ equipment and to achieve the highest operating standards, with emphasis on transparency and accountability, JKMSCL framed (January 2016) 'Standard

Procurement Procedures (SPP)'. JKMSCL invited e-bidding for procurement of material including drugs/ medicines, machinery/ equipment and other materials.

4.4.1 Time taken in finalisation of rates

The following issues were noticed in Notice Inviting Tender (NITs) and finalisation of Rate Contract (RC)/ Annual Rate Contract (ARC).

- JKMSCL had not prescribed any timeline in SPP for finalisation of technical/ financial evaluation, meeting of the State Level Purchase Committee (SLPC) and issue of ARC. Audit scrutiny of 42 test-checked NITs of allopathic drugs/ medicines (12), AYUSH drugs/ medicines (three) and machinery/ equipment (27) out of 70 NITs finalised during March 2016 to January 2022 revealed that considerable time was consumed at various stages of procurement as detailed in **Table 4.6**. Details of these tenders are given in **Appendix 4.1.**

Table 4.6: Time taken in procurement of Allopathic/ AYUSH drugs and Machinery/ equipment

Particulars	No. of test-checked NITs	Time taken from NIT to TEC[9]	Time taken from TEC to FEC[10]	Time taken from FEC to SLPC	Time taken from NIT to SLPC
		(In days)			
Allopathic drugs and medicines	12	15- 376	1-94	0-51	56-436
Ayush drugs and medicines	3	159-449	0-4	15-54	178-503
Machinery/ equipment and other items[11]	27	4-328	0-364	0-516	85-707

(Source: Data furnished by JKMSCL)

Audit observed that overall time taken from issue of NIT to finalisation of ARC/ RC (date of SLPC) ranged between 56 and 707 days. The indenting Departments (including HIs) forward requisitions for procurement of drugs/ medicines as per the requirement on the basis of Essential Drug List (EDL). Delay in finalisation of rate contract would have had adverse impact on timely supply of drugs/equipment to the health institutions.

After being pointed out in Audit, the Financial Advisor/ CAO JKMSCL stated (January 2025) that a Logistic Cell has been established (May 2023) in JKMSCL to provide data to the tendering sections with regard to rate contract of the items nearing expiry, at least three months prior to the expiry of valid rate contracts. It was further stated that all the HoDs were requested to provide Essential Equipment List (EEL) in order to finalise the rate contract of EEL to ensure annual generation of demand and further procurement.

4.5 Quality Control Mechanism

JKMSCL is the nodal agency for procurement of generic drugs, medicines, surgical items, sutures, equipment/ machinery and allied items with 'Zero Quality Tolerance'

[9] Technical Evaluation Committee
[10] Financial Evaluation Committee
[11] Hospital furniture, dressing/suture items, disposable items and blood bags

and their distribution at affordable price among various Government HIs of the State/ UT.

4.5.1 Delay in empanelment of laboratories for testing and analysis of drugs

During January 2017 to January 2021, three NITs were floated for empanelment of laboratories for testing/ analysis of drugs/ medicines. Time taken to complete the process for empanelment of laboratories in these cases is detailed in **Table 4.7**.

Table 4.7: Time taken to complete the process of empanelment of laboratories

Particulars	Test- checked NITs	Date of NIT	Date of finalisation	Time taken from NIT to TEC	Time taken from TEC to FEC	Time taken from FEC to SLPC	Time taken from NIT to SLPC
				(*In days*)			
Allopathic drugs and medicines	JKMSCL/tend./Empl. Lab/2017/5	31.01.2017	15.12.2018	338	8	337	683
AYUSH drugs and medicines	JKMSCL/Empl.Labs/ Ayd/Unani/2017/284	17.01.2018	11.02.2019	379	1	10	390
	JKMSCL/Empl.Labs/ Ayd/Unani/2021/448	18.01.2021	10.08.2021	81	117	6	204

(Source: Data furnished by JKMSCL)

In absence of any timeline for finalisation of rate contract, the time taken from issue of NIT to finalisation of the rate (date of SLPC) ranged between 204 and 683 days.

The Financial Advisor/ CAO JKMSCL stated (January 2025) that for finalising the rate contract, JKMSCL has to go through a lengthy procedure in case of empanelment of laboratories for test analysis of drugs/ medicines which are to be administered directly to patients.

4.5.2 Delay in furnishing of test/ analysis report by the empaneled laboratories

As per Quality Control Policy and Procedure of JKMSCL framed in December 2016, the empaneled laboratories were required to furnish test reports within 10 days of receipt of sample in case of tablets, capsules, pessaries, ointments, powder and liquid oral preparations and within 21 days in case of I.V. fluids and injections.

Audit test-checked five months (one month each year) during which 921 samples were sent to the empaneled laboratories[12] for testing/ analysis of drugs/ medicines. Details of samples sent, reports received within time and reports not received within time are given in **Table 4.8**.

[12] 2016-17: 4; 2017-18: 5; 2018-19: 9; 2019-20: 6, 2020-21: 4

Table 4.8: Test reports of samples received within time/ not received within time

Particulars	Nov-16		May-17		Apr-18		Jan-20		Feb-21		Total	
	Tab	Inj	Tab	Inj	Tab	Inj	Tab	Inj	Tab	Inj	Tab	Inj
Total samples sent for quality check	55	49	145	124	183	87	162	47	41	28	586	335
Samples which were reported within time	20	32	100	114	112	17	124	41	32	24	388	228
Sample reports not received in time	35	17	45	10	71	70	38	6	9	4	198	107

(Source: Data furnished by JKMSCL, Tab: Tablets; Inj: Injections)

Out of samples of 586 tablets and 335 injections sent for quality check, reports of only 388 tablets (66.2 *per cent*) and 228 injections (68 *per cent*) were received in time of which two samples were found 'Not of Standard Quality'. Similarly, two samples were also found 'Not of Standard Quality' in respect of sample reports of 198 tablets and 107 injections not received in time.

Delay in receipt of sample reports of 198 tablets and 107 injections is summarised in **Table 4.9**.

Table 4.9: Delay in receipt of sample reports

Delay (*in days*)	Tablets	Injections
Upto 10	122	83
11 to 30	65	16
31 to 50	7	1
51 to 100	3	5
100 onwards	1	2
Total	**198**	**107**

(Source: Departmental records)

The above table indicated that in most of the cases there was delay in receipt of sample reports by upto one month.

The Financial Advisor/ CAO attributed (January 2025) the reasons for delay by the laboratories to furnish the test reports to non-availability of Standard Testing Procedures for non-pharmacopeial items, re-testing of samples by the laboratories in case of any doubtful results, receipt of test reports through offline mode prior to 2020 etc.

4.6 Procurement of suture items from a single supplier

In the Report of the Comptroller and Auditor General of India on Revenue Sector and Public Sector Undertakings (Social, General and Economic Sectors) for the year ended 31 March 2018, the irregularity of extending undue benefit by JKMSCL to a single supplier (M/s Johnson and Johnson) for procurement of suture material valuing ₹ 25.48 crore during October 2017 to March 2019 rejecting the other tenderers was pointed out. During the current Performance Audit, it was noticed that during 2019-21,

JKMSCL had continued to procure the suture material valuing ₹ 9.68 crore from the same supplier (M/s Johnson and Johnson). JKMSCL had recorded in its file noting that in response to NIT (2019-20), M/s Johnson and Johnson had quoted high rates regarding 130 items which seemed unreasonable and there was lack of clarity in the price quoted by other bidders in respect of the remaining items as to whether the price quote was for each box or piece. It was also mentioned in the file that there was ambiguity in arriving at the lowest bidder. Consequently, JKMSCL then requested M/s Johnson and Johnson to revalidate their last contract (2016-17) to serve the dual purpose of procuring approved items from the firm while simultaneously according substantial benefit to the state exchequer. The justification on record regarding procurement of suture material on the basis of the old contract is not acceptable, as JKMSCL should have issued fresh tenders to ensure fair competitive bidding.

The Financial Advisor/ CAO JKMSCL stated (January 2025) that the existing rate contract was extended under compulsion in the best interest of patient care after due approval of the competent authority. New rate contract for various sutures was finalised in November 2021 in favour of M/s Meditronics India Pvt. Ltd. and M/s Johnson & Johnson Ltd.

4.7 Availability of reagents for conducting CECT Scanning

Contrast Enhanced Computed Tomography (CECT) scanning is often considered the best method for detecting abdominal pain, suspected cancer, kidney or gall bladder stone and various infections/ inflammations. In this test, intravenous contrast dye is ingested into the body which helps provide a detailed view of the blood vessels. It also helps a doctor to take a clearer and closer view of internal organs and soft tissues and assess the progress of treatment of any illness.

Records of CT scanning section of two test-checked TLHs[13] of Jammu revealed that scanning of 1,20,083 patients was conducted during 2016-2022, out of which CECT scanning was conducted on 24,482 patients. Audit noticed that during the period 2016-2021 the reagent (contrast-dye) required for conducting CECT scanning had not been procured through JKMSCL/ open market for issue to CT/ CECT scanning section which also had not requisitioned the same at any stage, resulting in non-issue of required reagent to 20,328 patients who had undergone CECT scanning during 2016-21. Due to non-procurement of CECT reagents, there was every possibility that underprivileged and poor patients may have had to purchase this from the open market thereby increasing their out-of-pocket expenditure. During 2021-22, out of 4,154 patients who underwent CECT scanning, only 14 *per cent* (582) patients were provided the required reagent (contrast-dye).

[13] SMGS Hospital and GMC Hospital, Jammu

4.8 Store Management

4.8.1 Physical Verification of Drug Warehouses (DWHs)

Rule 213 (1) and (2) of GFR-2017 prescribes physical verification of fixed assets at least once in a year and recording of outcome of verification in a corresponding register.

Audit noticed that physical verification of DWHs had not been conducted regularly by the Physical Verification Committee constituted by JKMSCL. During 2016-22, physical verification of the four DWHs (Anantnag, Baramulla, Bemina and Nagrota) was conducted once in June 2021 and that of three DWHs (Rajouri, Doda and Kathua) was conducted in November and December 2020. The Committee pointed out mismanagement of available storage space, improper maintenance of records, delay in verification and submission of bills without valid reasons, non-displaying of labels on the racks etc.

The Financial Advisor/ CAO, JKMSCL stated (January 2025) that physical verification of all the regional drug warehouses has been completed upto 2024.

4.8.2 Storage and dispensing of drugs at HIs

As per NHM Assessors Guidebook for Quality Assurance, the stores must have prescribed facilities for storage of drugs and defined procedures for inventory management and dispensing of drugs. Details of facilities in pharmacy areas of seven test-checked TLHs, six DHs and 28 SDHs/ CHCs as revealed by a visit of the areas by Audit are given in **Table 4.10**.

Table 4.10: Facilities in pharmacy areas of test-checked TLHs, DHs and SDHs/CHCs

Sl. No.	Parameters	Availability		
		TLHs (07)	DHs (06)	SDHs/ CHCs (28)
1	Labelled shelves/racks	5	5	22
2	Away from water and heat	7	6	28
3	Drugs stored above the floor	4	6	26
4	Drugs stored away from walls	6	6	23
5	Display instructions for storage of vaccines	4	5	20
6	Functional temperature monitoring device in freezers	5	6	24
7	Maintenance of temperature chart of deep freezers	3	5	21
8	Drugs kept under lock and key	7	6	28
9	Poisons kept in a locked cupboard	5	3	21

(Source: Data furnished by concerned HLs)

The data in **Table 4.10** indicates inadequate facilities in the pharmacy area of the test-checked HIs.

4.9 Non-implementation of e-Aushadhi system

To improve drug warehousing and supply chain management in all Government Hospitals in the State, GoJ&K launched (2015) e-Aushadhi/ Drug and Vaccine Distribution Management System (DVDMS) portal, a web based supply chain

management application at Jammu and Kashmir Medical Supplies Corporation Ltd (JKMSCL). Through the DVDMS portal, the system was to keep check on purchases, inventory management and distribution of various drugs and surgical items to various regional and District drug warehouses, DHs, CHCs, SDHs and PHCs.

Audit noticed that while DVDMS had been made functional at JKMSCL level but the end users (SDHs/ CHCs and PHCs) were using it only for uploading requirement of drugs and not for maintenance of stock and distribution of items to their sub-stores. Further, DVDMS was not being used for distribution of drugs to the patients, which was its final objective.

In a review meeting (23 April 2019), the Administrative Department decided to implement the DVDMS in the year 2019 by 6th May at the DH level, by 31st May at the SDH/ CHC level and by 30th June at PHC (including UPHCs) level. Audit noticed that as of June 2022, the decision had not been implemented even after lapse of over three years with the result that the health institutions continued to use DVDMS only for annual uploading of requirement and not for maintenance of stock and further distribution to their sub-stores.

Implementation of DVDMS can help in reducing cases like the following instances of non-utilisation or expiry of drugs noticed by audit:

- Out of 140 kits of RTI/ STI drugs received (September 2017) in DH Ramban, 111 kits had expired due to non-utilisation. The Medical Superintendent, DH Ramban stated (December 2023) that the kits were received without submission of specific requisition for supply of the same. The kits could not be utilised due to less number of patients suffering from RTI/ STI disease reporting at the health facility.

- Out of 1,55,540 kits for five tests (Hb, blood sugar, urine protein, HIV, Rapid pregnancy test) procured by the Directorate of AYUSH during 2019-2022, only 43,783 kits were utilised for testing, 82,207 kits remained unutilised with dispensaries and 29,550 kits expired. The Director, AYUSH J&K stated (October 2023) that these kits could not be utilised/expired due to non-availability of AYUSH staff and decrease in footfall of patients during COVID-19 pandemic.

- During 2016-2019, 59,800 injections/tablets whose shelf life had expired were declared unfit for human consumption and were destroyed in CHC Banihal. The Block Medical Officer, Banihal stated (December 2023) that due to non-issue/ issue of lesser quantity, non-existence of system for assessment of required drugs and identification of surplus drugs, the quantity of un-issued medicines/ drugs kept on accumulating over the years which resulted in expiry of shelf life.

The Financial Advisor/ CAO, JKMSCL stated (January 2025) that there were about 100 *per cent* active users at the level of Chief Medical Officers and Block Medical

Officers whereas at District Hospital level, Medical Colleges level and at CHC/ PHC level, there were about 60 per cent to 80 per cent active users as of December 2024.

4.10 Non-functional machinery and equipment

Audit noticed that 10 equipment[14] valuing ₹ 0.82 crore were lying non-functional in SMGS Hospital Jammu as on March 2022 though all these equipment were under warranty and procured during 2017-2021, thus rendering the expenditure of ₹ 0.82 crore incurred on procurement of these equipment unfruitful.

4.11 Jhelum Tawi Flood Recovery Project (JTFRP)-World Bank Aided Project

JKMSCL executed agreements with suppliers/ manufacturers for supply of items worth ₹ 289.69 crore sanctioned under World Bank aided projects.

Records showed that out of 5,868 items, 68 items valuing ₹ 10.22 crore were not received (March 2022) whereas 3,150 items valuing ₹ 123.41 crore were received with delay ranging between three and 306 days.

The Financial Advisor/ CAO JKMSCL J&K stated (January 2025) that against the purchase orders of ₹ 290 crore, 100 *per cent* supplies have been executed by the concerned companies.

In addition, 24 machines/ items valuing ₹ 1.61 crore received under World Bank funded project and issued to Trauma Care Centre, Udhampur had remained non-functional since date of receipt resulting in idle investment of ₹ 1.61 crore due to non-availability of staff.

The Medical Superintendent, Associated Hospital GMC Udhampur attributed (January 2025) non-functioning of Trauma Care Centre to non-availability of staff and adequate space.

Further, in spite of the fact that DH Ramban was already provided (January 2014) Laparoscopic equipment alongwith accessories worth ₹ 30.68 lakh by the Director Health Services, Jammu, two more "Full HDlcg Fleurosense Technology Laparoscope Endovision Set" valuing ₹ 1.08 crore was supplied (January 2021) by the JKMSCL to the hospital. Audit noticed that DH Ramban had not projected any such requirement. Further, laparoscopic equipment already lying with the hospital remained idle since June 2019 due to non-availability of trained paramedical staff. Supplying of equipment without any requisition by the user Department and in absence of trained manpower resulted in idling of laparoscopic equipment.

The Medical Superintendent, District Hospital Ramban stated (November 2023) that the laproscopic procedures have been started w.e.f. October 2022 and about 110

[14] Incubator, Pulse Oximeter, Radiant Warmer, Wall Monitor, Infusion Pump, C-Pap, Phototherapy Machine, Defibrilator, Patient Monitor and CTG machine

procedures have been performed as of November 2023. The machinery supplied in 2014 is in use with ENT Department of DH Ramban.

4.12 Conclusion

Availability of all essential drugs/medicines was not ensured in the test-checked health institutions. Absence of essential drugs may have compelled the beneficiaries to look and arrange for these medicines from outside. Therefore, procurement and availability of drugs/ medicines left a lot of scope for improvement for delivery of quality health care services to the masses in the UT of J&K. Availability of prescribed essential equipment was also found insufficient in the test-checked institutions. Delay in finalisation of rate contract would have had adverse impact on timely supply of drugs/ equipment to the health institutions. In the quality assurance aspect, issues such as delay in empanelment of laboratories for testing and analysis of drugs and delay in furnishing of test/ analysis reports by empanelled laboratories were noticed. Non-implementation of e-Aushadhi system for the entire chain of drug supply was also observed.

4.13 Recommendations

In view of the audit findings, GoJ&K may consider:

- ***Taking suitable steps to address the shortfall of drugs, equipment and other consumables in the healthcare institutions;***
- ***Avoiding delay in finalisation of rate contracts to ensure timely supply of drugs/ equipment to the health institutions;***
- ***Making efforts for timely empanelment of laboratories and obtaining of test/ analysis reports of drugs to provide quality drugs to the beneficiaries; and***
- ***Utilising e-Aushadhi/ DVDMS system optimally starting from placing of indents by the health institutions till final distribution of drugs to patient.***

CHAPTER-V
HEALTHCARE INFRASTRUCTURE

CHAPTER-V

Healthcare Infrastructure

Health infrastructure being the basic support for delivery of public health services, is an important indicator for understanding the health care policy and welfare mechanism in a State. It signifies the investment priority of the State with regard to creation of healthcare facilities. To deliver quality health services in the public health facilities, adequate and properly maintained building infrastructure is of critical importance.

In an effort to improve the quality of services and provide a uniform benchmark to assess the functionality of public health facilities, a set of standards known as the Indian Public Health Standards (IPHS) were first developed in the year 2007 and revised in 2012. These standards cover Sub-Health Centres (SHCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs) and District Hospitals (DHs). They provide guidance on the infrastructure, human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering health services at these facilities. However, the UT Government of Jammu and Kashmir has neither adopted IPHS norms nor framed their own norms till date.

5.1 Requirement and availability of healthcare facilities

As per Census 2011, UT of Jammu and Kashmir had a population of 1.23 crore. As per IPHS 2012 norms, to provide healthcare services in the tribal, hilly or difficult areas of the State, a Sub-Centre (SC) for approximately 3,000 population, Primary Health Centre (PHC) for approximately 20,000 population and Community Health Centre (CHC) for approximately 80,000 population are required. The Sub-District Hospital (SDH) caters to about 5-6 lakh people. Every District is expected to have a District Hospital.

The availability of health institutions against requirement as of March 2022 is given in **Table 5.1**.

Table 5.1: Availability of health institutions in the UT of J&K as of March 2022

Type of health institution	Requirement of health institutions as per IPHS 2012 norms vis-a-vis population as per Census 2011	Number of health institutions existing	Shortfall (*per cent*)
Sub-Centre	4,078	2,505	1,573 (39)
Primary Health Centre	602	975	---
Community Health Centre	142	30	112 (79)
Sub-District Hospital	22	47	---

Type of health institution	Requirement of health institutions as per IPHS 2012 norms vis-a-vis population as per Census 2011	Number of health institutions existing	Shortfall (*per cent*)
District Hospital	20	15[1]	---
Hospitals associated with Medical Colleges	--	23	---
AYUSH Dispensaries and units	--	602	---

(Source: Information furnished by the Administrative Department, Directors, Health Services, Jammu/Kashmir, Director, AYUSH, J&K and Chief Medical Officers concerned)

It was noticed that 30 CHCs and 2,505 SCs were available in the UT of J&K as of March 2022 against the requirement of 142 CHCs and 4,078 SCs as per IPHS 2012 norms. Shortages in CHCs and SCs were 79 *per cent* and 39 *per cent* respectively. The details of District-wise requirement and availability of CHCs, PHCs and SCs as per population norms as of March 2022 are given in **Table 5.2**.

Table 5.2: District-wise requirement and availability of SCs, PHCs and CHCs as per population norms as of March 2022

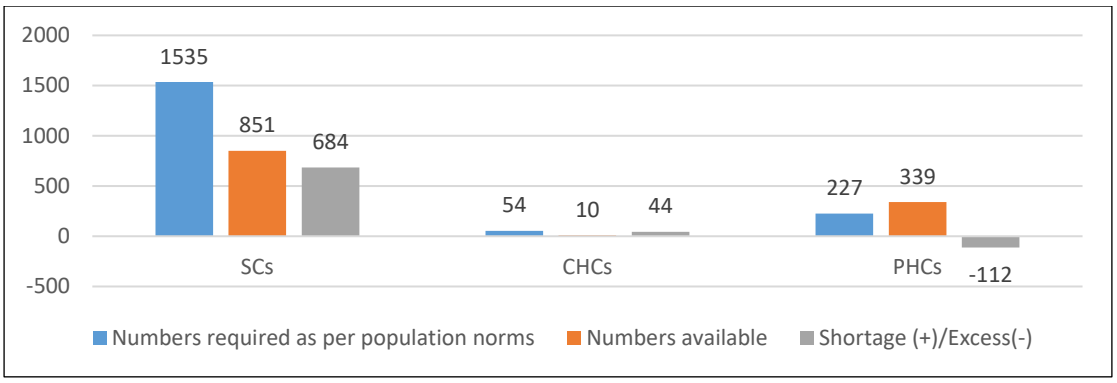
Sl. No.	Name of the District	Population as per Census 2011	SCs			PHCs			CHCs		
			R	A	S(-) /E(+)	R	A	S(-) /E(+)	R	A	S(-) /E(+)
1.	Anantnag	10,78,692	359	139	(-)220	53	60	(+)7	13	0	(-)13
2.	Bandipore	3,92,232	130	70	(-)60	19	27	(+)8	4	3	(-)1
3.	Baramulla	10,08,039	336	186	(-)150	50	86	(+)36	12	0	(-)12
4.	Budgam	7,53,745	251	134	(-)117	37	74	(+)37	9	4	(-)5
5.	Doda	4,09,936	136	167	(+)31	20	40	(+)20	5	2	(-)3
6.	Ganderbal	2,97,446	99	64	(-)35	14	32	(+)18	3	0	(-)3
7.	Jammu	15,29,958	509	183	(-)326	76	102	(+)26	19	3	(-)16
8.	Kathua	6,16,435	205	190	(-)15	30	53	(+)23	7	0	(-)7
9.	Kishtwar	2,30,696	76	87	(+)11	11	26	(+)15	2	1	(-)1
10.	Kulgam	4,24,483	141	117	(-)24	21	45	(+)24	5	0	(-)5
11.	Kupwara	8,70,354	290	235	(-)55	43	63	(+)20	10	3	(-)7
12.	Poonch	4,76,835	158	137	(-)21	23	44	(+)21	5	0	(-)5
13.	Pulwama	5,60,440	186	96	(-)90	28	48	(+)20	7	0	(-)7
14.	Rajouri	6,42,415	214	203	(-)11	32	54	(+)22	8	4	(-)4
15.	Ramban	2,83,713	94	85	(-)9	14	32	(+)18	3	3	0
16.	Reasi	3,14,667	104	103	(-)1	15	33	(+)18	3	2	(-)1
17.	Samba	3,18,898	106	82	(-)24	15	21	(+)6	3	1	(-)2
18.	Shopian	2,66,215	88	55	(-)33	13	16	(+)3	3	2	(-)1
19.	Srinagar	12,36,829	412	27	(-)385	61	69	(+)8	15	1	(-)14
20.	Udhampur	5,54,985	184	145	(-)39	27	50	(+)23	6	1	(-)5
Total		**1,22,67,013**	**4,078**	**2,505**	**(-)1,573**	**602**	**975**	**(+)373**	**142**	**30**	**(-)112**

(Source: Figures furnished by the Chief Medical Officers/ Block Medical Officers concerned)
(R: Requirement; A: Availability; S: Shortfall; E: Excess)

[1] Vide G.O.No:753-HME of 2019 dated 05.08.2019, the administrative control of five DHs Anantnag, Baramulla, Doda, Kathua and Rajouri was transferred to five new Government Medical Colleges in the respective Districts and are serving as Referral/ Associated Hospitals.

In the six sampled Districts, there was shortage of SCs (45 *per cent*) and CHCs (81 *per cent*) as detailed in **Chart 5.1**.

Chart 5.1: Availability of healthcare facilities in six sampled Districts as of March 2022



Further, variation was also seen across Districts in terms of population per CHC/PHC/SC as detailed in **Table 5.3**.

Table 5.3: District-wise number of persons per CHC/PHC/SC

Sl. No.	Name of the District	Population as per Census 2011	No. of SCs	No. of persons per SC	No. of PHCs	No. of persons per PHC	No. of CHCs	No. of persons per CHC
1.	Anantnag	10,78,692	139	7,760	60	17,978	0	-
2.	Bandipore	3,92,232	70	5,603	27	14,527	3	1,30,744
3.	Baramulla	10,08,039	186	5,420	86	11,721	0	-
4.	Budgam	7,53,745	134	5,625	74	10,186	4	1,88,436
5.	Doda	4,09,936	167	2,455	40	10,248	2	2,04,968
6.	Ganderbal	2,97,446	64	4,648	32	9,295	0	-
7.	Jammu	15,29,958	183	8,360	102	15,000	3	5,09,986
8.	Kathua	6,16,435	190	3,244	53	11,631	0	-
9.	Kishtwar	2,30,696	87	2,652	26	8,873	1	2,30,696
10.	Kulgam	4,24,483	117	3,628	45	9,433	0	-
11.	Kupwara	8,70,354	235	3,703	63	13,815	3	2,90,118
12.	Poonch	4,76,835	137	3,481	44	10,837	0	-
13.	Pulwama	5,60,440	96	5,838	48	11,676	0	-
14.	Rajouri	6,42,415	203	3,165	54	11,897	4	1,60,604
15.	Ramban	2,83,713	85	3,338	32	8,866	3	94,571
16.	Reasi	3,14,667	103	3,055	33	9,535	2	1,57,334
17.	Samba	3,18,898	82	3,889	21	15,186	1	3,18,898
18.	Shopian	2,66,215	55	4,840	16	16,638	2	1,33,108
19.	Srinagar	12,36,829	27	45,808	69	17,925	1	12,36,829
20.	Udhampur	5,54,985	145	3,827	50	11,100	1	5,54,985
Total		**1,22,67,013**	**2,505**		**975**		**30**	

(Source: Figures furnished by the Chief Medical Officers/ Block Medical Officers concerned)

It is evident from **Table 5.3** that SCs in only 11 out of 20 Districts were nearing the norm of 3,000 population per SC. The population norm of 20,000 per PHC were adhered to by all the 20 Districts. In respect of CHCs, only Ramban District was nearing the norm of 80,000 population.

5.2 Establishment of new Medical Colleges and creation of AIIMS in the UT of J&K

As of March 2022, there were 13 Medical Colleges in the UT of J&K. Four Medical Colleges viz. Government Medical College, Jammu, Government Medical College, Srinagar, Indira Gandhi Government Dental College, Jammu and Government Dental College, Srinagar existed in the erstwhile State of J&K as of April 2016. During 2016-22, seven medical colleges were sanctioned under the CSS "Establishment of New Medical Colleges", out of which five[2] were functioning as of March 2022. The physical and financial status of New Medical Colleges as of March 2022 is detailed in **Table 5.4**.

Table 5.4: Physical and financial status of new Medical Colleges as of March 2022

(₹ in crore)

Sl. No.	Name of the Medical College	Year of sanction	Estimated cost	Targeted date of completion	Expenditure incurred as of March 2022	Physical status as of March 2022
1.	GMC Anantnag	2016-17	116.53	March 2024	97.19	Ongoing
2.	GMC Baramulla	2016-17	139.00	June 2022	87.50	Ongoing
3.	GMC Doda	2016-17	139.00	March 2024	132.53	Ongoing
4.	GMC Rajouri	2016-17	139.00	October 2022	137.36	Completed in March 2023 after incurring expenditure of ₹ 139 crore
5.	GMC Kathua	2017-18	139.00	September 2024	131.37	Ongoing
6.	GMC Udhampur	2019-20	325.00	March 2025	0.44	Ongoing
7.	GMC Handwara	2019-20	325.00	December 2026	0.05	Ongoing

(Source: Information furnished by the Medical College concerned)

In addition, Ayurvedic Medical College, Akhnoor (Jammu) and Unani Medical College cum Hospital, Ganderbal sanctioned in 2011-12 started functioning with IPD services in August 2021 and January 2022 respectively in the UT of J&K.

➢ Creation of two AIIMS for healthcare in capital cities of J&K

In order to provide quality tertiary healthcare, medical education, nursing education and research, the Union Cabinet approved (January 2019) establishment of two[3] All India Institute of Medical Sciences (AIIMS) in J&K. The physical and financial progress of the project as of March 2022 is given in **Table 5.5**.

[2] GMC Anantnag, GMC Baramulla, GMC Doda, GMC Rajouri and GMC Kathua

[3] Vijaypur, Jammu and Awantipora, Kashmir

Table 5.5: Physical and financial progress of AIIMS in J&K

(₹ in crore)

Name of the project	Sanctioned cost	Funds released	Funds utilised	Physical status
AIIMS Jammu	1661.00	605.00	520.00	52 *per cent*
AIIMS Kashmir	1828.00	364.51	303.17	10 *per cent*

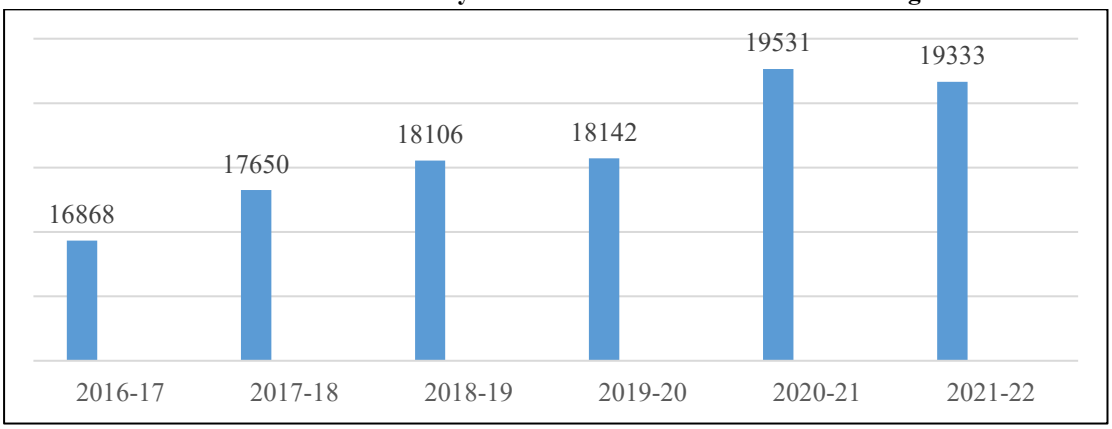
(Source: PMDP Progress Report)

The targeted date for completion was December 2023 for AIIMS Jammu whereas it is September 2025 for AIIMS Kashmir. The construction of AIIMS Jammu was yet to be completed (April 2024). The Deputy Director (Admin) AIIMS Vijaypur Jammu stated (January 2025) that OPD, IPD and OT services have been operationalised during August/ September 2024. Establishment of two AIIMS will add around 1,500 beds (750 beds for each AIIMS).

5.3 Availability of beds in the health institutions

The position of availability of beds in the health institutions of the State/ UT during 2016-2022 is detailed in **Chart 5.2**.

Chart 5.2: Year-wise availability of beds in the State/ UT of J&K during 2016-22



(Source: Figures provided by the Administrative Department)

Availability of beds in the HIs of the State/ UT had increased by 16 *per cent* during 2016-21 and decreased marginally during 2021-22 due to reduction in COVID-19 centres in the UT of J&K.

In the six sampled Districts, the position of availability of beds during 2016-22 is given in **Table 5.6**.

Table 5.6: Availability of beds in six sampled Districts during 2016-22

Year	Number of beds					
	Anantnag	Ganderbal	Jammu	Kupwara	Ramban	Udhampur
2016-17	874	212	602	425	200	423
2017-18	874	212	602	428	200	433
2018-19	1,044	248	637	428	200	439

Year	Number of beds					
	Anantnag	Ganderbal	Jammu	Kupwara	Ramban	Udhampur
2019-20	1,124	368	721	493	200	471
2020-21	1,169	363	757	493	200	531
2021-22	1,169	507	1,003	493	211	531
Percentage increase from 2016-17 to 2021-22	**34**	**139**	**67**	**16**	**6**	**26**

(Source: Figures furnished by CMOs concerned)

During 2016-2022, there was increase in number of beds in all six sampled Districts ranging between 06 and 139 *per cent*. The increase in number of beds in Districts Ganderbal and Jammu during 2021-22 was attributed to COVID-19 pandemic and increase in local as well as migratory population for augmenting the healthcare facilities.

5.3.1 Availability of beds in DHs

The availability of beds in the DHs[4] during 2016-22 is given in **Table 5.7**.

Table 5.7: Availability of beds in DHs during 2016-17 to 2021-22

Sl. No.	Name of the HI	No. of beds required as per IPHS 2012 norms	Number of beds available					
			2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
1.	DH Anantnag and MCCH Anantnag	100-500	240	240	410	410	410	410
2.	DH Bandipore	100-500	-	-	100	100	150	150
3.	DH Budgam	100-500	80	80	80	80	80	80
4.	DH Ganderbal	100-500	30	30	30	100	100	130
5.	DH Jammu	100-500	150	150	160	160	160	160
6.	DH Kishtwar	100-500	100	100	100	100	100	100
7.	DH Kulgam	100-500	85	105	145	200	200	200
8.	DH Handwara	100-500	80	80	80	73	73	73
9.	DH Poonch	100-500	200	200	200	200	200	200
10.	DH Pulwama	100-500	60	60	60	200	200	200
11.	DH Ramban	100-500	50	50	50	50	50	50
12.	DH Reasi	100-500	100	100	100	100	100	100

[4] Vide G.O.No. 298-HME of 2018 dated 24.04.2028, the DHs Anantnag, Baramulla, Rajouri, Doda and Kathua were attached with the New Medical Colleges in the respective Districts and serve as 'Referral Hospitals/Associated Hospitals'. The administrative control of these hospitals was transferred to concerned Government Medical Colleges vide G.O. No. 753-HME of 2019 dated 05.08.2019. Since District Anantnag was selected as sampled District, only the data of Associated Hospital Anantnag was taken as DH Anantnag.

Sl. No.	Name of the HI	No. of beds required as per IPHS 2012 norms	Number of beds available					
			2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
13.	DH Samba	100-500	100	100	100	100	100	100
14.	DH Shopian	100-500	50	50	50	100	100	100
15.	DH Srinagar	100-500	200	200	200	200	200	200
16.	DH Udhampur	100-500	200	200	200	200	200	200
Total			**1,725**	**1,745**	**2,065**	**2,373**	**2,423**	**2,453**

(Source: Information furnished by the Medical Superintendent concerned)

There was 42 *per cent* increase in number of beds in the DHs as the number of beds had increased from 1,725 in 2016-17 to 2,453 in 2021-22. However, adequate beds in accordance with IPHS 2012 norms of minimum 100 beds were not available in DH Budgam and in sampled DHs Handwara and Ramban.

5.3.2 Availability of beds in SDHs/ CHCs/ PHCs

As per IPHS 2012, the SDH should have minimum 31 beds, CHC should have 30 indoor beds and a PHC should cover a population of 20,000 with six indoors/ observation beds.

Out of sampled 10 CHCs, four CHCs have beds as per the IPHS norms whereas six CHCs did not have beds as per norms as shown in **Table 5.8**. Amongst 18 sampled SDHs, 07 SDHs have adequate beds as per IPHS norms whereas 11 SDHs had less than 31 beds. However, out of these 11 SDHs, 09 SDHs had 30 beds.

Table 5.8: Shortage of beds in selected SDHs and CHCs as of March 2022

Sampled District	SDH	No. of beds available in SDH	CHC	No. of beds available in CHC
Anantnag	Kokernag	30	-	-
	Dooru	30	-	-
	Seer Hamdan	30	-	-
	Bijbehara	30	-	-
	Shangus	20	-	-
Ganderbal	Kangan	30	-	-
Jammu	R.S.Pura	30	Sohanjana	16
	Kot-Bhalwal	75	Khour	30
	Marh	20	Jourian	10
	Bishnah	50		
	Akhnoor	60		
	Jagti	34		
	Sarwal	50		
Kupwara	Sogam	33	Kralpora	30
	Kupwara	150	Kralgund	10
	Langate	30	Zachaldara	10

Sampled District	SDH	No. of beds available in SDH	CHC	No. of beds available in CHC
	Tangdhar	30		
Ramban	-	-	Banihal	30
	-	-	Batote	20
	-	-	Gool	20
Udhampur	Ramnagar	30	Chenani	110

(Source: Test-checked SDHs and CHCs)

Colour code:	Adequate	Short

It was further noticed that out of 52 selected PHCs, seven[5] PHCs were functioning without beds and 33 PHCs were lacking required number of beds as per IPHS 2012.

5.3.3 Availability of beds for maternal care and childcare

Maternal care and childcare services were available in all the DHs as of March 2022. A comparison of availability of beds for maternal and childcare during 2016-17 and 2021-22 in the DHs is given in **Table 5.9**.

Table 5.9: Availability of beds for maternal care and childcare during 2016-17 and 2021-22

Sl. No.	Name of the HI	Availability of beds for			
		Maternal care		Child care	
		2016-17	2021-22	2016-17	2021-22
1.	MCCH Anantnag	96	96	14	14
2.	DH Bandipore	DH started w.e.f. July 2019	25	DH started w.e.f. July 2019	25
3.	DH Budgam	20	20	8	12
4.	DH Ganderbal	8	20	8	10
5.	DH Jammu	20	20	12	12
6.	DH Kishtwar	10	10	7	7
7.	DH Kulgam	13	14	0	7
8.	DH Handwara	20	20	18	19
9.	DH Poonch	50	50	32	32
10.	DH Pulwama	26	40	6	26
11.	DH Ramban	20	20	5	5
12.	DH Reasi	5	12	3	7
13.	DH Samba	20	20	10	10
14.	DH Shopian	8	10	0	16
15.	DH Srinagar	30	30	0	30
16.	DH Udhampur	36	36	35	35
Total		**382**	**443**	**158**	**267**

(Source: Information furnished by Medical Superintendents concerned)

There was 16 and 69 *per cent* increase in availability of number of beds in the DHs for maternal care and childcare respectively as the number of beds increased from 382 in 2016-17 to 443 in 2021-22 for maternal care and 158 in 2016-17 to 267 in 2021-22 for childcare.

[5] Kawa, Ari, Bain Bajalta, Digiana, Domana, Mugalpora and Gundishot

5.4 Citizen's Charter

IPHS 2012 norms provide for displaying prominently a Citizen's Charter for the Health Institutions indicating the services available, user fees charged, if any, and a grievance redressal system. During survey of the test-checked hospitals, it was noticed that while all the selected TLHs/ DHs/ SDHs/ CHCs displayed Citizen's Charter, the Charter of all these HIs did not display complete information about services. The deficiencies noticed in displaying services on the Citizen's Charter is detailed in **Table 5.10**.

Table 5.10: Services displayed by sampled HIs in the Citizen's Charter

Services displayed on the Citizen's Charter	Out of 7 Tertiary Level Hospitals[6]	Out of 6 DHs	Out of 28 CHCs/SDHs
Patient rights	5	3	3
Availability of services and entitlements in the Departments	5	5	13
User charges	3	3	15
Availability of OPD services and timing of OPD services Department-wise	4	3	12
Availability of diagnostic services	6	3	12
Available emergency and trauma care services	4	3	9
Availability of family welfare, maternity and childcare services	3	3	14
Availability of immunisation services	4	3	14
Availability of ambulance services	3	4	10
Responsibilities of users	3	3	0

(Source: Information provided by concerned HIs)

5.5 Health and Wellness Centres

The National Health Policy, 2017 recommended strengthening the delivery of primary healthcare, through establishment of "Health and Wellness Centres (HWCs)" as the platform to deliver Comprehensive Primary Healthcare and called for a commitment of two thirds of the health budget to primary healthcare.

As per Ayushman Bharat Comprehensive Primary Healthcare through Health and Wellness Centres Operational guidelines of February 2018, the Government of India (GoI) announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing SCs and PHCs to deliver Comprehensive Primary Healthcare and declared this as one of the two components of Ayushman Bharat. The other component of Ayushman Bharat, namely the Pradhan Mantri Jan Arogya Yojana (PMJAY) aims to provide financial protection for secondary and tertiary care hospitalisation in public and private empanelled hospitals in India.

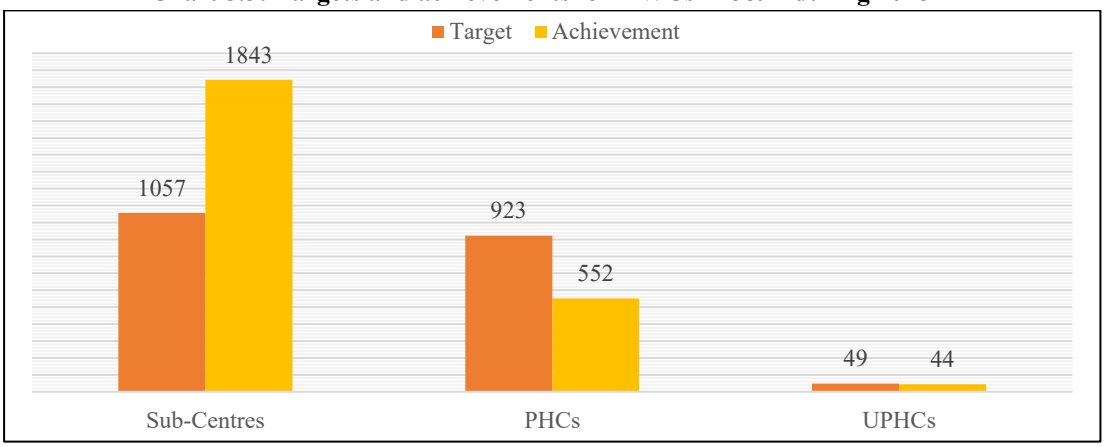
[6] (i) Govt. Medical College & Hospital, Jammu (ii) SMGS Hospital, Jammu (iii) Super Specialty Hospital, Jammu (iv) Lalla Ded Hospital, Srinagar (v) SMHS Hospital, Srinagar (vi) Super Specialty Hospital, Srinagar and (vii) G.B. Pant Hospital, Srinagar.

(A) Conversion of SCs and PHCs to Health and Wellness Centres

Ayushman Bharat Operational Guidelines stipulate that necessary infrastructure was to be created and manpower was to be provided for conversion of SCs and PHCs to Health and Wellness Centres (HWCs).

Audit noticed that against the target of conversion of 2,029 health institutions (SCs/ PHCs/ UPHCs), 2,439 HIs were upgraded to HWCs as of March 2022 in the UT of Jammu and Kashmir as shown in **Chart 5.3**.

Chart 5.3: Targets and achievements for HWCs in J&K during 2018-22



(Source: Information furnished by NHM J&K)

In the six[7] sampled Districts, 865 (SCs: 650, PHCs: 199 and UPHCs: 16) HWCs were established against the target of 719 (SCs: 381, PHCs: 320 and UPHCs: 18) HWCs as of March 2022.

(B) Non-availability of required infrastructure in HWCs

As per Ayushman Bharat Operational Guidelines, prescribed healthcare services, human resources, civil infrastructure upgrade and diagnostic services were to be provided in the HWCs.

Audit observed that required basic infrastructure and amenities were not available in HWCs of the sampled Districts as of March 2022 as detailed in the succeeding paragraphs:

(i) Non-availability of Healthcare Services

Operational Guidelines of Ayushman Bharat prescribe that 12[8] types of healthcare services would be delivered at HWC.

---

7 Anantnag: 181; Ganderbal: 79; Jammu: 187; Kupwara: 246; Ramban: 55 and Udhampur: 117

8 (i) Care in pregnancy and child-birth (ii) Neonatal and infant healthcare services (iii) Childhood and adolescent healthcare services (iv) Family planning, contraceptive services and other reproductive healthcare services (v) Management of communicable diseases-National Health Programmes (vi) General out-patient care for acute simple illness and minor ailments (vii) Screening, Prevention, Control and management of non-communicable diseases (viii) Care for common Ophthalmic and ENT problems (ix) Basic Oral healthcare (x) Elderly and palliative healthcare services (xi) Emergency medical services and (xii) Screening and basic management of mental health ailments

It was noticed that all 12 types of healthcare services were being provided by 810 out of 865 HWCs of the six sampled Districts. In Ramban District, all 12 types of healthcare services were not available in 11-29 HWCs out of 55 HWCs.

(ii) Shortage of human resources

Section 2 of Operational Guidelines (Inputs for Health and Wellness Centre) of Ayushman Bharat Comprehensive Primary Healthcare through Health and Wellness Centres (February 2018) requires that there should be at least three service providers (one Mid-Level Health Provider (Community Health Officer) and at least two Multi-Purpose Workers [MPW]) in each upgraded SC. In addition, a team of Accredited Social Health Activist (ASHA) workers (at the norm of one ASHA worker per 1,000 patients) is to be provided.

It was noticed that out of 865 HWCs in six sampled Districts, Mid-Level Health Providers (MLHP) were available in 617 HWCs whereas 248 HWCs lacks the availability of MLHP. At least two MPWs were not available in 381 HWCs. ASHA was available in all HWCs except 25 HWCs of District Ganderbal as of March 2022 as detailed in **Table 5.11**.

Table 5.11: Non-availability of manpower in HWCs in sampled Districts as of March 2022

Sl. No.	Non-availability of	Anantnag (181)	Kupwara (246)	Ganderbal (79)	Jammu (187)	Udhampur (117)	Ramban (55)	Total (865)
1	One Mid-Level Health Provider (MLHP) who would be a Community Health Officer (CHO)	43	37	25	77	37	29	248
2	At least two Multi-Purpose Workers (MPW)	35	197	45	86	0	18	381
3	Accredited Social Health Activist (ASHA)	0	0	25	0	0	0	25

(Source: Information furnished by Chief Medical Officers concerned)

(iii) Non-availability of essential civil infrastructure

Ayushman Bharat Guidelines prescribe that major civil infrastructure upgrade would largely be required for developing the Sub-Health Centre as Health and Wellness Centre.The basic essential facilities, as detailed in **Table 5.12**, were not available in the upgraded HWCs in the sampled Districts as of March 2022.

Table 5.12: Number of HWCs deficient in essential civil infrastructure

Sl. No.	Essential requirement of infrastructure	No. of HWCs in which infrastructure was not available (out of 865)
1.	A well-ventilated clinic room with examination space and office space for Mid-Level Health Provider/Community Health Officer	57
2.	Storage space for storing medicines, equipment, documents, health cards and registers	58
3.	Designated space for lab/ diagnostic centre	252
4.	Separate male and female toilets	608
5.	Deep burial pit for bio medical waste management	579
6.	Assured water supply that can be drawn and stored locally	240
7.	Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate	230
8.	Patient waiting area covered to accommodate at least 20-25 chairs	620
9.	Adequate residential facilities for the service providers	803
10.	Space/ room for yoga	340
11.	Facilities for people with disabilities	715

(Source: Information furnished by the CMOs concerned)

The data in **Table 5.12** indicated that out of 865 HWCs in six sampled Districts, 808 HWCs were having well-ventilated clinic room with examination and office space and 807 HWCs have adequate storage space for storing medicines, equipment, documents etc. However, basic requirements of water and electricity supply was not available in 240 and 230 HWCs respectively whereas 608 HWCs lacked availability of separate male and female toilets. Further, the designated space for lab/ diagnostic centre was not available in 252 HWCs and space/ room for yoga was not available in 340 HWCs. There was non-availability of facilities for people with disabilities in 715 HWCs.

(iv) Non-availability of required Diagnostic Services at HWCs

Ayushman Bharat Guidelines provide an indicative list of eight types of required diagnostic services. During scrutiny of records, it was noticed that the required diagnostic services viz. Haemoglobin, Urine Pregnancy Rapid Test, Urine Dipstick-Urine albumin and Sugar and Blood Glucose were available in all 865 HWCs of the six sampled Districts. However, Malaria Smear, Rapid Diagnostic Test Kit for Dengue, Sickle Cell Rapid Test and collection of sputum samples were not available in 482, 561, 441 and 05 HWCs respectively.

The Chief Medical Officers Anantnag and Kupwara attributed (December 2023) the reason for non-availability of diagnostic services to non-prevalence of Dengue and Malaria in Anantnag and Kupwara Districts. The Chief Medical Officer Ganderbal, Ramban and Jammu admitted non-availability of facility of diagnostic services in the HWCs.

Existing SCs and PHCs were transformed into HWCs to ensure universal access to an expanded range of comprehensive primary health services and to deliver quality healthcare services but this target could not be achieved due to lack of infrastructure, health services, diagnostic services, shortage of manpower etc.

Some illustrations regarding status of HWCs are shown in the following photographs.

Well maintained HWC-Kurag (District Ganderbal)

HWC-Naryana Lower (District Jammu) in good condition with separate toilets

HWC-Sangaldan (District Ramban) in good condition

HWC-Ossu (District Udhampur) without ventilation and adequate space

HWC-Hutmulla (District Kupwara) without ramp	**HWC-Awoora (District Anantnag) without ramp**

5.5.1 AYUSH Health and Wellness Centres

The AYUSH system advocates holistic wellness approach aiming at prevention of diseases and promotion of health and well-being. GoI has granted approval (March 2020) to operationalise 12,500 AYUSH Health and Wellness Centres (AH&WCs) through States/ UTs in Centrally Sponsored Scheme mode and under the broad umbrella of National AYUSH Mission (NAM) by upgrading the already functional AYUSH dispensaries or Sub-Health Centres.

(i) Conversion of AYUSH dispensaries to AYUSH Health and Wellness Centres

Out of 571 AYUSH dispensaries in the UT of J&K, 317 dispensaries were upgraded during 2019-22 to AH&WCs. In the six sampled Districts, out of 198 AYUSH dispensaries, 104 AYUSH dispensaries were upgraded to AH&WCs.

(ii) Non-availability of Healthcare Services

Operational Guidelines of Ayushman Bharat AYUSH Health and Wellness Centres proposed Ayurveda interventions under 12 service delivery areas. The availability/ shortfall of these services in respect of the six sampled Districts is given in **Table 5.13**.

Table 5.13: Availability of Healthcare services in AH&WCs

Sl. No	Availability of healthcare services	Anantnag (23)	Kupwara (14)	Ganderbal (12)	Jammu (24)	Udhampur (17)	Ramban (14)	Total (104)	Shortfall
1.	Care in pregnancy and child-birth	0	14	0	0	17	0	31	73
2.	Neonatal and infant healthcare services	0	0	0	0	0	0	0	104
3.	Childhood and adolescent healthcare services	0	14	12	22	17	0	65	39
4.	Family planning, contraceptive services and other reproductive healthcare services	0	0	0	0	17	0	17	87

Sl. No	Availability of healthcare services	Anantnag (23)	Kupwara (14)	Ganderbal (12)	Jammu (24)	Udhampur (17)	Ramban (14)	Total (104)	Shortfall
5.	Management of Communicable diseases -National Health Programmes	0	14	0	6	17	0	37	67
6.	General outpatient care for acute simple illness and minor ailments	23	14	12	24	17	14	104	0
7.	Screening, Prevention, Control and Management of Non-Communicable diseases.	23	14	12	24	17	14	104	0
8.	Care for Common Ophthalmic and ENT problems.	23	14	12	23	17	0	89	15
9.	Basic Oral health care.	23	14	12	21	17	0	87	17
10.	Elderly and Palliative healthcare services.	23	14	12	24	17	0	90	14
11.	Emergency Medical Services including Burns and Trauma	0	0	0	0	0	0	0	104
12.	Screening and basic management of mental health ailments.	23	14	0	17	17	0	71	33

(Source: Information furnished by District Ayush Officers concerned)
Figures in the brackets indicate number of AYUSH-H&WCs in the District

The data in **Table 5.13** indicates that out of 104 AH&WCs, services deliveries of family planning, contraceptive services and other reproductive healthcare services were available in 87 AH&WCs whereas the service delivery of care in pregnancy and child-birth was available in 73 AH&WCs. However, service deliveries under Neonatal and infant health care service, emergency medical services including burns and trauma were not available in all 104 AH&WCs. The balance 10 services were not available in 14-87 AH&WCs. In 14 AH&WCs in Ramban District, only two[9] services were available.

(iii) Shortage of human resources

Paragraph 5.1 of Operational Guidelines (HWC Team) requires that there should be Community Health Officer (CHO) assisted by Multi-Purpose workers (MPW), Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA). Upgraded AYUSH dispensaries may have pharmacist, nursing staff or technicians and qualified yoga instructor on part-time basis for all HWCs.

It was noticed that as on 31st March, 2022:

- CHO was available in 103 out of 104 AH&WCs.
- No MPW and ANM was available in all 104 AH&WCs.
- Nursing staff/ technician was not available in 96 AH&WCs.

[9] (i) General outpatient care for acute simple illness and minor ailments (ii) Screening, prevention, control and management of non-communicable diseases.

- No Pharmacist was available in 29 AH&WCs.
- Yoga instructor was not available in 55 AH&WCs.
- ASHA was available in 102 out of 104 AH&WCs,

(iv) Non-availability of essential civil infrastructure

The deficiency in availability of basic essential requirements for strengthening a facility to serve as a Health and Wellness Centre as per Paragraph 11 of the operational guidelines is detailed in **Table 5.14**.

Table 5.14: Number of AH&WCs deficient in essential civil infrastructure

Sl. No.	Essential requirement of infrastructure	No. of AH&WCs in which infrastructure was not available as of March 2022 (out of 104)
1.	A well-ventilated clinic room with examination space and office space for Mid-Level Health Provider/ Community Health Officer	0
2.	Storage space for storing medicines, equipment, documents, health cards and registers	0
3.	Designated space for lab/ diagnostic centre	43
4.	Separate male and female toilets	49
5.	Deep burial pit for bio medical waste management	99
6.	Assured water supply that can be drawn and stored locally	21
7.	Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate	6
8.	Patient waiting area covered to accommodate at least 20-25 chairs	73
9.	Adequate residential facilities for the service providers	102
10.	Space/ room for yoga	38
11.	Garden/space for display of medicinal plants	1

(Source: Information furnished by District AYUSH Officers concerned)

The data in **Table 5.14** indicates that all 104 AH&WCs have well-ventilated clinic room with examination space and office space for Mid-Level Health Provider/ Community Health Officer and storage space for storing medicines, equipment, documents, health cards and registers. However, water and electricity supply were not available in 21 and 06 AH&WCs respectively out of 104. Separate male and female toilets were not available in 49 AH&WCs whereas the designated space for lab/ diagnostic centre was not available in 43 AH&WCs. Further, space/ room for yoga was not available in 38 AH&WCs.

5.6 Execution of works

H&MED executed infrastructure works primarily under National Health Mission (NHM), Prime Minister's Development Package (PMDP) and Languishing projects. The details of works taken up for execution during 2016-2022 are given in **Table 5.15**.

Table 5.15: Works approved for execution and completed during 2016-22

Name of the Scheme	No. of ongoing works as of April 2016	No. of works approved for execution during 2016-2022	Total works	No. of works completed during 2016-2022	No. of ongoing works as on March 2022
National Health Mission (NHM)	68	69	137	69	68
Prime Minister's Development Package (PMDP)	0	140	140	104	36
Languishing projects	0	138	138	4	134
Total	**68**	**347**	**415**	**177**	**238**

(Source: Departmental figures)

Audit noticed that under NHM, construction and upgradation works of 137 healthcare facilities (including 68 ongoing works as on April 2016) were taken up, out of which 68 (50 *per cent*) works were incomplete as of March 2022.

- Out of 68 incomplete works, 33 works had remained incomplete for a period ranging between ten and 14 years.
- Fifteen works had remained incomplete for a period ranging between five and nine years whereas 20 works had remained incomplete for less than five years.

Under construction building of PHC Domana under NHM (02.02.2022)

PHC Domana functioning within the complex of AYUSH dispensary (02.02.2022)

5.6.1 Prime Minister's Development Package

A comprehensive Prime Minister's Development Package (PMDP) consisting of 63 individual projects was announced for J&K by the Hon'ble Prime Minister of India on 7 November 2015 with an outlay of ₹ 80,068 crore. One of the projects under PMDP was "Stepping up of support under creation of infrastructure in the District Hospitals, Sub-District Hospitals and PHCs over a period of five years" having sanctioned cost of ₹ 881.04 crore being implemented by H&MED of GoJ&K.

Audit noticed that:

➢ Out of 140 works under the project, as of March 2022, only 104 works had been completed after incurring expenditure of ₹ 500.49 crore.

➢ Out of the remaining 36 works, 16 works taken up for execution during the period 1995-96 to 2013-14 (prior to their inclusion under PMDP in 2015-16), remained incomplete even after incurring expenditure of ₹ 100.63 crore. The remaining 20 works taken up for execution after the announcement of PMDP had remained incomplete after incurring expenditure of ₹ 222.99 crore.

➢ Out of the above-mentioned 36 works, 35 works remained incomplete for periods ranging between three and 17 years, while one work remained incomplete since 1995-96.

Incomplete staff quarters at CHC Banihal taken up under PMDP	**Incomplete CHC Jourian (28.12.2021) taken up under PMDP**

The Department stated (November 2023) that all ongoing PMDP works are targeted for completion by/ before March 2024 and executing agencies have been directed to accelerate the pace of execution of works to achieve their completion well within the stipulated time.

➢ In order to overcome the acute shortage of space to accommodate the huge rush of patients in the old and dilapidated structure housing the Maternity and Childcare Hospital (M&CCH) Sherbagh, Anantnag, sanction was accorded (March 2017) by the Health & Medical Education Department for taking over of Rehmat-e-Alam Trust Hospital alongwith all its assets and liabilities. The sanction order also envisaged getting the infrastructure of the hospital upgraded through an executing agency of the State Government to a 125-bedded institution for subsequent shifting of M&CCH presently located at Sherbagh, Anantnag to this hospital. Accordingly, the balance work of the hospital was entrusted to Jammu and Kashmir Projects Construction Corporation Limited (JKPCC) during the year 2016-17 at a cost of ₹ 12.10 crore out of which ₹ 11.46 crore was released in favour of the executing agency. Expenditure of

₹ 5.25 crore was incurred as of March 2022 on account of raising 2nd and 3rd floors of Block A, B, C and 3rd slab of Blocks F and G and other civil works including truss[10]. However, during the course of execution of the work, safety audit of the building was entrusted (March 2020) to IIT Jammu on the directions of the then Advisor to Governor during his visit to the site in April 2019 and thereafter no further work was executed on the building. IIT Jammu finally reported (June 2021) that the building under structural audit is under-designed for hospital usage and should not be directly used for hospital usage. This not only resulted in unfruitful expenditure of ₹ 5.25 crore, but also deprived the population of the area of the intended benefits.

The Department stated (September 2022) that IIT Jammu had been requested to suggest latest technological interventions to make the building structurally safe to be used for hospital purpose.

The Principal, GMC Anantnag stated (January 2025) that the work is yet to be completed.

5.6.2 Languishing projects

GoJ&K accorded (September 2018) sanction to constitute a High Powered Committee (HPC) for approving unfunded infrastructure projects to be funded by Jammu and Kashmir Infrastructure Development Finance Corporation (JKIDFC), constituted simultaneously for raising loans from financial institutions including State/ Nationalised banks for completion of unfunded/ languishing infrastructure projects in the erstwhile State/ UT and by other new infrastructure projects which are a priority for the erstwhile State/ UT. Under the health sector, projects like construction/ up gradation/ renovation of health infrastructure in various Districts and Tertiary Level Hospitals of the UT were sanctioned.

The position of projects sanctioned, projects targeted for completion and projects actually completed under Languishing Projects scheme during the period 2018-2022 in respect of H&MED is given in **Table 5.16**.

Table 5.16: Projects approved and completed under Languishing Projects scheme

(₹in crore)

Year	Projects approved by HPC	Amount approved	Projects completed during the year	Expenditure as of March 2022
2018-19	102	290.76	0	165.66
2019-20	0	0	4	
2020-21	36	299.19	0	
2021-22	0	0	0	
Total	**138**	**589.95**	**4**	**165.66**

(Source: Information provided by Joint Director, Resources (Finance Department))

[10] A framework supporting a roof, bridge or other structure.

Audit noticed that:

- Against ₹ 589.95 crore approved for infrastructure projects, expenditure of only ₹ 165.66 crore (28 *per cent*) was incurred as of March 2022.
- Against 135 projects (target date for completion was not available for three projects) targeted for completion during 2018-2022, only four projects were completed after incurring expenditure of ₹ 3.25 crore as of March 2022. Delay in completion of these works ranged between one year and four years.
- In six sampled Districts, 53 works were taken up for execution during 2018-2022, out of which 49 works had remained incomplete after incurring expenditure of ₹ 97.47 crore.

Delay in completion of projects sanctioned under Languishing Projects Scheme had deprived the local population of the intended benefits.

NTPHC Gundishot (District Kupwara) functioning from a school building	**Incomplete structure of NTPHC Gundishot under Languishing projects**
NTPHC Ari (District Ganderbal) functioning from a rented shop	**Under-construction building of NTPHC Ari under Languishing projects**

The Chief Medical Officer, Ganderbal stated (January 2025) that NTPHC Ari has been completed and taken over (March 2024) by the BMO Kangan.

5.6.3 Works taken up under District Plan/NABARD/ BADP etc.

H&MED also took up works for execution under District Plan/ NABARD/ BADP etc. Details of such works taken up for execution in the six selected Districts are given in **Table 5.17**.

Table 5.17: Infrastructure works taken up under District Plan/NABARD/ BADP etc. during 2016-22

(₹in crore)

Name of the District	No. of works as of April 2016	Works taken up for execution during 2016-22	Total works	Works completed during 2016-22	Expenditure incurred on completed works	Ongoing works as of March 2022	Expenditure incurred on ongoing works
Anantnag	29	0	29	20	16.24	9	9.00
Ganderbal	6	15	21	17	9.25	4	1.58
Jammu	24	18	42	20	7.41	22	15.36
Kupwara	37	64	101	70	6.89	31	7.78
Ramban	12	32	44	20	5.22	24	8.42
Udhampur	29	57	86	52	36.42	34	11.83
Total	**137**	**186**	**323**	**199**	**81.43**	**124**	**53.97**

(Source: Information furnished by the Chief Medical Officers concerned)

It is evident from the table above that out of 323 works (137 ongoing works as on April 2016 and 186 works taken up for execution during 2016-2022), 199 works were completed during the period after incurring an expenditure of ₹ 81.43 crore and 124 works remained incomplete after incurring an expenditure of ₹ 53.97 crore as of March 2022.

Audit observed that:

- Construction work of five[11] health institutions of Jammu District were taken up for execution during 2010-2013 at an estimated cost of ₹ 6.68 crore. After incurring expenditure of ₹ 6.68 crore, the buildings were not taken over (November 2022) by the H&MED from the executing agency due to non-execution of works including sanitary fitting, electric works or other deficiencies. This had deprived the inhabitants of the area of better healthcare infrastructure and services.

SC Platan building District Jammu (19.03.2022)

Idle SC Kalah building District Jammu (19.03.2022)

The Chief Medical Officer, Jammu stated (January 2025) that the work of five health institutions vis. SC Platan, SC Kalah, SC Mallah, PHC Ghar Majoor and PHC Dori Dagar have been completed. All the five buildings have been taken over by the Department and are functional.

[11] SC Platan, SC Kalah, SC Mallah, PHC Ghar Majoor and PHC Dori Dager (SC Platan and PHC Ghar Majoor are working from the buildings, though not taken over by the Department)

- In District Kupwara, 14 works[12] estimated to cost ₹ 8.91 crore were taken up for execution during 2009-18. After incurring expenditure of ₹ 5.71 crore as of March 2021, these works could not be completed as of August 2022 and were at various stages of completion thus depriving the local population of intended benefits. The Chief Medical Officer, Kupwara stated (August 2022) that some incomplete works shall be completed during the current financial year and the remaining within the next two years.

- The Department had taken up execution of 17 works[13] in District Kupwara at a revised cost of ₹ 9.20 crore through various work executing agencies during 2009-10 and 2010-11. Despite incurring expenditure of ₹ 2.07 crore, all these 17 works were not complete as of March 2022 and were left half way at various stages due to cost escalation. Lapse of over 11 years since start of these works had resulted in unfruitful expenditure of ₹ 2.07 crore.

- In respect of four[14] works approved for execution in District Jammu during 2009-2014 at an estimated cost of ₹ 4.14 crore, ₹ 0.78 crore was advanced during 2009-10 and 2013-14 to the executing agencies without ensuring availability of land resulting in blocking of these funds for over eight to 12 years. The Chief Medical Officer, Jammu stated (January 2025) that the works could not be started as the process of land identification/ acquisition is in progress.

Out of the incomplete works as above, five construction works taken up at an estimated cost of ₹ 10.54 crore, are detailed in **Table 5.18**.

Table 5.18: Examples of some incomplete works

Sl. No.	Name of the District	Name of healthcare facility	Estimated cost	Expenditure incurred as of March 2022	Remarks
			(₹ in lakh)		
1.	Jammu	SC Bala	98.80	66.13	Building completed in 2020-21 but could not be taken over due to dispute with the land owner as confirmed by the Chief Medical Officer, Jammu (November 2022).
2.	Ganderbal	PHC Kullan	332.60	143.32	The building was taken up for execution by the J&K Housing Board in the year 2009-10 at an estimated cost of ₹ 143.32 lakh. The executing agency submitted (August 2015) to the DHS, Kashmir that due to poor soil strata consisting of filled

[12] NTPHC Nawgam, NTPHC Hajinar, SC Gundi Gujran, SC Tumina, SC Manwan, SC Moorie, MO's Quarter at PHC Behnipora, SC Kawari, SC Tumnard, NTPHC Diver, SC Hangikote, NTPHC Mankal, SC Haril and MO's Quarter Tangdar

[13] Construction of SCs at Sarajpora, Bahkiakaher, Dohama, Ahgam, Hajin, Palpora, Sonwani, Budbug, BadrehPayeen, Yamlar, Budshungi, Sodal, Pazalpora, Ucher, Badarkal, Construction of additional two room SC at Machipora and Construction of Allopathic Dispensary at Hayhama (District Kupwara)

[14] NTPHC Salehar, SC Shiva Patta, SC Gajansoo, SC Chatta

Sl. No.	Name of the District	Name of healthcare facility	Estimated cost	Expenditure incurred as of March 2022	Remarks
			(₹ in lakh)		
					up soil, the building needs RCC framed structure with raft foundation instead of normal load bearing structure and submitted (August 2015) a revised DPR for ₹ 332.60 lakh. The Chief Medical Officer, Ganderbal stated (January 2025) that the work of PHC Kullan is still at halt.
3.	Ramban	PHC Deeda	251.55	216.81	Work approved in 2010-11 under NABARD could not be taken up for execution till 2016-17 due to land dispute. Following change in the work site, the work was started during 2017-18 and an expenditure of ₹ 2.17 crore (November 2022) has been made. Pending release of balance funds, the finishing work had not been taken up as of November, 2022.
4.	Ramban	SC Tarana-Kheri	74.75	59.30	The building stands completed except for electrification and construction of boundary wall as of September 2022. The work could not be completed due to dispute with the land owner. As per the progress report furnished by the CMO Ramban, the work was incomplete ending December 2024.
5.	Kupwara	Allopathic Dispensary at PayerporaHayhama	166.85, revised to 296.00	128.47	Construction work of Allopathic Dispensary at Payerpora Hayhama was taken up by JKPCC at an estimated cost of ₹ 166.85 lakh during 2010-11.The Chief Medical Officer, Kupwara admitted (August 2022) that due to poor funding and slow pace, work could not be completed. However, an amount of ₹ 39 lakh was allotted for completion of the building and the work shall be completed during 2022-23 or the next year.
Total			**1,053.70**	**614.03**	

(Source: Information provided by the Department)

Non-completion/ non-taking over of the buildings by H&MED resulted in idle investment of ₹ 6.14 crore.

Locked newly constructed building of SC Bala (24.12.2021)	**Rented building of SC Bala (24.12.2021)**
Abandoned structure of PHC Kullan (District Ganderbal)	**Existing building of PHC Kullan (District Ganderbal)**

The Chief Medical Officer, Jammu stated (January 2025) that building of SC Bala was taken over by the Department in December 2023 and is functional.

5.7 Non-availability and non-maintenance of residential accommodation

As per IPHS 2012 norms, all essential medical and paramedical staff will be provided with residential accommodation. If accommodation cannot be provided due to any reason, then the staff may be paid house rent allowance and, in that case, they should stay in the vicinity, so that essential staff is available 24 x 7. Availability of residential accommodation in test checked DHs/ SDHs/ CHCs is given in **Table 5.19**.

Table 5.19: Availability of residential accommodation in test-checked DHs/ SDHs/ CHCs

Sl. No.	Name of the HI	Number of quarters available	Number of quarters occupied	Status
DH				
1.	DH Anantnag	6	6	-
2.	DH Ganderbal	0	0	-
3.	DH Handwara	3	3	-
4.	DH Jammu	6	6	-

Sl. No.	Name of the HI	Number of quarters available	Number of quarters occupied	Status
5.	DH Ramban	0	0	-
6.	DH Udhampur	18	11	Seven quarters are not in good condition
SDH				
1.	SDH Seer Hamdan	0	0	-
2.	SDH Bijbehara	0	0	-
3.	SDH Shangus	0	0	-
4.	SDH Dooru	2	2	-
5.	SDH Kokernag	3	3	-
6.	SDH Kangan	0	0	-
7.	SDH Kupwara	8	8	-
8.	SDH Sogam	2	2	-
9.	SDH Tangdar	0	0	-
10.	SDH Langate	2	2	-
11.	SDH R.S.Pura	6	0	Lying vacant for want of repairs and maintenance for the last six years.
12.	SDH Kot-Bhalwal	4	0	More than 35 years old. Beyond repair.
13.	SDH Marh	6	0	All the six quarters have been occupied by the Revenue Department for the last eight years.
14.	SDH Bishnah	0	0	-
15.	SDH Akhnoor	12	7	Five quarters need repair and maintenance.
16.	SDH Jagti	0	0	-
17.	SDH Sarwal	2	0	Quarters are in dilapidated condition and require repair and renovation.
18.	SDH Ramnagar	6	4	Two quarters need repair and renovation.
CHC				
1.	CHC Kralpora	0	0	
2.	CHC Kralgund	1	1	-
3.	CHC Zachaldara	1	1	-
4.	CHC Sohanjana	12	0	The staff quarters got damaged during the floods of 2014 and need extensive repair and maintenance, hence, are lying vacant.
5.	CHC Jourian	0	0	-
6.	CHC Khour	17	0	The quarters were constructed in 2019. However, they could not be utilised due to non-execution of some internal works by the executing agency.
7.	CHC Banihal	6	6	Needs repair and renovation.
8.	CHC Batote	15	14	One vacant quarter which needs repair and renovation.
9.	CHC Gool	2	0	Needs repair and renovation.
10.	CHC Chenani	6	1	Five quarters need repair.
Total		**146**	**77**	

(Source: Information furnished by the department)

It is evident from the **Table 5.19** that:

- Out of available 146 residential quarters at test-checked 34 health institutions, only 77 (53 *per cent*) were occupied by the staff.
- Out of 33 available residential quarters in 04 out of 06 sampled DHs, 26 residential quarters were occupied by the staff.
- Out of 53 residential quarters at 18 SDHs, 25 quarters were either in bad condition and required repair or were occupied by other Departments and the remaining 28 quarters were occupied by the staff.
- Out of 60 residential quarters at 10 CHCs, 23 quarters were occupied by the staff and the remaining 37 quarters either needed repair and renovation or were not handed over to the Department owing to non-execution of some internal works by the executing agency since 2019.
- In 11 health institutions (DHs: two; SDHs: seven and CHCs: two), no residential quarter was available for staff.

The Medical Superintendent, AH GMC Udhampur stated (December 2023) that no funds have been received for repair & renovation of staff quarters during 2016-22. The matter however, shall be taken up with the higher authorities. The Chief Medical Officer, Jammu stated (January 2025) that no funds have been received for repair and maintenance of staff quarters. The Chief Medical Officer, Udhampur stated (December 2023) that the proposal for repair/ renovation of residential quarters at SDH Ramnagar under UT CAPEX was submitted to Director, Health Services Jammu in May 2023 and the Superintending Engineer, PWD (R&B) was requested (April 2022) to prepare the DPR for repair of quarters at CHC Chenani. The Chief Medical Officer, Ramban stated (December 2023) that this office has taken up the matter with the concerned authorities for adequate release of funds to get the staff quarters repaired.

Further, the details of availability of residential quarters in the test-checked PHCs as on March 2022 is detailed in **Table 5.20**.

Table 5.20: Availability of residential accommodation in test-checked PHCs

Name of the District	No. of PHCs test checked	Number of PHCs having residential quarters	No. of quarters available	No. of quarters occupied	Status
Anantnag	9	3	5	3	Two quarters are yet to be handed over by the executing agency in respect of PHC Budroo Kalan.
Ganderbal	6	0	0	0	-
Jammu	10	0	0	0	-
Kupwara	10	3	3	3	-

Name of the District	No. of PHCs test checked	Number of PHCs having residential quarters	No. of quarters available	No. of quarters occupied	Status
Ramban	7	1	1	1	-
Udhampur	10	4	15	5	Quarters are being used for night duty room and for storage of medicines (PHC Majalta- two quarters). Posting of local staff (PHCs Madha and Garhi)
Total	**52**	**11**	**24**	**12**	

(Source: Information furnished by the Department)

It is evident from the **Table 5.20** that 24 quarters were available at 11 out of 52 test-checked PHCs. Of these, 12 were occupied by the staff and the remaining were lying vacant either due to posting of local staff, being used as drug store or non-handing over of quarters to the department by the executing agency. No staff quarter was available in 41 PHCs.

Status of residential accommodation

Vacant staff quarters at SDH, R.S Pura (09.06.2022)

Residential quarters of SDH Marh occupied by Revenue Department (22.06.2022)

Vacant staff quarters at CHC Sohanjana

Vacant residential quarters at CHC, Khour

Vacant staff quarters at PHC B. Kalan

The above findings reflect the lack of serious efforts on the part of the Department to get the damaged quarters renovated or to allot available quarters to staff.

5.8 Non-establishing of infrastructure

➢ Creation of separate isolation ward and Swine Flu H1N1 Laboratory

For molecular diagnosis of Swine Flu and other epidemics to tackle the situation arising due to Swine Flu virus, Ebola virus, HIV, Bird Flu etc. at Govt. Medical College (GMC) Jammu, a proposal for creation of Swine Flu H1N1 Laboratory along with separate isolation ward was submitted (February 2015) by the Principal, GMC Jammu to H&MED having total cost of ₹ 6.28 crore (₹ 2.98 for creation of isolation ward and ₹ 3.30 crore for Swine Flu H1N1 Laboratory). H&MED released (March 2015) funds of ₹ 6.30 crore in favour of Principal, GMC Jammu for establishment of H1N1 (Swine Flu) Testing Laboratory at GMC Jammu within the shortest possible time.

Audit observed that out of ₹ 6.30 crore, funds of ₹ three crore (₹ one crore in March 2015 and ₹ two crore in January 2016) were released in favour of the executing agency (PWD) for construction of isolation ward at GMCH Jammu. The executing agency completed the work and submitted (May 2016) Utilisation Certificate for funds of ₹ three crore (including funds advanced to Mechanical Division, GMC for ₹ 13.69 lakh and material at site valuing ₹ 39.31 lakh).

Further, for establishment of Swine Flu H1N1 Laboratory, the tenders invited (2015) by the purchase committee could not be finalised as only one firm qualified technical round of the tender. The Department approached the National Centre for Disease Control (NCDC), New Delhi and they recommended four specialised agencies out of which the Department had approached the three[15] specialised agencies. Finally, the work of establishment of BSL-3 Lab at GMC Jammu was authorised

[15] The Kartos International, the Biosafe Lab India Private Limited and The Techcomp (Singapore) Private Limited.

(September 2018) to the Biosafe Lab India Private Limited at a cost of ₹ 343.16 lakh by the Principal, GMC Jammu and the agreement was executed (December 2018) with the Firm. Audit further noticed that no provision was kept in the initial estimates (₹ 6.28 crore) for Supply, Testing, Installation and Commissioning (SITC) of electromechanical[16] works for operating of BSL-3 Lab at GMCH Jammu. Accordingly, the Administrative Approval for execution of the work "SITC of 500 KVA DG set with AMF panel, water softener plant, RO Plant and 1 MVA electric sub-station" was accorded (June 2022) at an estimated cost of ₹ 143.66 lakh against which funds of ₹ 75 lakh was placed (June 2022) at the disposal of Mechanical Engineering Department for operationalising BSL-3 Lab. However, the work of SITC of DG set and distribution panel with proper rated cables for making all interconnections between DG set, AMF panel and distribution panel is yet to be completed (December 2023).

The Department stated (December 2023) that all the equipment and machinery of the H1N1 Lab supplied by the vendor is awaiting final testing and commissioning and the lab can be operationalised by the end of January 2024.

Delay in operationalising the laboratory had deprived patients of the advanced healthcare facilities.

➢ Delay in establishment of a State Cancer Institute

For providing state of the art facilities to cancer patients and conducting research activities in various aspects of cancer care, the Ministry of Health & Family Welfare (MoH&FW), Government of India (GoI) communicated (February/ March 2014) its approval for setting up of a State Cancer Institute (SCI) at GMC Jammu under the Centrally Sponsored Scheme-National Programme for Prevention of Cancer, Diabetes, Cardio Vascular Disease and Strokes (NPCDCS). Against ₹ 120 crore proposed by the Principal GMC Jammu, MoH&FW approved (March 2018) grant-in-aid of ₹ 104 crore (civil works: ₹ 32 crore and equipment: ₹ 72 crore) and an amount of ₹ 16 crore was to be contributed by GoJ&K as matching State share.

Audit noticed that H&MED released (January 2020 and January 2021) Central share of ₹ 30.06 crore[17] to the Principal GMC for construction of the SCI and the work was stipulated to be completed by December 2021. Out of this, an expenditure of ₹ 29.62 crore was incurred by the executing agency (Chief Engineer PW (R&B) Department Jammu). Audit however noticed that against the targeted date of completion of March 2022, 90 *per cent* civil works have been completed (November 2023) and balance work stopped by the contractor due to non-payment of bills.

For procurement of the equipment, H&MED placed (January 2020 and January 2021) ₹ 40.14 crore[18], received from GoI for purchase of equipment, at the disposal of

16 500 KVA DG set with AMF panel, water softener plant, RO Plant and 1 MVA electric sub-station.
17 January 2020: ₹ 13.06 crore & January 2021: ₹ 17 crore
18 January 2020: ₹ 30.00 crore & January 2021: ₹ 10.14 crore

Director Finance, H&MED out of which ₹ 2.35 crore was released (December 2020) to Principal GMC for replacement of radiation source and upgradation of Tele-cobalt machine and ₹ 37.79 crore[19] was transferred (December 2020 and January 2021) to JKMSCL for purchase of the equipment. Out of ₹ 2.35 crore released to Principal GMC, ₹ 0.54 crore was advanced (April 2021) to Accounts Officer, Board of Radiation & Isotope Technology (BRIT) Mumbai for replacement of radiation source and balance amount of ₹ 1.81 crore was transferred (December 2021) to JKMSCL for purchase of new Tele-Cobalt machine thereby taking the total amount transferred to JKMSCL for purchase of equipment to ₹ 39.61 crore[20]. The Principal, Govt. Medical College Jammu intimated (December 2023) that the equipment is under procurement and is expected to be installed by March 2024.

Thus, due to slow execution of works by the executing agency, establishment of SCI at GMC Jammu has been delayed which subsequently delayed the procurement of necessary equipment and consequential deprival of advanced healthcare and specialised treatment to cancer patients.

➢ Regional Cancer Centre under National Cancer Control Programme

Ministry of Health & Family Welfare (MoH&FW), GoI approved (March 2008) development of GMC Jammu and its Associated Hospitals as additional Regional Cancer Centre (RCC) under the revised National Cancer Control Programme (NCCP). For managing the affairs and to oversee all aspects of development of the RCC, a Governing Body (GB) was also constituted (July 2008) under the Chairmanship of Secretary, H&MED. For carrying out construction activities and purchase of equipment, funds of ₹ three crore was placed (April 2008) at the disposal of Principal, GMC, Jammu. Out of ₹ three crore, an amount of ₹ 0.10 crore was to be utilised for construction activities. The RCC was also entitled to further funds of ₹ two crore which was to be released by MoH&FW after ascertaining the progress of the scheme.

Audit observed that for about six and a half years from the date of receipt of funds from GoI, no action was taken by the GB to oversee development of RCC except release (August 2012) of ₹ 10 lakh to the executing agency for civil works. Finally, a decision was taken (September 2014) for purchase of equipment amounting to ₹ 2.90 crore. An amount of ₹ 2.88 crore was spent between July 2014 and December 2020 for procurement of equipment and on miscellaneous items including transfer of ₹ 29.63 lakh to JKMSCL for procurement of pathology equipment. However, due to non-maintenance of relevant records, the status of receipt of equipment from JKMSCL could not be ascertained.

No further expenditure was incurred after December 2020 and ₹ 1.75 crore[21] (including interest of ₹ 1.63 crore) was lying unutilised (November 2023) with GMC

[19] ₹ 27.65 crore in December 2020 & ₹ 10.14 crore in January 2021
[20] ₹ 1,014.28 lakh, ₹ 2,765 lakh & ₹ 181.45 lakh
[21] FDR: ₹ 175.16 lakh & Bank: ₹ 0.27 lakh

Jammu. Due to slow progress in implementation of the scheme, the RCC at GMCH Jammu was deprived of the remaining amount of ₹ two crore receivable from GoI.

➢ Non-acquisition of land for construction of building

The Controller, Drug and Food Control Organisation released (August 2015 and February 2016) funds of ₹ 0.35 crore to the Deputy Commissioner, Pulwama for acquisition of land for construction of office building of Assistant Controller, Drugs and Assistant Commissioner, Food Safety in District Pulwama. These funds were transferred (March 2016) to the Collector, Land Acquisition, Pulwama. It was noticed (July 2022) by Audit that the land had not been transferred for construction of office building resulting in blocking of a sum of ₹ 0.35 crore for over seven years.

The Accounts Officer stated (August 2022) that the matter would be taken up with the Collector, Land Acquisition, Pulwama through Deputy Drug Controller, Drugs and Food Control Organisation, Kashmir for transfer of the land in favour of this organisation.

5.9 Deficiencies in infrastructure facilities as per the Medical Council of India Guidelines

Medical Council of India (MCI), replaced (September 2020) by National Medical Commission (NMC) prescribed minimum standard requirements for every Medical College on the basis of annual MBBS admission intake capacity. As per regulations, a Medical College and Associated Hospitals shall create infrastructure as per the minimum standards prescribed therein. Records revealed that GMC Jammu had annual MBBS admission intake capacity of 100 students during the period 2016-17 to June 2018. It was increased to 150 seats from June 2018. The intake capacity was subsequently increased (June 2019) to 180 students. Audit noticed that 20 Departments[22] were functional in GMC Jammu as per prescribed regulations. However, the infrastructure available in various Departments of GMC Jammu was far below the minimum standards prescribed by MCI.

The MCI minimum standard requirements for the Medical College provides for accommodation and infrastructure facilities for nine Departments. Out of nine Departments[23] of GMC Jammu for which minimum standard requirements for accommodation and infrastructure were prescribed by MCI, only two Departments (Blood Bank and Biochemistry) had complied with the basic minimum requirements. The deficiencies in the remaining seven Departments were far less than the minimum standard requirements prescribed by MCI. It was noticed that five Departments[24] did not have basic facility of lecture halls and one Department[25] did not have library.

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22 Excluding dentistry

23 Anatomy, Physiology, Biochemistry, Pathology, Microbiology, Pharmacology, Forensic Medicine, Community Medicine and Blood Bank.

24 Pathology, Microbiology, Pharmacology, Forensic Medicine and Community Medicine

25 Microbiology.

MCI had also conducted annual inspections of GMC Jammu for checking its compliance with minimum standard requirements but the reports thereof were not made available to Audit due to which observations made by MCI could not be ascertained.

5.10 Conclusion

There was shortage of health institutions (Sub-Centres and CHCs) in the UT of J&K. Shortage of beds were noticed in PHCs, CHCs and SDHs. Requisite number of HWCs have been upgraded but there was acute shortage of infrastructure, availability of services, human resources, diagnostic services etc. in the HWCs in the selected Districts. Out of 415 construction works taken up for execution under NHM/ PMDP/ Languishing projects programme, only 177 works were completed and 238 works remained incomplete resulting in denial of the intended benefits to the general public. The building infrastructure created under District Plan/ NABARD/ BADP etc. either remained incomplete or unutilised either due to dispute or non-completion of balance minor works. Out of available 170 residential quarters, only 89 quarters were allotted to the staff and remaining 81 quarters were either requiring repair/ renovation, occupied by other Department or not taken over by the Health Department from executing agencies for execution of balance works. Moreover, in 52 health institutions, no residential quarters were available for the staff. Further, the Swine Flu H1N1 Laboratory at GMCH Jammu could not be made functional.

5.11 Recommendations

In light of the audit findings, GoJ&K may consider:

- ***Setting up of adequate number of health institutions viz., SCs/ CHCs so that universal accessibility of healthcare is provided to all sections of society;***
- ***Strengthening HWCs by providing requisite infrastructure, medicines, equipment and diagnostic services to deliver Comprehensive Primary Health Care as envisaged under the operational guidelines of HWC;***
- ***To look into the issues of delays in commencement and completion of planned infrastructural works with a view to remove bottlenecks and ensure speedy completion; and***
- ***Provision of functional residential quarters for ensuring round-the-clock availability of medical/ paramedical staff.***

CHAPTER-VI
FINANCIAL MANAGEMENT

CHAPTER-VI

Financial Management

6.1 Introduction

Health facilities in Jammu and Kashmir work under the Health & Medical Education Department (H&MED).

6.2 Expenditure on healthcare *vis-a-vis* budget allotment

Total expenditure of GoJ&K during 2016-17 to 2021-22 was ₹ 3,60,198.78 crore while expenditure on the Health sector was ₹ 25,127.63 crore against budget allotment of ₹ 30,513.98 crore. Expenditure on the Health sector thus accounted for 6.97 *per cent* of the total expenditure of the State/ UT. The position of investment in the Health sector in the State/UT during the period 2016-2022 is given in **Table 6.1.**

Table 6.1: Statement showing the investment in Health sector in State/ UT during 2016-2022

(₹ in crore)

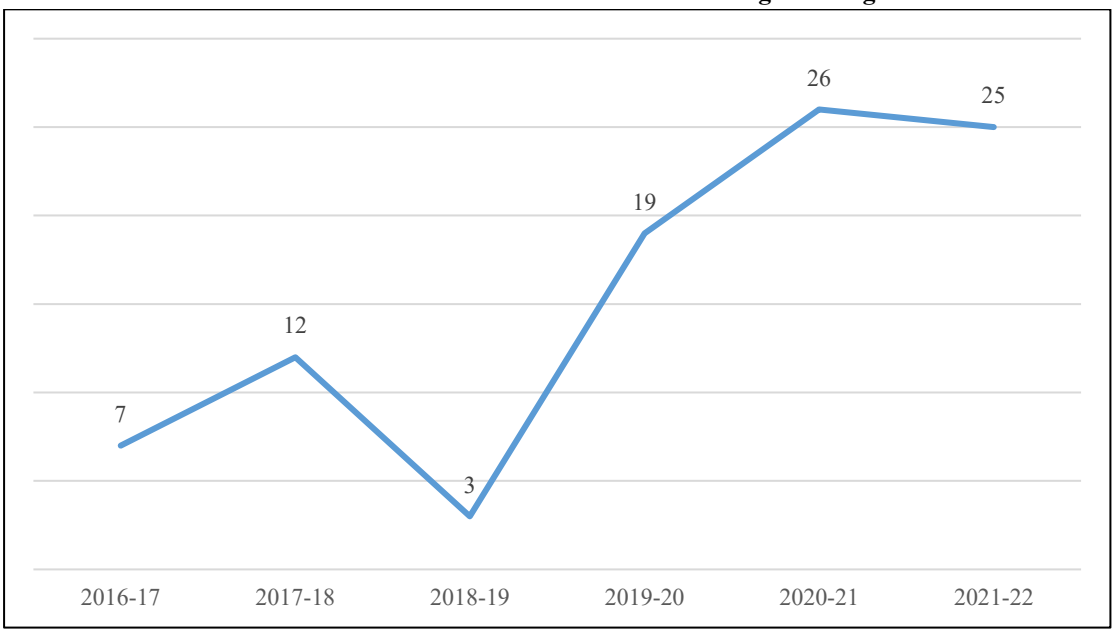
Year	State/ UT GSDP	Total expenditure of State/UT[1]	Budgetary outlay on Health sector			Expenditure on Health sector			Shortfall in utilisation of Health budget	Percentage of total expenditure on Health sector *vis-a-vis* State GSDP	Percentage of expenditure on Health sector *vis- a-vis* total expenditure of State/ UT Government
			CS	SS	Total	CS	SS	Total			
2016-17	1,24,848	48,097.71	393.49	2,643.12	3,036.61	394.48	2,415.86	2,810.34	226.27	2.25	5.84
2017-18	1,39,709	51,269.38	595.59	2,913.15	3,508.74	607.58	2,470.13	3,077.71	431.03	2.20	6.00
2018-19	1,59,859	64,503.55	596.45	3,982.77	4,579.22	1,158.47	3,265.29	4,423.76	155.46	2.76	6.86
2019-20 (01.04.2019 to 30.10.2019)		**34,766.01**		**2,277.07**			**2,093.51**		**183.56**		
2019-20 (31.10.2019 to 31.03.2020)		**28,141.63**		**2,962.37**			**2,150.88**		**811.49**		
2019-20	1,64,203	62,907.64	1,328.63	3,910.81	5,239.44	895.59	3,348.80	4,244.39	995.05	2.58	6.75
2020-21	1,67,652	63,104.13	1,678.21	4,993.37	6,671.58	932.48	4,024.96	4,957.44	1,714.14	2.95	7.85
2021-22	1,99,917	70,316.37	1,771.73	5,706.66	7,478.39	972.51	4,641.47	5,613.98	1,864.41	2.80	7.98
		3,60,198.78			**30,513.98**			**25,127.63**			

(Source: Figures from Ministry of Statistics and Program Implementation, State/UT Finance Accounts Vol-I and Appropriation Accounts 2016-17 to 2021-22)

Shortfall in utilisation of allotted funds ranged between three *per cent* and 26 *per cent* during the period 2016-2022. The trend of shortfall in utilisation of Health budget is depicted in **Chart 6.1**.

[1] Excluding Loans & Advances and Public Debt

Chart 6.1: Trend of shortfall in utilisation of Health budget during 2016-2022



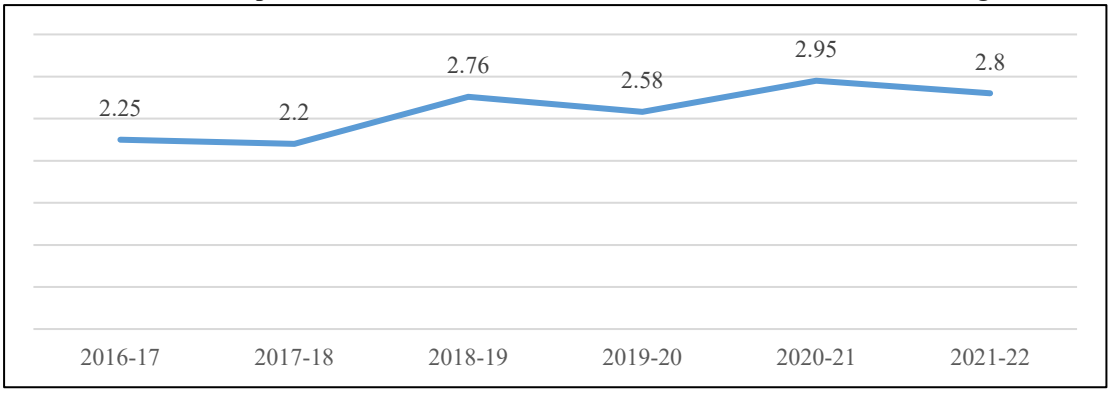
Shortfall in utilisation of funds has significantly increased from 2018-19 onwards as the Department failed to utilise available funds for Revenue and Capital expenditure as depicted in **Table 6.2**.

6.3 Funding target for Health sector

The National Health Policy, 2017 envisages increase of Government expenditure on health to 2.5 *per cent* of GDP by 2025 and increase of State sector health spending to more than eight *per cent* of the State budget by 2020. Audit noticed that:

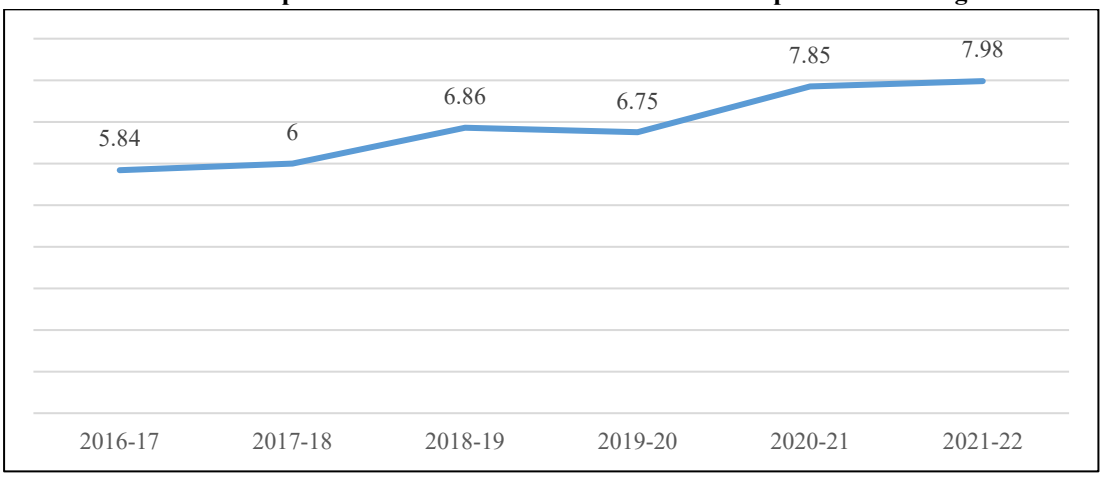
- The expenditure on Health sector to State/ UT GSDP had increased from 2.25 *per cent* in 2016-17 to 2.95 *per cent* in 2020-2021 but decreased to 2.80 *per cent* during 2021-22 as depicted in **Chart 6.2**.

Chart 6.2: Trend of expenditure on Health sector in the State/ UT *vis-a-vis* GSDP during 2016-2022



- Expenditure on Health sector *vis-a-vis* total expenditure of the State/UT Government had increased from 5.84 *per cent* in 2016-17 to 7.98 *per cent* in 2021-2022 as depicted in **Chart 6.3**.

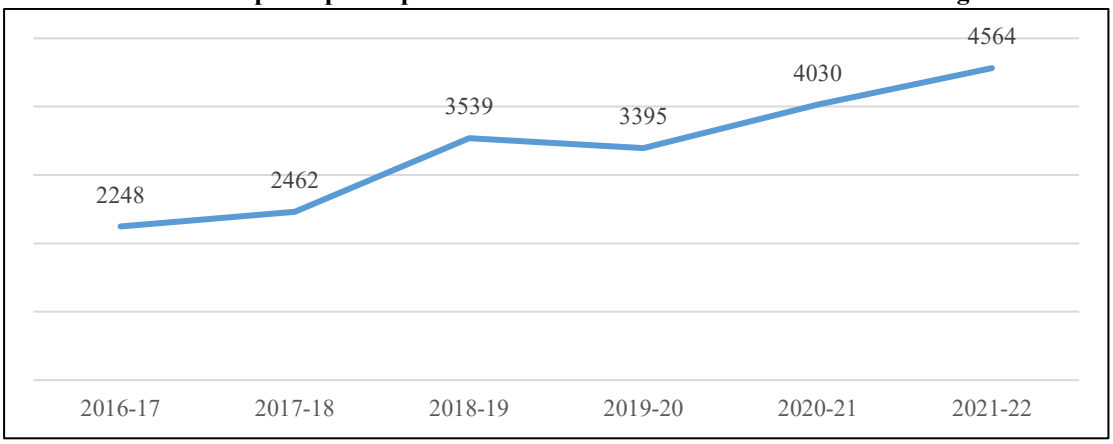
Chart 6.3: Trend of expenditure on Health sector *vis-a-vis* total expenditure during 2016-2022



Thus, there is still scope for the Government to increase expenditure on the Health sector.

Further, the per capita expenditure[2] in the Health sector increased from ₹ 2,248 in 2016-17 to ₹ 4,564 in 2021-22 as shown in **Chart 6.4**.

Chart 6.4: Trend of per capita expenditure in Health sector in the State/ UT during 2016-2022



(Source: J&K Government Appropriation Accounts for the years 2016-17 to 2021-22 and Census-2011)

Expenditure on different functions of the Government is either through Revenue expenditure or Capital expenditure. Revenue expenditure is that which has to be incurred for running of administration, maintenance of assets already created or meeting of pensionary and debt obligations of the Government. Capital expenditure, on the other hand, refers to activities which are undertaken as a result of implementation of pre-conceived plans.

Trend of expenditure under Revenue and Capital heads during 2016-2022 is given in **Table 6.2.**

[2] After taking into consideration the population of 1,25,41,302 for the erstwhile State of Jammu and Kashmir from 01.04.2016 to 30.10.2019 and 1,22,67,013 for UT of Jammu and Kashmir from 31.10.2019 to 31.03.2021 after excluding the population of UT of Ladakh (Census-2011)

Table 6.2: Expenditure incurred vis-a-vis Budget allotment under revenue and capital heads

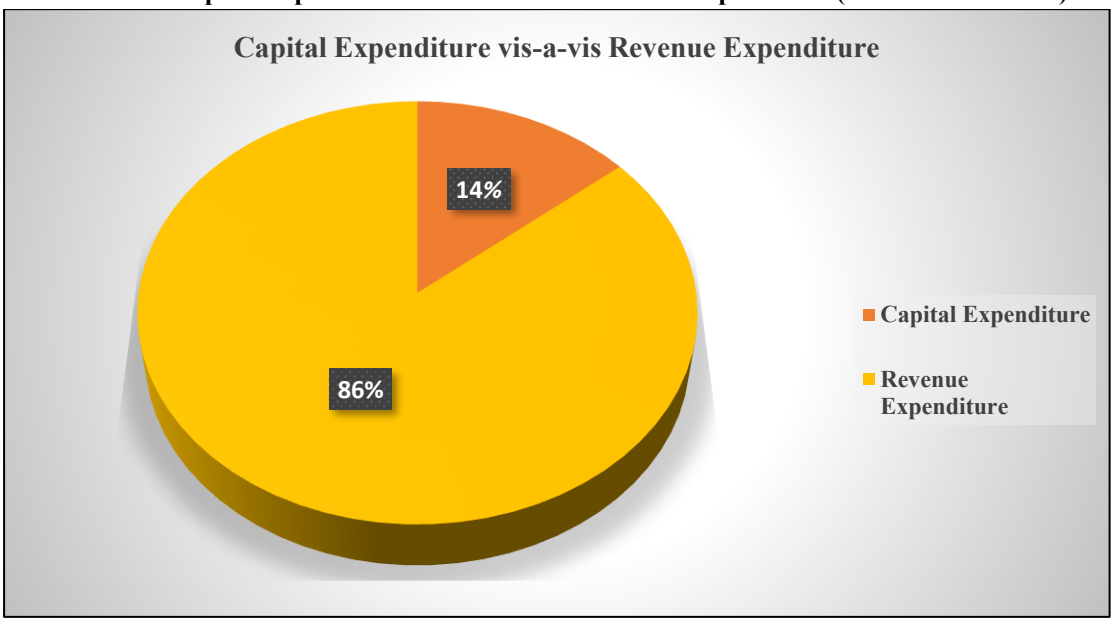
(₹ in crore)

Year	Revenue			Capital		
	Allotment	Expenditure	Shortfall percentage of expenditure against allotment	Allotment	Expenditure	Shortfall percentage of expenditure against allotment
2016-17	2,433.21	2,375.49	2	603.40	434.85	28
2017-18	2,715.73	2,567.13	5	793.01	510.58	36
2018-19	3,725.63	3,549.40	5	853.59	874.36	-
2019-20	4,385.69	3,699.07	16	853.75	545.33	36
2020-21	5,216.51	4,427.59	15	1,455.07	529.85	64
2021-22	5,907.72	4,977.19	16	1,570.67	636.79	59
Total	**24,384.49**	**21,595.87**		**6,129.49**	**3,531.76**	

(Source: J&K Government Appropriation Accounts for the years 2016-17 to 2021-22)

There was decline in utilisation of funds received under Capital heads during 2016-2022 except in 2018-19. Out of total expenditure of ₹ 25,127.63 crore incurred on Health during 2016-22, Revenue expenditure was ₹ 21,595.87 crore (86 *per cent*) while Capital expenditure was ₹ 3,531.76 crore (14 *per cent*) as indicated in **Chart 6.5**.

Chart 6.5: Capital Expenditure status *vis-a-vis* Revenue Expenditure (2016-17 to 2021-22)

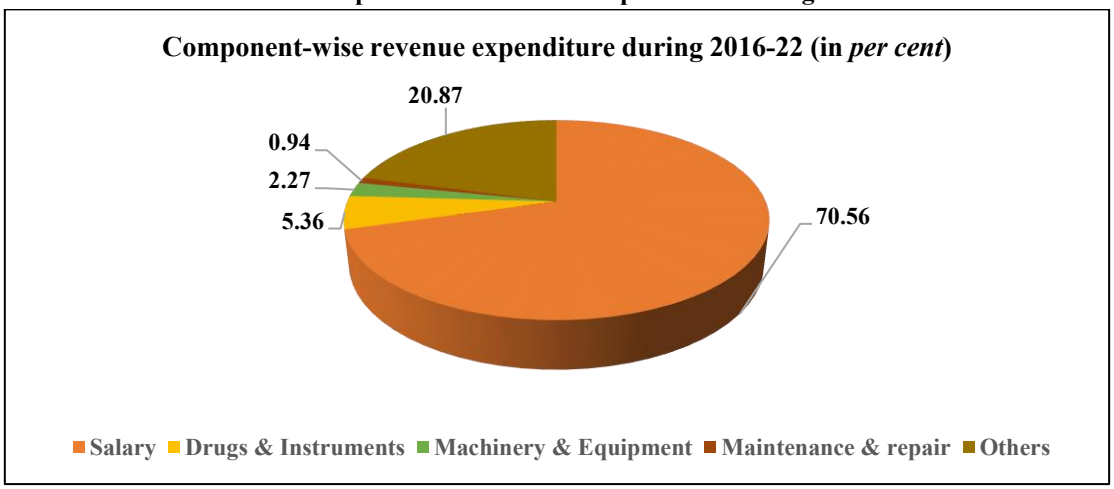


H&MED was not able to utilise Government funds due to shortage of manpower, inefficient procurement system in JKMSCL, delay in construction works etc. as discussed in **Chapters II, IV** and **V** of this report.

6.4 Component-wise revenue expenditure

The component-wise revenue expenditure incurred during 2016-2022 is given in **Chart 6.6**.

Chart 6.6: Component-wise revenue expenditure during 2016-2022



6.5 Allotment and Expenditure in selected Districts

Details of year-wise allotment of funds and expenditure incurred in the six sampled districts during 2016-22 are given in **Table 6.3**.

Table 6.3: Allotment and Expenditure in test-checked districts

(₹ in crore)

Year	Anantnag[3]		Ganderbal		Jammu		Kupwara		Ramban		Udhampur	
	B	E	B	E	B	E	B	E	B	E	B	E
2016-17	NA	NA	22.02	21.92 (100)	78.27	76.23 (97)	62.04	61.09 (98)	20.34	19.88 (98)	42.53	41.92 (99)
2017-18	NA	NA	23.01	22.91 (100)	82.68	74.23 (90)	83.87	77.44 (92)	18.44	17.90 (97)	43.34	41.28 (95)
2018-19	91.71	89.34 (97)	35.49	35.08 (99)	129.64	119.71 (92)	108.14	100.61 (93)	38.88	36.48 (94)	63.38	61.08 (96)
2019-20	72.43	55.02 (76)	41.51	31.67 (76)	49.81	47.39 (95)	109.21	85.47 (78)	31.74	23.16 (73)	66.57	57.39 (86)
2020-21	85.69	85.41 (100)	33.73	33.59 (100)	109.69	107.43 (98)	83.39	81.79 (98)	28.11	27.30 (97)	61.65	59.59 (97)
2021-22	96.22	95.75 (100)	38.08	37.69 (99)	130.68	126.51 (97)	94.49	91.16 (96)	37.50	29.55 (79)	75.97	69.21 (91)

(B: Budget; E: Expenditure)
(Source: Information furnished by concerned CMOs)
(Figures in bracket indicates percentage)

Utilisation of funds in the selected six districts was satisfactory and ranged between 73 *per cent* and 100 *per cent* during 2016-22.

[3] During the years 2016-17 and 2017-18, figures of budget and expenditure were not consolidated at district level in Anantnag District.

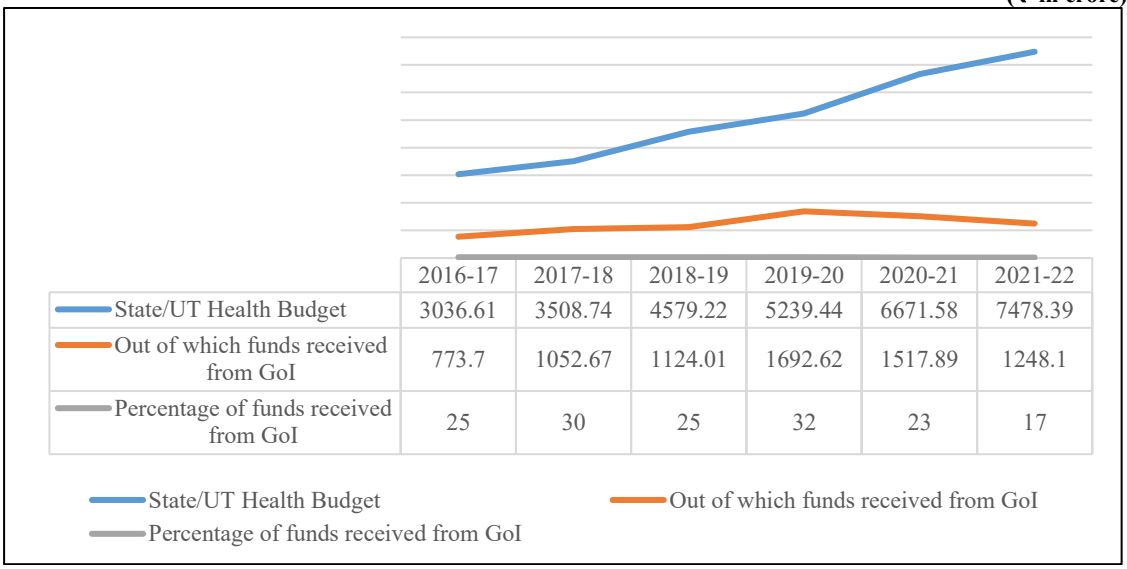
6.6 Funds received from GoI

Health being a State subject, the Central Government supplements the efforts of the State Governments in delivery of Health services mainly through Centrally Sponsored Schemes (CSSs) such as National Health Mission (NHM), National AYUSH Mission (NAM), Prime Minister's Development Package (PMDP) and Establishment of New Medical Colleges etc. Besides, National AIDS Control Programme (NACP), a Central Sector Scheme was also being implemented in the UT of J&K.

The percentage of funds received from GoI in comparison to the State/ UT Health budget ranged between 17 *per cent* and 32 *per cent* as shown in **Chart 6.7**.

Chart 6.7: Trend of percentage of State/ UT Health budget received from GoI

(₹ in crore)



	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
State/UT Health Budget	3036.61	3508.74	4579.22	5239.44	6671.58	7478.39
Out of which funds received from GoI	773.7	1052.67	1124.01	1692.62	1517.89	1248.1
Percentage of funds received from GoI	25	30	25	32	23	17

The percentage of funds received from GoI declined from 25 *per cent* in 2016-17 to 17 *per cent* in 2021-22.

The Director Finance, H&MED, J&K stated (December 2023) that in the interest of better patient care, developmental projects of non-recurring nature were approved under various Centrally Sponsored Schemes leading to increase in receipts from GoI. However, during the year 2021-22, less funds were received by the Department resulting in decline in the receipts.

6.6.1 Utilisation of funds under NHM

Among the CSSs, National Health Mission (NHM) is the flagship scheme of GoI to improve the overall Health status of the country by providing universal access to equitable, affordable, and quality healthcare services that are accountable and responsive to people's needs.

The funding pattern under the Mission was in the ratio of 90:10 between GoI and GoJ&K. The fund flow from GoI to Health Institutions (HIs) is as following:

Funds are released by GoI to the Finance Department of GoJ&K, which releases these funds to the State Health Society[4] (SHS) for further release to the HIs through District Health Societies and Block Medical Officers. The position of funds available and expenditure incurred under the Mission during 2016-2022 is given in **Table 6.4**.

Table 6.4: Funds available and expenditure incurred under NHM during 2016-2022

(₹ in crore)

Year	Opening balance	Release by GoI	State share	Total funds available	Expenditure *per cent*	Closing balance
2016-17	132.86	366.94	42.95	542.75	422.91 (78)	119.84
2017-18	119.84	440.96	54.69	615.49	432.86 (70)	182.63
2018-19	182.63	466.62	22.50	671.75	485.21 (72)	186.54
2019-20	186.54	641.05	99.60	927.19	737.15 (80)	190.04
2020-21	190.04	609.64	51.75	851.43	648.62 (76)	202.81
2021-22	202.81	668.93	102.98	974.72	865.49 (89)	109.23
Total		**3,194.14**	**374.47**		**3,592.24**	

(Source: Data furnished by NHM, J&K)

Audit noticed that funds ranging between 70 *per cent* and 89 *per cent* were utilised during 2016-2022. However, due to non-spending of the allotted funds, the closing balances increased from ₹ 119.84 crore in March 2017 to ₹ 202.81 crore in March 2021. The same, however, decreased to ₹ 109.23 crore ending March 2022 after incurring an expenditure of ₹ 865.49 crore during 2021-22.

The Mission Director, NHM, J&K stated (December 2022) that release of funds by the GoI/ GoJ&K at the fag end of the financial year had resulted in low utilisation of funds.

With effect from 1st July 2021, the revised procedure for release of funds under CSSs, including for National Health Mission, and monitoring utilisation of the funds released as stipulated by the Department of Expenditure, Ministry of Finance envisages that the entire unspent amount was required to be remitted by all implementing agencies to a Single Nodal Account (SNA). The Department, however, failed to provide the related documents in the absence of which Audit could not ascertain the actual amount remitted to the SNA. The Financial Advisor and CAO, NHM, J&K stated (September 2023) that preparation of details of the remittance of

[4] Responsible for implementation of the Mission in the State/ UT through Governing Body and Executive Committee.

unspent balances to SNA account is a time consuming process and some time was needed to share data.

6.6.1.1 Budget allocation and expenditure under National Health Mission

There was wide variation in the Budget provision and actual expenditure under NHM during 2016-17 to 2021-22. Important components under NHM with high variations in Budget provision and actual expenditure are shown in **Table 6.5**.

Table 6.5: Budget allocation and Expenditure on important components under NHM

Name of the scheme	Total allotment for 2016-17 to 2021-22 (₹ in crore)	Total expenditure for 2016-17 to 2021-22 (₹ in crore)	Percentage of total expenditure to allotment	Percentage utilisation					
				2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Reproductive, Maternal, Newborn Child Health plus Adolescent Health	1,065.38	645.05	61	81	67	66	73	40	42
Routine Immunisation and Integrated Pulse Polio Immunisation	72.64	39.25	54	54	54	77	65	46	37
Health System Strengthening under NRHM	2,872.71	1,714.68	60	67	58	65	59	54	61
National Vector Borne Disease Control Programme	5.82	3.07	53	92	61	42	54	44	31
Revised National Tuberculosis Control Programme	112.71	73.58	65	44	47	71	61	76	90
National Leprosy Elimination Control Programme	4.55	3.65	80	34	43	253	144	60	45
Integrated Disease Surveillance Programme	21.66	16.72	77	71	90	1,322	40	143	86

(Source: State Programme Implementation Plan and Financial Management Reports)

As can be seen from the **Table 6.5**, the percentage utilisation of funds varied across the years during 2016-17 to 2021-22 as mentioned below:

- In case of Reproductive, Maternal, Newborn Child Health plus Adolescent Health, out of the allotment of ₹ 1,065.38 crore, only ₹ 645.05 crore (61 *per cent*) was utilised.

- In case of Routine Immunisation and Integrated Pulse Polio Immunisation, the percentage of expenditure against allotment ranged between 37 and 77 *per cent*.

- Allotment for the Health System Strengthening under NRHM, was increased from ₹ 164.05 crore in the year 2016-17 to ₹ 697.92 crore in the year 2021-22 but utilisation of funds was only 61 *per cent* during 2021-22.

- In case of National Vector Borne Disease Control Programme and Revised National Tuberculosis Control Programme, utilisation of funds was only 53 *per cent* and 65 *per cent* respectively.

- There was wide variation in utilisation of funds under National Leprosy Elimination Control Programme during 2016-17 to 2020-21. Utilisation of funds was 34 *per cent* in 2016-17 and 253 *per cent* in 2018-19. Similarly, in respect of Integrated Disease Surveillance Programme, utilisation of funds was 1,322 *per cent* in 2018-19 and 40 *per cent* in 2019-20. The Financial Advisor and CAO, NHM, J&K stated (December 2023) that the expenditure was made on the approved activities out of the committed unspent balance of the last financial year(s).

6.6.1.2 Delay in release of funds received under NHM

Funds of ₹ 2,410.86 crore released by the GoI, Ministry of Health and Family Welfare (MoH&FW) to GoJ&K during 2016-17 to 2020-21 were not released by the Finance Department to State Health Society within the stipulated period of 15 days. Delay in release of funds ranged between 10 days and 615 days.

The Financial Advisor and CAO, NHM, J&K stated (July 2022) that after fulfilment of procedural formalities and availability of liquidity with the Finance Department, State Health Society receives the NHM funds from the J&K Government. However, some times the Ministry of Health and Family Welfare, GoI releases funds to the State Health Society at the fag end of the financial year due to which GoJ&K would not be able to release the funds during the financial year for which it was sanctioned.

6.6.1.3 Utilisation Certificates awaited

For implementation of various programmes of NHM, ₹ 39.21 crore was transferred by Principal, Government Medical College (GMC), Jammu and ₹ 5.18 crore by the

Principal, GMC, Srinagar to various HIs/ Departments[5] during 2016-2021. However, detailed accounts and Utilisation Certificates in respect of these funds were not obtained (September 2023) from the concerned HIs/ Departments to ascertain whether funds were utilised for the intended purposes of the programmes.

6.6.1.4 Non-utilisation of funds under Ayushman Bharat-Health and Wellness Centres

The National Health Policy, 2017 recommended strengthening delivery of primary healthcare through establishment of Health and Wellness Centres (AB-HWCs) as the platform to deliver comprehensive primary healthcare. For primary healthcare to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspect of care. The GoI announced (February 2018) creation of HWCs by transforming existing Sub-Health Centres and Primary Health Centres.

The position of funds available and expenditure incurred under AB-HWCs during the period 2018-22 is given in **Table 6.6**.

Table 6.6: Funds available and expenditure incurred under AB-HWCs in J&K during 2018-22

(₹ in crore)

Year	Opening Balance	Funds released during the year	Total funds available during the year	Expenditure incurred during the year (*per cent*)	Closing Balance
2018-19	0.00	21.52	21.52	5.89 (27)	15.63
2019-20	15.63	26.69	42.32	20.19 (48)	22.13
2020-21	22.13	4.68	26.81	7.89 (29)	18.92
2021-22	18.92	8.08	27.00	9.97 (37)	17.03

(Source: Figures furnished by the SHS, NHM)

- Utilisation of funds ranged between 27 *per cent* and 48 *per cent* during the period 2018-2022 with the result the closing balance increased from ₹ 15.63 crore in March 2019 to ₹ 17.03 crore in March 2022.
- The unspent balances in the six selected Districts ranged between 05 *per cent* and 48 *per cent* during 2018-2022. As a result, there were deficiencies in providing healthcare services and civil infrastructure in the Health and Wellness Centres as discussed in **Chapter V** of this report.

6.6.2 National AIDS Control Programme

For checking spread of HIV[6]/AIDS[7], National AIDS Control Programme (NACP) is implemented in the State/ UT of J&K by J&K AIDS Control Society (JKACS) with the help of H&MED, other Government departments, Non-Government Organisations (NGOs), civil society etc. The programme is 100 *per cent* funded by GoI.

[5] SMGS Hospital Jammu; SSH Jammu; GMCH Jammu and HODs, Lalla Ded Hospital Srinagar, G.B.Pant Hospital Srinagar, SMHS Hospital, Srinagar and Bone & Joint Hospital, Srinagar

[6] Human Immunodeficiency Virus

[7] Acquired Immuno Deficiency Syndrome

The position of funds received under NACP and expenditure incurred thereagainst in the State/ UT during 2016-22 is given in **Table 6.7**.

Table 6.7: Funds received under NACP and expenditure incurred thereagainst during 2016-2022

(₹ in crore)

Year	Opening balance	Funds received during the year including interest	Total funds available	Expenditure during the year (*per cent*)	Closing balance
2016-17	0.06	8.00	8.06	6.80 (84)	1.26
2017-18	1.26	8.01	9.27	7.15 (77)	2.12
2018-19	2.12	8.64	10.76	10.01 (93)	0.75
2019-20	0.75	12.09	12.84	10.48 (82)	2.36
2020-21	2.36	14.57	16.93	11.78 (70)	5.15
2021-22	5.15	17.33	22.48	15.06 (67)	7.42

(Source: Information furnished by J&K AIDS Control Society)

As indicated in the **Table 6.7**, utilisation of funds by JKACS had declined from 84 *per cent* in 2016-17 to 67 *per cent* in 2021-22 with the result that the closing balance increased by about six times as of March 2022 as compared to March 2017. Non-utilisation of funds resulted in non-achievement of targets of activities under Information, Education and Communication (IEC) as depicted in Chapter VII of this report.

On being pointed out, the Assistant Director (F), JKACS stated (September 2023) that during COVID-19 period the funds utilised were below the estimated expenditure for the financial years 2020-21 and 2021-22. It was further stated that the expenditure was booked only after the submission of Red account[8]/ Utilisation Certificates by the District authorities and other agencies after the close of the financial year due to which there were unutilised funds at the end of the financial year.

6.6.3 National AYUSH Mission

Government of India (GoI) launched National AYUSH Mission (NAM) during 12th Plan to promote AYUSH medical system in States/ UTs. Under NAM, financial assistance is being provided by Ministry of AYUSH (MoA) to the State/ UT Governments for promotion of AYUSH healthcare facilities as per proposals made in the State Annual Action Plan (SAAP). MoA sanctions AYUSH funds on the basis of SAAPs submitted to it by GoJ&K which releases funds to the Directorate of AYUSH (DoA) for implementation of NAM in the State/ UT.

6.6.3.1 Receipt and utilisation of funds under NAM

During 2016-22, funds of ₹ 94.37 crore were approved by GoI as per the SAAP. Keeping in view the funding pattern of 90:10, GoI released ₹ 83.45 crore to GoJ&K out of due share of ₹ 84.93 crore. GoJ&K released ₹ 8.62 crore to DoA out of due share of ₹ 9.44 crore. Out of ₹ 83.45 crore released by GoI, GoJ&K released ₹ 79.85 crore to DoA during 2016-22.

[8] Detailed Contingent bills

Position of Central funds/ State share released by GoJ&K under NAM and expenditure incurred thereagainst by Directorate of AYUSH during 2016-2022 is given in **Table 6.8**.

Table 6.8: Position of funds released and expenditure incurred under NAM during 2016-22

(₹ in crore)

Year	Opening Balance	Funds received		Interest earned	Total availability	Expenditure incurred	Unspent balance (percentage of unspent balance to total availability)
		Central Share	State/UT Share				
2016-17	2.47[9]	7.08	0.00	0.00	9.55	0.55	9.00 (94)
2017-18	9.00	0.85	0.00	0.00	9.85	4.46	5.39 (55)
2018-19	5.39	16.06	0.00	0.00	21.45	6.67	14.78 (69)
2019-20	14.78	18.93	0.00	0.00	33.71	14.21	19.50 (58)
2020-21	19.50	9.63	0.39	0.46	29.98	18.89	11.09 (37)
2021-22	11.09	27.30	8.23	0.42	47.04	34.18	12.86 (27)
		79.85	**8.62**	**0.88**		**78.96**	

(Source: Figures furnished by the Directorate of AYUSH)

DoA was able to utilise ₹ 78.96 crore (86 *per cent*) of available funds of ₹ 91.82 crore[10]. There was, however, improvement in utilisation of funds from during 2019-22.

The GoI released funds to the State/ UT Government under NAM for approved activity of a particular year. The funds were required to be further released by the State/ UT Government within 15 days of receipt of funds from GoI.

Audit observed that after receipt of Central funds, GoJ&K had released the funds to DoA with delays[11] as detailed in **Table 6.9.**

Table 6.9: Delay in release of Central funds by GoJ&K

Delay (range in days)	Amount ₹ in crore
1-50	18.32
51-100	28.02
101-150	23.95
151-200	9.08
201 and above	0.48
Total	**79.85**

(Source: Information furnished by DoA)

Audit further noticed that in one case GoJ&K had released funds after 1,329 days of receipt of funds from GoI.

[9] Includes revalidated funds of ₹ 0.46 crore

[10] OB: ₹ 2.47 crore +CS: ₹ 79.85 crore + SS: ₹ 8.62 crore + Interest: ₹ 0.88 crore

[11] The days were calculated after excluding 15 days

The Chief Accounts Officer, Directorate of AYUSH, J&K stated (January 2025) that owing to procedural delay at higher authority level, the funds could not be released to SNA in time. Further, due to revised procedure, the flow of funds under NAM has improved.

6.6.4 Submission of wrong Utilisation Certificate

The Ministry of Health and Family Welfare, GoI sanctioned (January 2017) ₹ 13 crore for establishment of 'Modern Drug and Food Testing Laboratory at Lakhanpur, Kathua' under CSS 'Strengthening of State Drug Regulatory System'. The amount of ₹ 13 crore was released (January 2018) by H&MED at the fag end of the year in favour of Controller, Drug and Food Control Organisation, J&K after a delay of about one year. Due to non-utilisation of the sanctioned funds, ₹ 13 crore was revalidated (August 2018) by H&MED in favour of Controller, Drug and Food Control Organisation, J&K. Audit noticed that the latter had submitted (January 2019) Utilisation Certificate for ₹ 11.26 crore out of ₹ 13 crore to GoI well before accord of sanction (March 2019) by H&MED for advance drawal of ₹ 13 crore for establishment of 'Modern Drug and Food Testing Laboratory at Lakhanpur, Kathua'. The UC in January 2019 was furnished in anticipation of incurring of expenditure only to seek further funding under the project.

The State Drugs Controller, Drug and Food Control Organisation Jammu and Kashmir stated (January 2025) that the latest and corrected Utilisation Certificate stands submitted to the competent authority in January 2024.

6.6.5 Non-utilisation of funds

- The funds received for various schemes/programmes were either utilised partially or not utilised at all in GMC, Jammu. The unutilised funds were kept under fixed deposits for years together with a view to earn interest instead of utilising these for medical/ patient care services. An amount of ₹ 8.15 crore [including ₹ 1.75 crore pertaining to National Cancer Control Programme (NCCP) launched by the GoI in March 2008] was kept under fixed deposits as of September 2022. The Department could not furnish details of schemes/ programmes to which the remaining ₹ 6.40 crore pertained as no related records were maintained.

- In compliance to the sanction accorded (March 2020) by the H&MED for acquisition of land for 'Establishment of Medi-city at Vijaypur, District Samba' under Capex Budget 2019-20, the Director Health Services (DHS), Jammu credited (March 2020) ₹ 4.75 crore to Deposit Head and withdrew (March 2020) ₹ 2.76 crore as advance drawal for acquisition of 83 *kanals* of land belonging to J&K Evacuees' Property Department. The amount of ₹ 2.76 crore was kept in the current bank account of DHS, Jammu. Audit observed that due to non-acquisition of land the whole amount of ₹ 7.51 crore (₹ 4.75 crore + ₹ 2.76 crore) had remained unutilised (January 2023). Moreover, parking of ₹ 2.76 crore outside the exchequer in bank

account since March 2020 has a commensurate impact on the liquidity of the State/ UT.

On being pointed out by Audit, the Director Health Services, Jammu stated (October 2023) that ₹ 2.76 crore has been transferred (May 2023) into revenue account of the Government. It was further stated that the balance ₹ 4.75 crore remained kept in Civil Deposits in the absence of any directions from the Administrative Department for its utilisation.

- An amount of ₹ 5.21 crore was released (August 2015) under CSS 'Upgradation/Strengthening of State Nursing Services' to DHS Jammu for procurement of transport, lab equipment, AV aids, books, computer lab and furniture for four[12] ANM/ GNM schools. As these funds were not utilised during 2015-16, they were revalidated and again released to DHS Jammu in February 2017. Out of ₹ 5.21 crore, an expenditure of ₹ 1.08 crore was incurred by DHS, Jammu for procurement of lab equipment, furniture etc. Funds of ₹ 0.36 crore were placed at the disposal of four[13] CMOs concerned for procurement of petty items[14]. The Utilisation Certificates, however, were awaited (December 2023) from four CMOs. Besides, ₹ 0.61 crore was transferred to JKMSCL for procurement of lab items and ₹ 0.28 crore paid to SICOP against the bills of furniture. An amount of ₹ 2.68 crore was lying in the current bank account of DHS Jammu for over five years and details of ₹ 0.20 crore could not be ascertained during audit. Failure of the DHS Jammu to utilise available funds of ₹ 2.68 crore defeated the purpose for which the funds were released.

The Director Health Services, Jammu stated (October 2023) that ₹ 2.40 crore out of ₹ 2.68 crore has been transferred (May 2023) into revenue account of the Government and ₹ 0.28 crore retained being the liability created by CMO Kathua for purchase of furniture for GNM Kathua.

The Chief Accounts Officer, Directorate of Health Services Jammu stated (January 2025) that ₹ 0.28 crore have been remitted into Govt. account in January 2025.

6.6.6 Non-submission of Utilisation Certificates

JKMSCL received funds from HoDs of indenting departments as well as from H&MED for procurement and supply of the drugs/instruments and machinery/ equipment. JKMSCL was required to furnish UCs in respect of these funds to the HoDs concerned within 12 months of closure of the financial year in terms of Rule 238 (1) of GFR 2017. Audit observed that out of ₹ 1,550.78 crore received during 2019-22, UCs for only ₹ 762.88 crore (49 *per cent*) were submitted to H&MED.

[12] ANM Kishtwar (₹ 84.90 lakh), ANM Ramban (₹ 84.90 lakh), GNM Jammu (₹ 175.75 lakh) and GNM Udhampur (₹ 175.75 lakh)
[13] Jammu, Kishtwar, Ramban and Udhampur
[14] Books, AV aids, teaching material, mannequins etc.

UCs in respect of the funds received directly from the HoDs could not be reviewed in absence of complete records.

The Financial Advisor/ CAO JKMSCL stated (January 2025) that Utilisation Certificates amounting to ₹ 922.88 crore have been submitted to the concerned DDOs.

Non-submission of UCs in time indicated poor financial control.

6.7 Conclusion

There was shortfall in utilisation of allotted funds ranging between three *per cent* and 26 *per cent* against the budget allocated by GoJ&K on the Health sector during 2016-17 to 2021-22. The Government spending on the Health sector increased from 5.84 *per cent* of total expenditure in 2016-17 to 7.98 *per cent* in 2021-22. Expenditure on the healthcare sector was highly skewed in favour of Revenue expenditure with a smaller proportion of Capital expenditure. GoJ&K released funds to the State Health Society with delays. Funds were lying unutilised outside Government account in contravention of codal provisions.

6.8 Recommendations

In the light of the audit findings, GoJ&K may consider:

- ***Ensuring timely release of funds so that they are fully utilised to ensure availability of quality healthcare infrastructure and services to the people of the UT;***
- ***Reviewing the healthcare ecosystem in the UT to identify the constraints/ factors adversely impacting the absorptive capacity of funds and make concerted efforts for their resolution;***
- ***Releasing funds to the State/UT Health Society well in time for effective utilisation of the funds in programme implementation; and***
- ***Ensuring deposit of Government money lying outside Government account into the Consolidated Fund of the UT for its optimum utilisation.***
- ***Rigorous monitoring of expenditure to ensure that funds allotted are spent fully for intended purposes.***

CHAPTER-VII

IMPLEMENTATION OF CENTRALLY SPONSORED SCHEMES

CHAPTER-VII

Implementation of Centrally Sponsored Schemes

7.1 Introduction

Health being a State/ UT subject, the Central Government supplements the efforts of the State/ UT Governments in delivery of health services through various schemes of primary, secondary and tertiary care. The findings with respect to audit of implementation of Centrally Sponsored Schemes in the UT of J&K are discussed in the succeeding paragraphs

7.2 National Health Mission

Observations noticed during review of various components of NHM programme are discussed in the succeeding paragraphs.

7.2.1 Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NHM being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery. The scheme integrates cash assistance with delivery and post-delivery care. Janani Surakhsha Yojana (JSY) provides all pregnant women with a cash compensation of ₹ 1,400 in rural areas and ₹ 1,000 in urban areas.

The position of institutional deliveries and compensation provided to the beneficiaries during the period 2016-2022 in the UT of J&K is given in **Table 7.1**.

Table 7.1: Institutional/ home deliveries and compensation provided to beneficiaries in the State/ UT under JSY during 2016-2022

Year	Number of pregnant women registered	Total number of deliveries	Institutional deliveries (*per cent*)	Beneficiaries provided incentive under JSY (*per cent*)
2016-17	1,25,265	2,00,503[1]	1,85,440 (92)	1,23,181 (66)
2017-18	3,99,020	1,92,896	1,81,006 (94)	1,23,518 (68)
2018-19	3,98,421	1,96,921	1,86,614 (95)	1,36,364 (73)
2019-20	3,57,609	1,93,420	1,83,035 (95)	1,20,433 (66)
2020-21	3,71,639	1,77,960	1,66,338 (93)	1,00,267 (60)
2021-22	3,20,015	1,90,190	1,80,625 (95)	1,02,000 (56)

(Source: Figures furnished by the State Health Society)

Audit noticed that percentage of institutional deliveries remained in the range of 92 and 95 *per cent* during 2016-2022. However, cash compensation was provided to beneficiaries ranging between 56 *per cent* and 73 *per cent* of institutional deliveries. Poor coverage in providing incentive under JSY defeated the purpose of the mission to promote safe institutional deliveries.

[1] Figures include private as well as home deliveries.

The Financial Advisor and CAO NHM, J&K stated (December 2023) that only those mothers were being paid incentive who were registered on Reproductive and Child Health (RCH) online portal and have Aadhaar seeded bank account, which is a must for DBT mode. Some of the beneficiaries either had non-functional bank account or did not claim JSY incentive.

In respect of the six test checked Districts[2], the position regarding institutional deliveries and incentives provided under JSY is given in **Table 7.2**.

Table 7.2: Institutional deliveries and compensation provided to beneficiaries in selected Districts under JSY during 2016-2022

Year	Number of pregnant women registered	Total number of deliveries	Institutional deliveries (*per cent*)	Beneficiaries provided incentives under JSY
2016-17	96,754	52,353	48,306 (92)	47,206
2017-18	93,312	48,406	45,075 (93)	44,215
2018-19	89,083	49,739	46,967 (94)	47,709
2019-20	72,867	44,057	41,343 (94)	41,273
2020-21	72,074	39,959	36,713 (92)	36,686
2021-22	71,066	43,033	40,394 (94)	34,038
Total		**2,77,547**	**2,58,798 (93)**	**2,51,127 (97)**

(Source: Records of Chief Medical Officers of the selected Districts)

Institutional deliveries in the six selected Districts were about 93 *per cent* and 97 *per cent* beneficiaries were provided incentives during 2016-2022 against institutional deliveries.

7.2.2 Maternal and Infant mortality

The objective of NHM was to reduce the maternal and infant mortality rate. The position of maternal and infant deaths in the State/ UT during 2016-2022 is given in **Table 7.3**.

Table 7.3: Maternal and infant deaths in the State/ UT during 2016-2022

Year	Number of deaths	
	Maternal	Infants
2016-17	132	2,288
2017-18	99	2,375
2018-19	82	2,358
2019-20	97	2,486
2020-21	93	1,504
2021-22	84	2,108

(Source: Figures furnished by the State/UT Health Society)

The data in **Table 7.3** indicates that maternal mortality and infant mortality had decreased from 132 to 84 and 2,288 to 2,108 respectively during 2016-22.

[2] Anantnag, Ganderbal, Jammu, Kupwara, Ramban and Udhampur.

In the six sampled Districts, maternal deaths declined from 31 to 23 during 2016-21 and again increased to 31 during 2021-22 whereas infant deaths declined from 234 to 76 during 2016-2022.

7.2.3 Janani Shishu Suraksha Karyakram

Janani Shishu Suraksha Karyakram (JSSK) is an initiative to assure free services to all pregnant women and sick new-born accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries, Caesarean operations and also treatment of sick newborns (up to 30 days after birth) in all Government health institutions.

The targets in respect of deliveries to be benefitted and treatment of sick newborns and actual achievements in this regard in the State/ UT during the period 2016-2022 are given in **Table 7.4**.

Table 7.4: Achievements against targets for deliveries to be benefitted and treatment of sick newborns in the State/ UT during 2016-2022

Year	Targets for deliveries to be benefitted and actual achievements		Targets for sick newborns to be treated and actual achievement	
	Targets	Achievements (*per cent*)	Targets	Achievements (*per cent*)
2016-17	1,87,800	1,68,317 (90)	45,962	44,775 (97)
2017-18	1,87,800	1,65,163 (88)	45,962	51,742 (113)
2018-19	1,87,800	1,69,621 (90)	45,962	47,568 (103)
2019-20	1,87,800	1,62,110 (86)	45,960	51,798 (113)
2020-21	1,87,800	1,44,524 (77)	45,960	37,870 (82)
2021-22	1,72,000	1,63,247 (95)	45,111	48,141 (107)

(Source: Figures furnished by State Health Society)

The data in **Table 7.4** indicates that targets fixed for deliveries to be benefitted and sick newborns to be treated remained almost unchanged during 2016-2021 but achievements in respect of targets for deliveries to be benefitted declined from 90 to 77 *per cent*. The achievement increased to 95 *per cent* in 2021-22. The achievement against the targets in respect of sick new-borns to be treated was more than the targets fixed in four years (2017-18 to 2019-20 and 2021-22).

The Director (P and S) State Health Society, J&K stated (September 2023) that the achievement is based on the actual number of deliveries conducted at public health facilities. It was further stated that the targets were reduced because of exclusion of UT of Ladakh.

In five out of the six sampled Districts, during 2016-22, the achievement in respect of deliveries benefitted decreased from 81 to 76 *per cent* whereas in respect of Ganderbal District, no targets were fixed for deliveries to be benefitted during 2016-21. However, there was 92 *per cent* achievement against targets fixed for 2021-22. Similarly, out of

the six sampled Districts, no targets were fixed in three[3] Districts for treatment of sick new-born. In the remaining three[4] Districts the achievement in respect of treatment of sick new-born ranged between 47 and 81 *per cent* during 2016-22.

JSSK guidelines provide for availability of 39 essential drugs and 26 essential consumables for postnatal and intra-partum period in respect of C-section deliveries.

Audit observed that there was shortage in availability of essential drugs and consumables ranging between 28 *per cent* and 79 *per cent* in respect of drugs and 23 *per cent* and 73 *per cent* in respect of consumables in six selected DHs during 2016-21. The maximum shortage of 79 *per cent* drugs and 73 *per cent* consumables was observed in DH Handwara.

7.2.4 Immunisation

Immunisation Programme is one of the key interventions for protection of children from life threatening conditions which are preventable. Immunisation Programme in India was introduced in 1978 as Expanded Programme of Immunisation (EPI) and in 1985 it was expanded as Universal Immunisation Programme (UIP). The Immunisation activities have been an important component of National Reproductive and Child Health Programme under NHM. Under the Programme, vaccination is provided to prevent 11 vaccine preventable diseases such as Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis, Hepatitis B, Meningitis, Pneumonia caused by Haemophilus Influenza type B, Rubella and Rotavirus Diarrhoea.

Details of vaccines provided under UIP for prevention of different diseases are given in **Table 7.5**.

Table 7.5: Details of vaccines administered for different diseases

Name of vaccine	Administered to
Bacillus Calmette- Guerin (BCG)	Protect the infants from tubercular meningitis and disseminated Tuberculosis
Oral Polio Vaccine (OPV)	Protect children from Poliomylitis.
Pentavalent Vaccine (PV)	Protect children from five diseases (Diphtheria, Pertussis, Haemophilis Influenza, Type B infection and Hepatitis B).
Fractional Inactivated Poliomylitis Vaccine (fIPV)	Boost protection against Poliomylitis.
Hepatitis-B (Hep-B)	Protect from Hepatitis B virus infection
Diphtheria, Pertussis and Tetanus (DPT) booster	Protect children from Diphtheria, Tetanus and Pertussis.
Measles Rubella (MR) Vaccine	Protect children from Measles and Rubella infection.
Tetanus and adult Diphtheria (TT/ Td)	Boost immunity against Diphtheria in adolescents at 10 and 16 years of age.
Rotavirus Vaccine (RVV)	Protect infants and children from Rotavirus Diarrhoea.

(Source: National Health Portal of India)

[3] Jammu, Kupwara and Anantnag
[4] Ganderbal, Ramban and Udhampur

Audit noticed that against target of 13,49,948 doses each for BCG, OPV, PV, IPV, Hep-B, DPT-B, and Measles, the achievement had ranged between 71 *per cent* and 94 *per cent* whereas the achievement in respect of DPT-5, TT-10 and TT-16 was 64, 56 and 40 *per cent* respectively during 2016-2022 as detailed in **Table 7.6**.

Table 7.6: Targets and achievements in respect of immunisation during 2016-22

Name of the vaccine	Targets	Achievements	Percentage achievement
BCG	13,49,948	11,63,547	86
OPV	13,49,948	11,03,997	82
PV	13,49,948	12,66,294	94
IPV	13,49,948	11,82,179	88
Hep-B	13,49,948	9,65,036	71
DPT-B	13,49,948	11,89,786	88
Measles	13,49,948	12,27,857	91
DPT-5	16,29,913	10,41,292	64
TT-10	15,44,128	8,70,332	56
TT-16	17,15,698	6,83,410	40

(Source: Information furnished by the Directorate of Family Welfare, MCH and Immunisation, J&K)

The lowest achievement was in respect of providing doses of TT-16 and highest in respect of PV. Further, the average achievement in respect of Rotavirus Vaccine was 64 *per cent* during 2019-22.

In five out of the six selected Districts (in Ramban District targets were not recorded) Audit observed that:

- BCG, OPV, PV, IPV, DPT-B and Measles were administered in excess of targets fixed during 2016-2022.
- Achievement in respect of Hep-B, DPT-5, TT-10 and TT-16 was 92, 89, 58 and 43 *per cent* respectively during 2016-2022.
- The Rotavirus Vaccine was also administered in excess of targets fixed during 2019-22.

Vitamin A is an important micronutrient for maintaining normal growth, regulating cellular proliferation and differentiation, controlling development and maintaining visual and reproductive functions. Vitamin A with two mega doses each year for children between nine months to five years of age was required to be provided. Audit observed that:

i) There was 12 *per cent* increase in administering Vitamin-A to children during 2016-2021. However, it had declined by eight *per cent* during 2021-22 with the result that there was shortfall of 20 *per cent* in achieving the target fixed for the year 2021-22.

ii) In five out of the six selected Districts (in Ramban District targets were not recorded) there was shortfall ranging between one *per cent* and 12 *per cent* against targets fixed during 2016-2022.

The Financial Advisor and CAO NHM, J&K stated (December 2023) that due to non-availability of rate contract of Vitamin A with JKMSCL, the procurement of Vitamin A got delayed.

7.2.5 Family Planning

The National Family Planning Programme aims to provide eligible couples with information and guidance on family planning methods and services available, to ensure individuals and couples lead a healthy, happy and prosperous life. Methods of contraception include oral contraceptive pills, implants, injectables, intra uterine devices, condoms, male and female sterilisation etc. Permanent methods of family planning are female sterilisation (Tubectomy or Tubal ligation) and male sterilisation (Vasectomy).

Targets in respect of male/ female sterilisation set for the years 2016-17 to 2021-22 and achievements thereagainst are given in **Table 7.7**.

Table 7.7: Achievement against targets for male/ female sterilisation during 2016-2022

Year	Male Sterilisation (Vasectomy)		Female Sterilisation (Tubectomy/ Laparoscopy)	
	Target	Achievement	Target	Achievement
2016-17	6,015	437 (7)	24,060	13,102 (54)
2017-18	6,348	340 (5)	25,394	10,479 (41)
2018-19	6,532	361 (6)	26,127	9,616 (37)
2019-20	397	271 (68)	10,577	7,667 (72)
2020-21	397	99 (25)	10,577	5,976 (56)
2021-22	397	122 (31)	24,810	8,774 (35)

(Source: Figures furnished by State Health Society)

Percentage achievement under Vasectomy was very poor ranging between five *per cent* and seven *per cent* during 2016-19. However, the percentage achievement under Vasectomy was improved during the period 2019-22 and ranged between 25 *per cent* and 68 *per cent*. Similarly, in respect of Tubectomy, percentage achievement increased from 54 *per cent* to *72 per cent* during 2016-20 and thereafter decreased to 35 *per cent* during 2021-22. Audit observed that H&MED significantly reduced the targets for 2019-20 but still failed to achieve 100 *per cent* targets. The Deputy Director (E&S), Family Welfare MCH and Immunisation J&K stated (September 2023) that the targets were reduced as these were excessively set using faulty methods and without accurately assessing the actual achievements during these years.

In five out of six selected Districts (in Ramban District targets were not recorded), percentage achievement under Vasectomy was very poor ranging between one *per cent* and 14 *per cent* whereas in respect of Tubectomy, achievement ranged between

18 *per cent* and 77 *per cent* during 2016-2022. There was nil achievement under Vasectomy in respect of Ganderbal District during 2016-21.

7.2.6 Birth spacing

Intrauterine devices (IUD), oral contraceptive pills and condoms are three main contraceptive methods of family planning to help birth spacing. Audit observed the following:

i) Achievement under distribution of oral contraceptive pills and condoms was satisfactory against targets fixed.

ii) In respect of IUD, during 2016-2019 achievement was low against targets ranging between 29 *per cent* and 47 *per cent.* Targets in respect of IUD were reduced by 68 *per cent* from 44,535 in 2018-19 to 14,098 in 2020-21, but the targets could still not be fully achieved as percentage achievement ranged between 57 *per cent* and 88 *per cent.* After targets were again increased during 2021-22, achievement was mere 28 *per cent*. No reasons were on record for reduction of targets under IUD.

Similarly, in five out of six selected Districts (in Ramban District targets were not recorded) achievement against targets in respect of IUD was low ranging between 27 *per cent* and 53 *per cent* during 2016-2022.

7.2.7 Rashtriya Bal Swasthya Karyakram

Rashtriya Bal Swasthya Karyakram (RBSK) is a programme to improve overall quality of life of children and provide them comprehensive healthcare. The programme involves screening of children from birth to 18 years of age for four Ds - Defects at birth, Diseases, Deficiencies and Development delays spanning 32 common health conditions for early detection and free treatment and management including surgeries at tertiary level.

Targets fixed under RBSK and achievements thereagainst in the State/ UT during 2016-2022 are detailed in **Table 7.8**.

Table 7.8: Achievement against targets fixed under RBSK in the State/ UT during 2016-2022

Year	Targets			Achievements			Children found positive for identified health conditions (0-18 years)	Children referred to CHC/DH/ Tertiary care institutions
	0-6 weeks	6 weeks to 6 years	6 years to 18 years	0-6 weeks	6 weeks to 6 years	6 years to 18 years		
2016-17	2,29,000	6,94,600	16,66,920	42,898 (19)	8,17,073	12,54,241 (75)	2,41,977	1,67,829
2017-18	2,29,000	6,94,600	16,66,920	57,736 (25)	8,82,640	14,39,259 (86)	3,01,043	1,92,111
2018-19	2,29,000	6,94,600	16,66,920	89,594 (39)	10,41,289	15,84,804 (95)	2,78,696	1,99,662
2019-20	2,29,000	6,94,600	16,66,920	64,140 (28)	8,75,514	11,96,436 (72)	2,16,258	1,55,857
2020-21	2,06,100	6,25,140	15,00,228	1,37,134 (16)		1,35,205 (9)	15,083	11,053
2021-22	2,06,100	6,25,140	15,00,228	1,17,196 (14)		3,44,169 (23)	74,331	59,619
Total								**7,86,131**

(Source: Figures furnished by State Health Society)

Audit observed that

i) Achievement regarding children screened in the age group 0-6 weeks was low ranging between 19 *per cent* and 39 *per cent* during 2016-20.

ii) In age group of 6-18 years, achievement was 72 *per cent* to 95 *per cent* during 2016-20. Though, there was low achievement in 2020-21, the achievement further increased to 23 *per cent* during 2021-22.

iii) 7,86,131 children were referred to CHC/ DH/ tertiary care institutions for advanced treatment during 2016-22.

Poor performance, particularly in the age group 0-6 weeks, was due to non-availability of trained staff of delivery points in comprehensive newborn screening and ASHAs under Home Based Newborns Care (HBNC) programme which was indicative that the objectives of the programme were not achieved. The achievements under 0-6 weeks and six weeks to six years were merged in 2020-21 and 2021-22 for which no reasons were on record.

The Director (P&S) State Health Society, J&K stated (September 2023) that the screening of children in the age group of six weeks to six years at *Anganwadi* Centres and 6 years to 18 years at Govt. and Govt. aided schools was affected due to COVID-19 pandemic.

The Financial Advisor and CAO NHM, J&K stated (December 2023) that children in the age group of 0-6 weeks are screened under the scheme through Comprehensive Newborn Screening at delivery points by existing staff of the health facilities.

In the six sampled Districts, Audit observed the following:

i) Achievement of children screened in the age group 6 to 18 years ranged between 11 *per cent* and 76 *per cent* during 2016-22.

ii) No targets were fixed by Anantnag, Udhampur and Jammu Districts in respect of age group 0-6 weeks during 2016-2022.

7.2.8 Accredited Social Health Activists

Accredited Social Health Activist (ASHA) is a trained female health activist in the community who creates awareness on health and its social determinants and mobilises the community towards local health planning and increased utilisation and accountability of existing health services. ASHA mobilises and facilitates the community in accessing health and health-related services available at various health institutions. As per the guidelines of ASHA issued in 2006, there should be one ASHA for a population of 1,000.

Audit observed that:

i) Against the cumulative target of engagement of 13,236 ASHA workers, 12,850 ASHA workers were in position in the State/ UT as of March 2022. In the six sampled Districts, there was 93 *per cent* to 99 *per cent* availability of ASHA workers.

ii) Capacity building of ASHA is critical in enhancing her effectiveness and to equip her with necessary knowledge and skills. About 88 *per cent* ASHAs were provided with the prescribed four rounds of training in the UT of J&K whereas in the six sampled Districts, 87 to 100 *per cent* ASHAs were provided the requisite training as of March 2022.

Further, ASHAs are responsible for facilitation of ante-natal checkups and for accompanying the mothers to the health institutions for treatment/ admission.

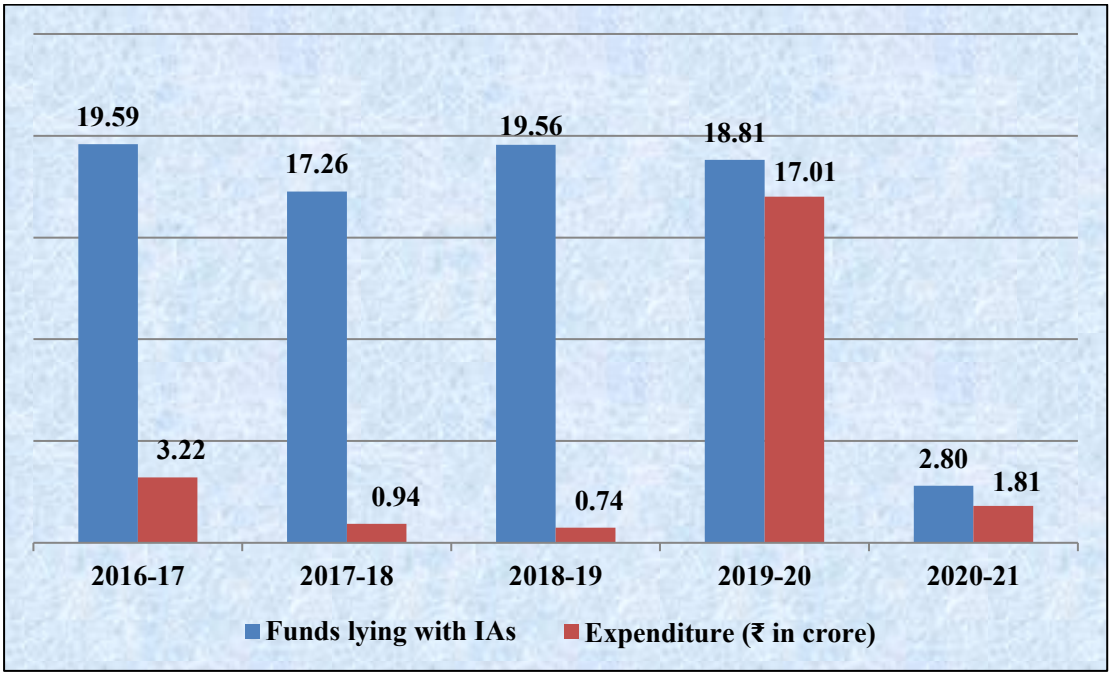
Audit observed that during 2016-2022, only 54 *per cent* to 75 *per cent* of women who gave birth at health institutions were accompanied by ASHAs whereas in the six sampled Districts the percentage ranged between 62 *per cent* and 87 *per cent* indicating that the assigned responsibilities have not been effectively performed by ASHAs despite the fact that there were sufficient number of trained ASHAs.

7.2.9 National Mental Health Programme

The objective of Mental Health Programme is to provide mental health services including preventive, promotion, and long-term continuing care at different levels of

District level health care system. The details of funds lying with the implementing agencies (IAs) *vis-a-vis* expenditure incurred on NMHP during the period 2016-21 is shown in **Chart 7.1**.

Chart 7.1: Funds lying with the implementing agencies and expenditure under NMHP in the State/UT of J&K



(Source: Information supplied by National Health Mission, J&K)

Audit observed that despite availability of funds during the years 2016-17 to 2018-19, the expenditure incurred ranged between 04 and 16 *per cent* only. The utilisation of funds improved during 2019-20 and it was 65 *per cent* in 2020-21.

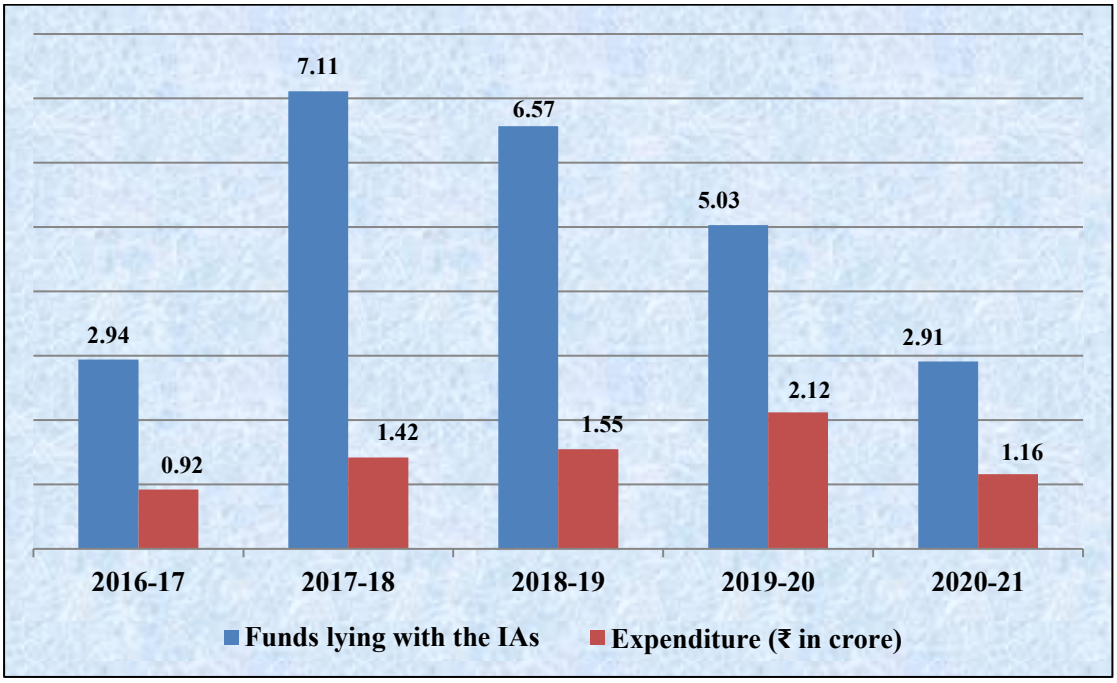
The Financial Advisor and CAO NHM, J&K stated (December 2023) that the District Mental Health Programme (DMHP) was not fully functional and the activities sanctioned under the programme could not be performed within the scheduled time.

7.2.10 National Programme for Healthcare for the Elderly (NPHCE)

The National Programme for Healthcare for the Elderly (NPHCE) is an articulation of the International and National commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the Government of India in 1999 and Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of Senior Citizens.

The details of funds lying with the IAs and expenditure incurred on National Programme for Healthcare for the Elderly (NPHCE) in the State/ UT of J&K during the period 2016-17 to 2020-21 is shown in **Chart 7.2**.

Chart 7.2: Funds lying with the IAs and expenditure under NPHCE in the State/UT of J&K



(Source: Information supplied by National Health Mission, J&K)

Audit observed that during the years 2016-17, 2017-18, 2018-19, 2019-20 and 2020-21, the expenditure incurred was 31 *per cent,* 20 *per cent,* 24 *per cent,* 42 *per cent* and 40 *per cent* respectively. Keeping in view the increasing life expectancy, a focused approach needs to be adopted for geriatric care.

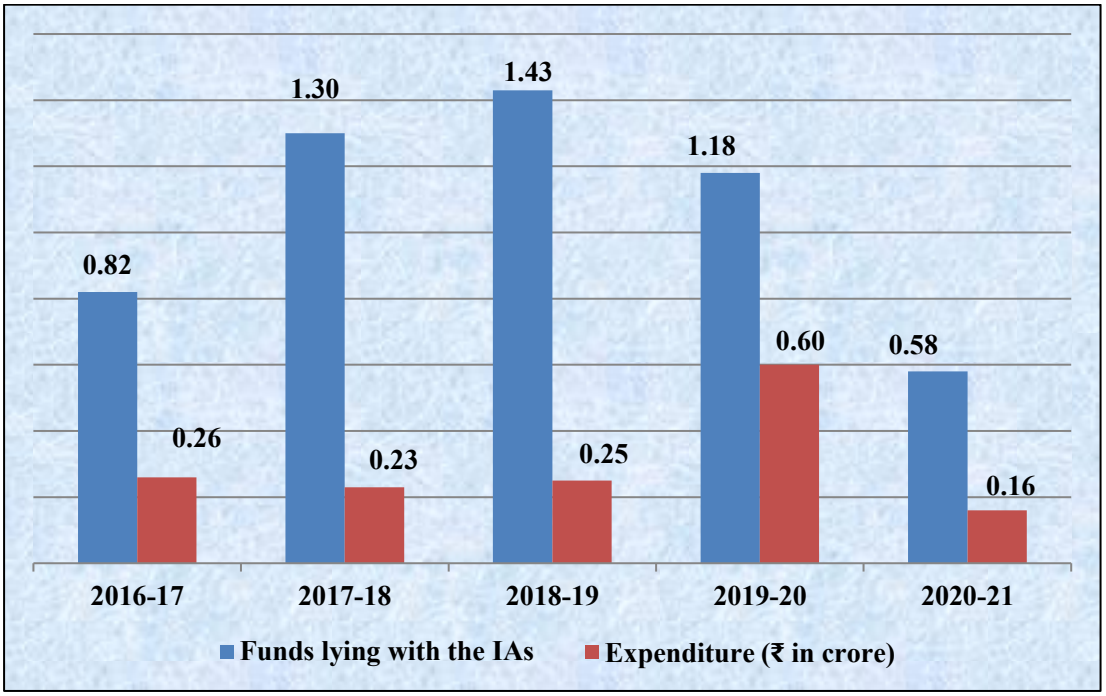
The Financial Advisor and CAO NHM, J&K stated (December 2023) that due to shortage of manpower, the funds sanctioned under salaries head remained unutilised and the activities could not be performed to optimal level.

7.2.11 National Tobacco Control Programme (NTCP)

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08, with the aim to - (i) create awareness about the harmful effects of tobacco consumption; (ii) reduce the production and supply of tobacco products; (iii) ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA); (iv) help the people quit tobacco use; and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

The details of funds lying with the IAs and expenditure incurred on National Tobacco Control Programme (NTCP) is shown in **Chart 7.3**.

Chart 7.3: Funds lying with the IAs and expenditure under NTCP in the State/UT of J&K



(Source: Information supplied by National Health Mission, J&K)

Audit observed that due to low absorptive capacity of the Department to spend the allotted funds, the Department was unable to utilise the available funds during the years 2016-17 to 2020-21 which ranged between 17 *per cent* and 51 *per cent*.

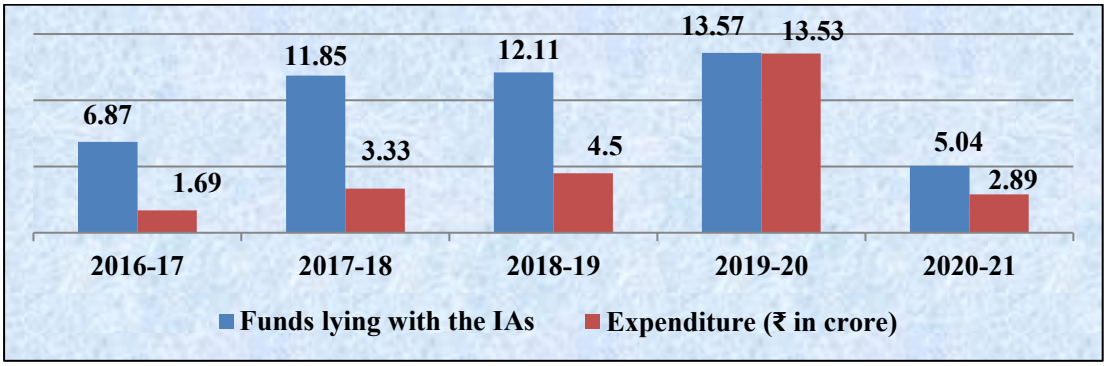
The Financial Advisor and CAO NHM, J&K stated (December 2023) that initially the processing of the funds approved was slow and moreover, the Tobacco Cessation Centres were established in all Districts during 2019-20. Due to COVID-19 pandemic during 2020-21, the activities could not be performed as a result of which the funds remained unutilised.

7.2.12 National Programme for Control of Blindness

The National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100 *per cent* centrally sponsored programme with the goal of achieving a prevalence rate of 0.3 *per cent* of the population. The four-pronged strategy of the programme is strengthening service delivery, developing human resources for eye care, promoting outreach activities and public awareness and developing institutional capacity.

The details of funds lying with the IAs and expenditure incurred on National Programme for Control of Blindness (NPCB) in the State/ UT of J&K during the period 2016-17 to 2020-21 is shown in **Chart 7.4.**

Chart 7.4: Funds lying with the IAs and expenditure under NPCB in the State/UT of J&K



(Source: Information supplied by National Health Mission, J&K)

Audit observed that there was inconsistency in utilisation of funds under National Programme for Control of Blindness (NPCB) during the period 2016-21 which ranged between 25 *per cent* and 100 *per cent.*

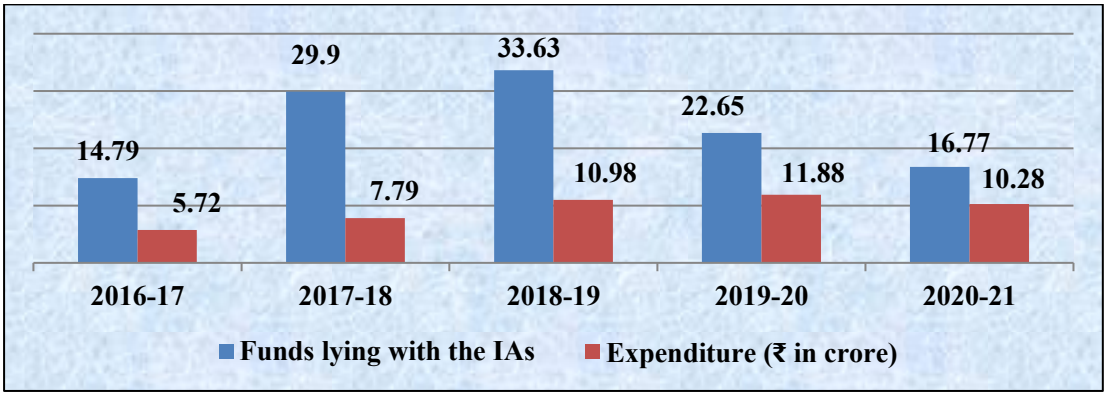
The Financial Advisor and CAO NHM, J&K stated (December 2023) that the processing of funds approved for construction of eye OTs at various DHs was slow and the work was completed for these eye OTs in 2022-23. Moreover, during COVID-19 pandemic all the cataract surgeries and distribution of spectacles was halted.

7.2.13 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke

The Non-Communicable Diseases (NCD) like Cardiovascular diseases, Cancer, Chronic Respiratory Diseases, Diabetes etc. are estimated to account for around 60 *per cent* of all deaths. In order to prevent and control major NCDs, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched in 2010 with focus on strengthening infrastructure, human resource development, health promotion, early diagnosis, management and referral.

The details of funds lying with the IAs and expenditure incurred on NPCDCS by the NHM, J&K during the period 2016-17 to 2020-21 is shown in **Chart 7.5**.

Chart 7.5: Funds lying with the IAs and expenditure under NPCDCS in the State/UT of J&K



(Source: Information supplied by National Health Mission, J&K)

Audit observed that during the years 2016-17, 2017-18, 2018-19, 2019-20 and 2020-21, the utilisation of funds was 39 *per cent,* 26 *per cent*, 33 *per cent,* 52 *per cent* and 61 *per cent* respectively which indicated that the Department failed to utilise the available funds.

The Financial Advisor and CAO NHM, J&K attributed (December 2023) reasons for low expenditure to delay in release of funds for various approved activities, non-availability of rate contract with JKMSCL and COVID-19 pandemic.

7.3 National AIDS and STD Control Programme

National AIDS and STD Control Programme (NACP) was launched by GoI in the year 1992. Phase I of NACP (1992-1999) focused on awareness generation and blood safety. Phase II (1999-2007) witnessed launch of direct interventions across the prevention-detection-treatment continuum with capacity building of States on programme management. Phase III (2007-2012) was the story of scale-up with programme management decentralised up to the District level. Phase IV (2012-2017) was a period of consolidation and enhanced government funding. Phase IV (Extension) of NACP was first approved for the period 2017-2020 and then extended up to 2020-21.

Targeted Intervention (TI) is one of the main components under NACP-IV. The programme is designed to reduce the rate of HIV transmission among the core group such as Female Sex Workers (FSWs), Men having Sex with Men (MSM), Injecting Drug Users (IDUs) and bridge population like migrants and truckers. The TI programme is being implemented through Community Based Organisations (CBOs), Non-Government Organisations (NGOs) and various government Departments. For implementation of the programme, funds are being placed at the disposal of CBOs, NGOs and Drawing and Disbursing Officers (DDOs).

Audit observed that detailed accounts/ Utilisation Certificates (UCs) in respect of funds released under NACP were outstanding against CBOs/ NGOs/ DDOs as of March 2022 as detailed in **Table 7.9**.

Table 7.9: Amounts for which Utilisation Certificates outstanding against CBOs/ NGOS/ DDOs

(₹ in lakh)

Particulars	Outstanding ending					
	March 2017	March 2018	March 2019	March 2020	March 2021	March 2022
CBOs/ NGOs/ DDOs	34.53	80.66	173.73	175.05	212.01	260.45

(Source: Data furnished by Chief Accounts Officer, AIDS Control Society, J&K)

The **Table 7.9** indicates that detailed accounts/ UCs outstanding against CBOs/ NGOs/ DDOs had increased eight times from ₹ 34.53 lakh in March 2017 to ₹ 260.45 lakh in March 2022.

The Assistant Director (Finance) J&K State AIDS Control Society stated (September 2023) that the expenditure was booked only after receipt of red[5] accounts/ utilisation from the District authorities and other agencies. Due to this there were unutilised funds at the end of the financial year. It was further stated that the last instalment was mostly received from NACO during the last week of March every year and it was not possible to utilise the funds without completion of codal formalities.

Further, the Information, Education and Communication (IEC) component of NACP played a great role in bringing awareness among the general population and helped in removing stigma and discrimination associated with AIDS. Audit noticed shortfall in achievement of some of the targets under IEC as depicted in **Table 7.10**.

Table 7.10: Shortfall in achievement of targets under IEC component of NACP

Name of the activity	2016-17		2017-18		2018-19		2019-20		2020-21		2021-22	
	T	A	T	A	T	A	T	A	T	A	T	A
Exhibition/Innovation (*number*)	-	-					10	8	Nil	9	-	-
Adolescent Education Programme (*number*)	500	322	500	100	700	400	400	300	450	250	200	200
Out of School Youth Programme (*number of programmes*)	2	2	22	7	-	-	40	26	30	30	20	20
Mainstreaming trainings (*persons sensitisation*)	1,500	1,500	3,280	3,280	3,431	3,431	1,210	1,080	4,800	830	1,720	1,680
Red Ribbon Clubs[6] in Colleges & Universities (*Number*)	116	116	24	4	150	142	8	8	94	94	30	30

(T: Targets; A: Achievements)
(Source: Information furnished by JKACS)

Audit observed that there was significant reduction in targets during the year 2021-22 due to outbreak of COVID-19 and IEC programmes being in the nature of outdoor activities. The fixed targets were, however, mostly achieved during 2021-22. Moreover, no targets were fixed in respect of exhibition/ innovation during the years 2016-17 to 2021-22 except for the year 2019-20. However, there was satisfactory progress in respect of spread of awareness through electronic media such as TV, Radio, Website etc.

The Assistant Director (Publicity), J&K AIDS Control Society attributed (September 2023) shortfall in achieving targets to outbreak of COVID-19, lack of timely necessary approvals, procedural/ administrative delays and non-availability of budget at that particular time. It was further stated that reduction or addition in the targets of IEC is not merely based on achievements of the previous years but also based

[5] Detailed contingent bills
[6] Red ribbon club is a movement started by GoI in educational institutions for awareness of AIDS.

on discussions during the formulation of Annual Action Plans, availability of funds and the need of that particular activity at regional level.

7.4 Conclusion

Various inconsistencies were noticed in implementation of Centrally Sponsored Schemes. Cash compensation under JSY was not provided to all the beneficiaries. There was shortage in availability of essential drugs and consumables under JSSK. The targets under Immunisation were not fully achieved. Besides this, achievement against the fixed target for sterilisation and spacing methods (IUD) was significantly low. The achievements against the targets fixed for screening of infants in the age group 0-6 weeks under RBSK was very poor. The targets under IEC component of NACP were not fully achieved.

7.5 Recommendations

In light of the audit findings, GoJ&K may consider;

- ***Disbursement of incentive to all the beneficiaries under JSY for effective implementation of the scheme;***
- ***Providing adequate essential drugs and consumables under Janani Shishu Suraksha Karyakram;***
- ***Prioritising immunisation of children of all age groups;***
- ***Conducting awareness programmes and holding camps to create awareness amongst the population of sterilisation and spacing methods; and***
- ***Prioritising screening of infants under RBSK.***

CHAPTER-VIII

ADEQUACY AND EFFECTIVENESS OF REGULATORY MECHANISMS

CHAPTER-VIII

Adequacy and effectiveness of regulatory mechanisms

National Health Accounts[1] (NHA) is a tool to describe health expenditures and flow of funds in both Government and private sector in the country. Focus of NHA is on describing (1) entities[2] that provide resources to spend for health goods and services in the health system; (2) entities[3] receiving and managing funds from financing sources to pay for or to purchase health goods and services; (3) entities[4] receiving finances to produce/ provide health goods and services; and (4) use of funds across various health care services[5].

Expenditure on healthcare services is incurred through the Government sector as well as the private sector. However, the role of Government is not limited to Government Hospitals but also includes regulation of the private sector hospitals, clinics, pharmacies, etc. in the healthcare sector. Therefore, the existence of a regulatory mechanism is important to protect healthcare consumers from health risks, provide a safe working environment for healthcare professionals and to ensure public health and welfare provided through health programmes.

Regulatory agencies thus monitor individual and corporate healthcare practitioners and facilities, inform the Government about changes in the way the healthcare industry operates, ensure that higher safety standards and local, State and federal guidelines are followed and attempt to improve healthcare quality. With a view to check the adequacy and effectiveness of the regulatory mechanisms, implementation of the following acts/rules have been analysed in audit:

- The Drugs and Cosmetics Act, 1940 and Rules, 1945.
- The Clinical Establishments (Registration and Regulation) Act, 2010 and Rules, 2020.
- Bio Medical Waste (BMW) Management Rules, 2016.
- Atomic Energy (Radiation Protection) Rules, 2004.

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1 National Health Accounts (NHA) estimates for India for Financial Year 2018-19 released in the year 2022.

2 (a) Union Government: 11.71 *per cent;* (b) State Government: 19.63 *per cent* (c) Local Bodies: 1.01 *per cent* (d) Enterprises: 5.51 *per cent;* (e) Household Revenues: 60.11 *per cent* and (f) Others: 2.03 *per cent.*

3 (a) Union Government: 11.30 *per cent* (b) State Government: 14.27 *per cent;* (c) Local Bodies: 2.84 *per cent;* (d) Government Health Insurance (GHI): 6.04 *per cent;* (e) Private Health Insurance: 7.25 *per cent;* (f) Other Schemes: 5.07 *per cent* and (g) Out of Pocket Expenditure: 53.23 *per cent.*

4 (a) Providers of Preventive Care: 5.34 *per cent;* (b) Government Hospitals: 17.34 *per cent;* (c) Others: 2.49 *per cent;* (d) Private Hospitals: 28.69 *per cent;* (e) Patient Transport: 3.50 *per cent;* (f) Government Clinics: 7.75 *per cent;* (g) Private Clinics: 4.37 *per cent*; (h) Diagnostic Labs: 3.92 *per cent;* (i) Pharmacies: 22.60 *per cent;* and (j) Administrative Agencies: 4.00 *per cent.*

5 (a) Governance and Administration: 3.96 *per cent;* (b) Preventive Care: 9.44 *per cent;* (c) Other functions: 3.03 *per cent;* (d) Pharmaceutical and other medical goods: 22.49 *per cent;* (e) Patient transport: 3.50 *per cent;* (f) Inpatient Curative Care: 34.55 *per cent;* (g) Outpatient Curative Care: 18.86 *per cent;* and (h) Lab and Imaging: 4.17 *per cent.*

8.1 The Drugs and Cosmetics Act, 1940 and Rules, 1945

One of the main interventions of GoJ&K is to achieve its public health objectives by ensuring that drugs available to the public are safe, efficacious and conform to the prescribed quality standards. Drug control is the only tool to ensure availability of drugs of the highest quality and purity. In order to provide safe, effective and quality drugs, the State Drug Controller (SDC) under Drugs and Food Control Organisation (D&FCO) is responsible for effective implementation of The Drugs and Cosmetics (D&C) Act 1940, and D and C Rules, 1945.

As of March 2022, there were 14,945 retail outlets, 7,129 wholesale drug premises and 84 manufacturing units. In addition, two drug testing laboratories at Srinagar and Jammu were also functioning in the UT of J&K.

8.1.1 Licensing of pharmacies

Section 18(c) of D&C Act, 1940 prohibits manufacture for sale or for distribution or sale of any drug except in accordance with the conditions of a licence issued for such purpose.

Audit noticed that during 2016-22, 160 unlicensed drug shops/ manufacturing units were detected during 1,01,217 inspections conducted by D&FCO.

The State Drugs Controller stated (January 2025) that the matters/ complaints as referred to Hon'ble courts are pending adjudication at different stages vis. Summons/ framing of charges/ under trial.

8.1.2 Shortcomings in drug testing

Rules 51 and 52 of the D&C Rules, 1945 authorise the Inspector to inspect any premises, take samples, send samples for testing or analysis and institute prosecution in respect of breaches of the Act or Rules thereunder. Audit noticed that:

- No targets for inspections were fixed during 2016-2022.
- During 2016-22, 21,832 samples were lifted in the UT in the course of 1,01,217 inspections and in the six selected Districts, 8,422 samples were lifted during 42,417 inspections.
- Out of 21,832 samples lifted, 20,451 samples were received for testing during 2016-22 against which 20,044 (98 *per cent*) samples were tested in the two provincial drug testing laboratories and 548 (about 3 *per cent*) samples were found 'Not of Standard Quality (NOSQ)'. However, after the manufacturers filed appeal for retesting of samples, 21 samples were sent for retesting to Central Drug Testing laboratory (CDTL), Kolkata and all were declared to be of Standard Quality.

On being pointed out in audit, the State Drugs Controller stated (October 2023) that the samples received do not include 1,381 samples which were referred to the Drug Testing Laboratories located outside UT of J&K and the clearance of backlog of 407 samples is a continuous process. It was also stated (August 2023) that the difference in the opinion of the analysts of the laboratories of UT/ CDTL, Kolkata can be attributed to calibrations, instrumental errors, separation techniques as also lack of acumen to test special categories of drug molecules.

The State Drugs Controller stated (January 2025) that the constraints of testing facility have been addressed to a larger extent by way of upgradation of two existing Drug Testing Laboratories and establishment (March 2024) of new 'Modern Drug Testing Laboratory' at Kathua.

Audit further observed that H&MED had not devised any mechanism under which samples were to be referred to SDC for testing on a regular basis. Instead the samples were lifted by SDC for testing on random basis or on complaint basis.

Rule 51(5) of the D&C Rules, 1945 empowers the Inspector to initiate prosecutions in respect of breaches of the Act and Rules thereunder.

As of March 2016, 466 cases were pending in the courts. During 2016-22, 244 prosecutions were launched and 121 cases were decided by the courts. The pending cases thus increased by 26 *per cent* (589 cases) ending March 2022. The conviction percentage in prosecution cases was a mere 23 *per cent* (56 cases) during 2016-22. In the six selected Districts, the conviction percentage was only 12 *per cent* (11 cases) in respect of 90 prosecution cases during 2016-22.

Low percentage of conviction indicated that the Department had failed to prove the breaches of the Act and Rules thereunder beyond all reasonable doubt.

8.1.3 Testing of medical devices

Medical Devices Rules, 2017 defines Medical devices as substances used for *in vitro* diagnosis and surgical dressings, surgical bandages, surgical staples, surgical sutures. ligatures, blood and blood component collection bag with or without anticoagulant, mechanical contraceptives (condoms, intrauterine devices, tubal rings), disinfectants, insecticides etc. For quality control and price monitoring, medical devices were brought under Government regulation as drugs with effect from April 2020.

Rule 18(1) of the Medical Device Rules (MDR), 2017 notified (January 2017) by Ministry of Health and Family Welfare under Drugs and Cosmetic Act, 1940 provides for designation of Medical Device Testing Officer (MDTO) by the Central Government and Rule 18 (2) provides for designation of Medical Device Officer (MDO) by the Central Government or, as the case may be, the State Government. Accordingly, H&MED designated (April 2018) 27 Drug Inspectors as MDOs after a delay of over a year. The SDC, D and FCO had taken up (June 2022) the matter for nomination of

MDTOs with the Central Drugs Standard Control Organisation and it was stated (August 2022) that the name(s) from the 15 notified MDTOs for the whole of India are to be proposed for the purpose of nomination to be appointed as MDTOs for Jammu and Kashmir at various Central Medical Device Testing Laboratories (CMDTL) with due approval of UT of Jammu and Kashmir. Thereafter, six MDTOs for six CMDTLs were nominated (December 2022) by the SDC, D&FCO, J&K for issue of notification for UT of J&K by GoI. However, Rule 18 (1) of the MDR, 2017 was amended (June 2023) and the State Governments were empowered to notify centrally notified MDTOs. Despite the matter been taken up (June 2023) with H&MED by the SDC, D&FCO, J&K for issue of notification of MDTOs, H&MED failed to take any action (September 2023). Since the notified CMDTLs entertained samples of medical devices only after the State/ UT gets MDTOs working in CMDTLs notified, the delay in issue of notification for nomination of MDTOs resulted in non-lifting of samples by the 27 nominated MDOs for testing by MDTOs. There was as such lack of adequate regulatory control in providing quality medical devices to consumers.

The State Drugs Controller, Drug and Food Control Organisation, Jammu and Kashmir stated (January 2025) that H&MED has notified (June 2024) MDTOs of six Central Medical Device Testing Laboratories for UT of J&K.

8.2 Clinical Establishments Act, 2010 and Rules thereunder

GoI repealed (August 2019) the Jammu and Kashmir Nursing Homes and Clinical Establishments (Registration and Licensing) Act, 1963 by the Jammu and Kashmir Reorganisation Act, 2019. The Central Act viz. The Clinical Establishment (Registration and Regulation) Act, 2010 was implemented in the State/ UT by issue of notification (May 2020) for Jammu and Kashmir Clinical Establishments (Registration and Regulation) Rules, 2020. By the same notification District Registering Authorities (DRA) were established for each District of J&K headed by District Magistrate as Chairperson, Chief Medical Officer as Convener and three other Members.

Prior to establishment of DRAs, the registering authorities were Directors, Health Services, Kashmir and Jammu under Jammu and Kashmir Nursing Homes and Clinical Establishments (Registration and Licensing) Act, 1963.

As per provision of Section 2(c) of the CEA, 2010, clinical establishment means a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognised system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not, and shall include a clinical establishment owned, controlled or managed by (a) a Government or a Department of the Government, (b) a trust, whether public or private; (c) a corporation registered under a central, provincial or state act, whether owned by the Government; (d) a local authority; and (e) a single doctor.

8.2.1 Institutional Mechanism

The institutional mechanism including role of National Council/ State Council and District Registration Authority as per Clinical Establishment (Registration and Regulation) Act, 2010 is as under:

National Council

- Classify the Clinical Establishments (CEs) into different categories.
- Develop and recommend minimum standards.
- Collect statistics and information in respect of CEs

State Council

- Compile and update the State Registers of CEs.
- Send monthly returns for updating the National Register
- Hear appeals against the orders of the authority

District Registration Authority

- Registration of CEs and renewal/ cancellation of registration of CEs.
- Inspection of CEs
- Maintenance of data for updating State Register.

Audit observed that even after lapse of over two years since CEs (Registration and Regulation) Rules, 2020 were notified, GoJ&K had not constituted the UT Council as of November 2022 and as such functions assigned to the UT Council remained unattended.

8.2.2 Registration of CEs

DRA is responsible for registration of CEs in a District. The details of CEs in the private sector in the test-checked six Districts as of March 2022 are given in **Table 8.1**.

Table 8.1: Clinical establishments in private sector in selected Districts as of March 2022

Sl No.	Name of the District	Clinics including polyclinics, dental clinics and others	Hospital/nursing homes	Diagnostic Labs
1	Anantnag	0	10	277
2	Ganderbal	23	0	52
3	Jammu	389	43	98
4	Kupwara	25	5	65
5	Ramban	5	1	20
6	Udhampur	63	6	35
	Total	**505**	**65**	**547**

(Source: Information furnished by Convener, District Registration Authority concerned)

The Clinical Establishment Act, 2010 provides for two types of registration (a) provisional registration for which no enquiry is to be done prior to grant of certificate of provisional registration and (b) permanent registration after complying with the prescribed minimum standards. With the implementation (May 2020) of the Central Act of 2010, all the previously issued registration certificates under the Act of 1963 stood cancelled.

Audit observed that:

- No survey was conducted by the DRAs concerned to ascertain the actual number of CEs in the District eligible for registration. As a result, the possibility of CEs operating without registration could not be ruled out. Provisional registration was granted after proprietors of the CEs approached the DRA on voluntary basis for registration of CE. The Chief Medical Officer, Jammu admitted (January 2025) the audit contentions. The Chief Medical Officer, Ramban stated (January 2025) that establishments not registered are being advised to get registered.

- As of November 2022, the system for registration of clinics had not been started in Anantnag District. As such, the number of clinics operating in Anantnag District could not be ascertained.

- Section 22 of the Act envisages that application for renewal of registration shall be made 30 days before expiry of validity of provisional registration. However, no system was in place by which provisional registrations about to expire could be watched by DRAs.

- Section 33 of the Act provides for inspection of registered CEs. As of March 2022, there were 1,117 registered CEs. However, no inspection was conducted by the sampled six DRAs except DRA Ganderbal who had conducted 24 inspections during 2021-22. No targets were fixed for inspections. Instead, the inspections were conducted on random or complaint basis. Due to non-conducting of adequate inspections, the violation of provisions of the Act by the registered CEs remained unnoticed.

- The monthly reports as required under Rule 31 (1) of the CEs (Registration and Regulation) Rules, 2020 were not submitted by the CEs to the three[6] DRAs.

- The DRA for registration of CEs under AYUSH was established (March 2021) after a delay of 10 months of notification of CEs (Registration and Regulation) Rules, 2020. Audit observed that as of December 2022, no CE had been registered in the six selected Districts under AYUSH even after lapse of about 21 months since the Rules were notified. The Director, AYUSH, J&K stated (February 2023) that the process of registration of CEs has been started by DRAs of all Districts. The Chief Accounts

[6] Kupwara, Ramban and Udhampur

Officer, Directorate of AYUSH, J&K stated (January 2025) that 206 CEs have been registered by District Registering Authorities.

8.3 Fixation of rates for delivery of services by private healthcare establishments

Affordability of healthcare is critical to ensure all income groups of the population have access to healthcare. H&MED had accorded (February 2012) sanction for rates to be charged by private CEs/ Nursing Homes/ Hospitals/ Diagnostic Centres from patients for treatment, diagnostic services and other facilities. However, the Hon'ble High Court of J&K in a writ petition (Kashmir Private Hospitals versus State and others) stayed (April 2012) the Government Order. Though the stay was vacated (August 2021) by the Hon'ble High Court of Jammu & Kashmir and Ladakh after a lapse of about nine years, H&MED failed to grant sanction (November 2023) either for the revised rates or for implementing the existing rates. This was indicative of a lackadaisical approach of the Department in dealing with the important issue of fixation of rates, a matter which closely concerns the public.

Absence of Government approved rates and lack of uniformity in rates charged by Healthcare Establishments (HEs) from consumers for various healthcare services had left ample scope for over-charging and profiteering by HEs. Some instances of charging of different rates by different CEs for the same tests are given in **Table 8.2**.

Table 8.2: Rates charged by private CEs *vis-a-vis* rates approved for Government HIs for various tests

(Amount in ₹)

Name of the test	Rates approved (January 2019) by H&MED for Govt. HIs	Rates being charged by private CEs			
		Swastik Diagnostic Laboratory Jammu	Dr Qadri's Hematology Centre and Clinical Laboratory, Srinagar	Medicare Diagnostic Laboratory Udhampur	Excess rate charged by private CEs w.r.t to govt. rates
Complete Blood Count (CBC)	80	170	160	200	2-2.5 times
Erythrocyte Sedimentation Rate (ESR)	10	60	70	70	6-7 times
Urea	20	70	80	80	3.5-4 times
Creatinine	20	70	90	80	3.5-4.5 times
Uric Acid	15	70	80	80	4.5-5.5 times
Liver Function Test	175	450	600	450	2.5-3.5 times
Lipid Profile	120	750	550	400	3.5-6 times
Platelet Count	15	70	120	100	4.5-8 times
Total Protein	15	80	80	50	3-5 times
Serum Amylase	35	220	350	250	6-10 times
Reticulocyte Count	20	170	250	100	5-12.5 times
Blood Sugar-Fasting	Free	35	70	50	
Urine examination	Free	100	70	60	
Stool examination	Free	50	70	60	

(Source: Information provided by the Administrative Department and concerned CMOs)

Disparity in rates of various pathological/ radiological tests was rampant in the UT of J&K. Rates charged by private CEs for pathological tests were two to more than 12 times higher than the rates fixed (January 2019) by H&MED for hospital investigations in Government HIs. Besides different rates were charged by private CEs for the same pathological tests. Private CEs were charging exorbitant rates for tests which were available free in Government HIs.

Further, no Government rates were fixed for consultation fee to be charged by private practitioners/ doctors as confirmed (January 2023) by the CMOs of five[7] out of six selected Districts.

Absence of fixed rates for consultation fee and diagnostic services had a direct bearing on lower income groups of society.

The Director Finance, H&MED, J&K stated (December 2023) that the rate revision will take some time to complete the process to revise the existing rates of private Clinical Establishments/ Nursing Homes/ Hospitals/ Diagnostic Centres.

8.4 Quality Certificate from NABL and NABH

National Accreditation Board of Laboratories (NABL) certificate signifies a ready means for customers to identify and select reliable testing, measurement and calibration services that are able to meet their needs. Accredited laboratories receive a form of international recognition, which allows their data and results to be more readily accepted.

Further, National Accreditation Board for Hospitals and Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organisations. Accreditation results in improved quality of care and patient safety.

Audit noticed that:

- H&MED had framed (September 2012) a time schedule for getting 11 public HIs[8] accredited by NABH by April 2013. However, even after lapse of over nine years, no hospital had got accreditation from NABH. On being pointed out in audit, the Director Finance H&MED, J&K stated (December 2023) that no response has been received from the HODs. Out of 11 HIs, Audit took up the matter with the seven[9] sampled HIs, of which three[10] replied that they had not applied for accreditation. DH Anantnag had transferred an amount of ₹ 11.56 lakh to Quality Council of India in

[7] Anantnag, Jammu, Ganderbal, Kupwara and Udhampur

[8] (i) Govt. Hospital, Gandhi Nagar Jammu (ii) G.B.Pant Hospital, Srinagar (iii) CHC Akhnoor (iv) DH Kathua (v) DH Udhampur (vi) SMGS Hospital, Jammu (vii) L.D. Hospital, Srinagar (viii) DH Baramulla (ix) DH Anantnag (x) JLNM Hospital, Srinagar and (xi) SDH Chadoora

[9] (i) Govt. Hospital, Gandhi Nagar Jammu (ii) G.B.Pant Hospital, Srinagar (iii) SDH Akhnoor (iv) DH Udhampur (v) SMGS Hospital, Jammu (vi) L.D. Hospital, Srinagar (vii) DH Anantnag

[10] (i) Govt. Hospital, Gandhi Nagar Jammu (ii) DH Udhampur (iii) SDH Akhnoor

May 2017 as accreditation fee, but further outcome was not available with the DH. Medical Superintendent, Lalla Ded Hospital Srinagar stated (January 2025) that the process of obtaining NABH accreditation has already been taken up with the higher authorities. Medical Superintendent, SMGS Hospital Jammu stated (December 2023) that no application has been moved so far in absence of any directions from higher authorities for accreditation. Medical Superintendent, G.B.Pant Hospital (now Children Hospital) Srinagar stated (December 2023) that this hospital had remitted ₹ six lakh in March 2017 to the Quality Council of India for NABH accreditation. There was however, no communication between both the parties since 2017.

- As of March 2022, out of 373 HIs (DHs: 06; SDHs/ CHCs:28; PHCs:339) in the six test-checked Districts and 94 diagnostic labs in four test-checked Districts (except Districts[11] Anantnag and Ganderbal), no HI/ diagnostic lab in the public sector had been granted accreditation by NABH/ NABL. However, in Jammu District, three Hospitals/ Nursing Homes and three Laboratories in the private sector were granted NABH and NABL accreditation respectively. The Chief Medical Officer Ganderbal and Chief Medical Officer Anantnag stated (January 2025) that accreditation under NABH/ NABL has not been applied as no instructions have been received from higher authorities whereas the CMO, Kupwara stated (September 2023) that none of the hospitals across the District was falling under NABH/ NABL guidelines/ standards. The CMO Udhampur and CMO Jammu stated (January 2025) that no directions have been received from higher authorities for obtaining the NABH and NABL accreditation. The CMO Ramban stated (January 2025) that matter shall be taken afresh with the authorities in the light of audit observation.

Even though the NABH/ NABL accreditation is voluntary, the fact also remains that absence of accreditation results in lack of assurance of high standards of care and patient safety to the public.

The Combined Food and Drug Laboratory, Jammu was granted Certificate of Accreditation (January 2022) for a period of two years.

8.5 Bio-Medical Waste Management

The Bio-Medical Waste (BMW) Management Rules, 2016 stipulate the procedures for collection, handling, transportation, disposal and monitoring of BMW with clear roles for waste generators and Common BMW treatment facilitators (CBMWTF).

8.5.1 Grant of authorisation

In terms of Rule 10 of BMW Rules, every occupier or operator handling BMW, irrespective of the quantity is required to obtain authorisation from the State Pollution Control Board and Pollution Control Committee, as the case may be. Audit however

[11] Information not furnished by the CMOs Anantnag and Ganderbal

noticed that:

- During January 2017 to December 2022, 6,257 HIs had applied for authorisation, out of which authorisation was granted to 3,689 HIs by the J&K Pollution Control Committee[12] (JKPCC). Reasons for non-granting of authorisation included incomplete documents and unsatisfactory BMW management practices. Information for the year 2016 was not available with JKPCC.

- All the seven test-checked Tertiary Level Hospitals (TLHs) had applied for authorisation for handling BMW as of March 2021. However, none of the test-checked TLHs had been granted authorisation as of March 2024. Out of the six selected DHs, only four[13] DHs had applied for authorisation whereas two[14] DHs had not applied for authorisation. Authorisation was obtained by DH Jammu. Similarly, out of the selected 28 SDHs/ CHCs, 14 SDHs/ CHCs had applied for authorisation whereas nine[15] SDHs/ CHCs had not applied for authorisation. The authorisation in respect of remaining five[16] SDHs was not granted due to technical issues like revenue papers of the site and other observations raised by JKPCC. Out of 52 selected PHCs, only 10 PHCs had applied for authorisation. However, the authorisation has not been granted as of March 2024.

- There was no system by which expiry of authorisation could be watched by the Jammu & Kashmir Pollution Control Committee for necessary action for their renewal. Audit noticed an instance where the authorisation granted in respect of SDH Bishnah expired in November 2020. However, in absence of any system for watching of expired authorisation, the HI applied for renewal only in July 2022.

8.5.2 Constitution of Advisory Committee

Rule 11 of BMW Rules, 2016 provides for constitution of an Advisory Committee under the Chairmanship of the Health Secretary. The Advisory Committee shall meet at least once in six months and review all matters related to implementation of the provisions of these rules. Audit observed that:

- Advisory Committee re-constituted (July 2017) in the UT of J&K had conducted five (2018-19: one; 2019-20: four) meetings. Information regarding meetings conducted in 2016-17, 2017-18 and 2020-21 was not available with JKPCC. The information regarding number of Advisory Committee meetings conducted during 2016-22 was not available with H&MED.

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12 Jammu & Kashmir Pollution Control Committee came into existence vide notification dated 25th March 2021 of the Central Pollution Control Board

13 DHs Anantnag, Ganderbal, Jammu and Udhampur

14 DH Handwara and DH Ramban

15 CHC Sohanjana, CHC Jourian, CHC Khour, SDH Jagti, SDH R.S.Pura, SDH Langate, CHC Kralpora, CHC Gool and CHC Batote

16 SDHs Dooru, Bijbehara, Seer Hamdan, Shangus and Kokernag

8.5.3 Constitution of District Level Monitoring Committee

Rule 12 (4) of BMW Rules, 2016 provides that every State Government or Union Territory Administration shall constitute a District Level Monitoring Committee (DLMC) in the Districts under the chairmanship of the District Magistrate or Deputy Commissioner or Additional District Magistrate to monitor the compliance of the provisions of these rules in the healthcare facilities generating BMW and in CBMWTFs. DLMC had to submit its report regularly once in six months to the Advisory Committee and a copy to the State Pollution Control Board or Pollution Control Committee. Audit observed that:

- DLMC was constituted (July 2017) at District level to oversee the implementation of BMW Rules, 2016.

- Only Ramban District had submitted report to JKPCC in 2019-20. No information was available with JKPCC for the years 2016-17 to 2018-19 and 2020-21.

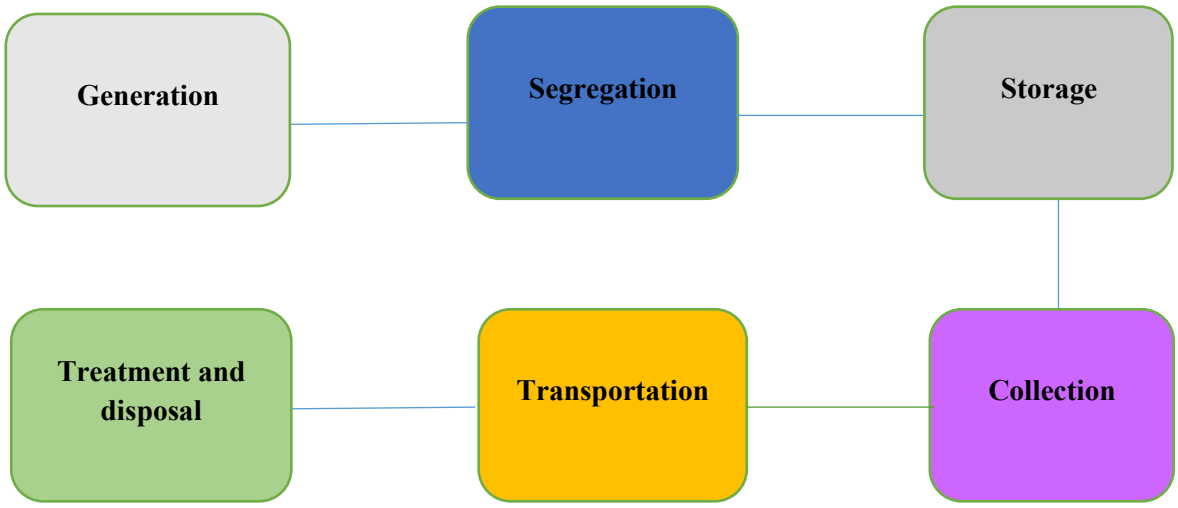
8.5.4 Submission of Annual Reports

Rule 13 of BMW Rules provides for submission of Annual Reports by every occupier or operator of CBMWTF to the prescribed authority.

Audit noticed that Annual reports had not been submitted by two[17] out of seven selected TLHs, two[18] out of six selected DHs and 10[19] out of 28 selected SDHs/ CHCs to JKPCC during 2016-21. SDH Jagti had also not submitted the Annual reports to JKPCC since its upgradation (June 2019) to 2020-21.

8.5.5 Stages of Bio-Medical Waste management

The following are the stages for management of BM waste.



[17] SMHS Hospital. Srinagar and Super Specialty Hospital, Srinagar
[18] DHs Handwara and Ramban
[19] Anantnag-3; Jammu-3; Kupwara-1; Ramban-2 and Udhampur-1

8.5.6 Generation, segregation, collection and disposal of Bio-medical waste

Rule 8 of BMW Rules, 2016 read with Schedule I requires HIs to segregate different categories of BMW in separate containers or bags at the source of generation.

Audit noticed that segregation of BMW at the source of generation in separate coloured bins was being done in 31 (DHs: 06; SDHs/ CHCs: 25) out of 34 test checked secondary level HIs and 37 out of 52 test-checked PHCs.

Colour coded bins at the point of generation in CHC Khour (19.03.2022)	**BMW Collection Point in SDH R.S Pura (10.06.2022)**

Further, in respect of liquid chemical waste generated in HIs, Rule 4 (j) of BMW Rules mandate segregation of waste at source and its pre-treatment or neutralisation prior to mixing with other effluents generated in HIs. Audit observed that:

- Out of 34 test-checked secondary level HIs, only DH Udhampur and SDH Kot-Bhalwal had established Effluent Treatment Plant (ETP) for pre-treatment of the liquid chemical waste.

- Only GMC Hospital, Jammu out of seven test-checked Tertiary Level Hospitals had established ETP.

Non-establishment of ETP was not only a violation of the BMW Rules but was also hazardous to public health at large.

ETP in DH, Udhampur (04.07.2022)	**ETP in SDH Kot-Bhalwal (25.01.2022)**

Incomplete ETP at DH Anantnag (22.04.2022)	**Incomplete ETP at SDH Dooru (11.04.2022)**

Rule 5 (a) of BMW Rules envisages that the operator of a CBMWTF is responsible for collection of BMW from HIs and its proper disposal. Audit observed that three[20] CBMWTFs had been authorised by JKPCC for collection and disposal of BMW from HIs. The HIs of the State/ UT had entered into agreements (on different dates) with these CBMWTFs for collection and disposal of BMW. Some instances came to the notice of audit, where after execution of agreement, the operator of the CBMWTF had failed to lift the BMW in violation of the stipulated terms and conditions.

- Though agreement (April 2021) was in place with the authorised CBMWTF[21], it had failed to lift BMW from CHC, Chenani which was burning the BMW in the open in close proximity to the CHC resulting in damage to the environment with possibility of spread of infection in the adjacent areas.

- Despite agreement (March 2020) in place with the CBMWTF, it was not lifting BMW from CHC, Jourian which was either burning the BMW in the open or burying it in a pit within the hospital complex. However, after continuous complaints, the firm started collection of BMW from January 2023 after a lapse of about 22 months.

BMW being burnt in the vicinity of CHC, Chenani (23.03.2022)	**BMW disposal in open in CHC, Jourian (28.12.2021)**

- Six DHs and 24 SDHs/ CHCs were disposing BMW through CBMWTF duly authorised by JKPCC and four[22] SDHs/ CHCs were disposing BMW either by burning it in the open or by deep burial within the complex.

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20 (i) Anmol Health Care, Samba (ii) Clean City Waste Management Co., Budgam and (iii) Kashmir Health Care, Lassipora.

21 Anmol Health Care, Samba

22 SDH Marh and CHCs Jourian, Gool and Banihal

BMW disposal in an open pit within SDH, Marh (26.11.2021)

8.6 Atomic Energy (Radiation) Protection Rules, 2004

As per Rule 3 of the Atomic Energy (Radiation Protection) Rules, 2004 issued by Department of Atomic Energy, GoI, no person shall, without a licence establish or decommission a radiation installation and no person shall handle any radioactive material, or operate any radiation generating equipment except in accordance with the terms and conditions of the licence.

Contrary to the provisions of the said Rules, Audit noticed that requisite license from Atomic Energy Regulatory Board (AERB) had not been obtained in two[23] out of six selected DHs, 12[24] out of selected 18 SDHs and eight[25] out of 10 selected CHCs where radiation generating equipment were available as of March 2022.

Rule 19 read with Rule 22 of the Atomic Energy (Radiation Protection) Rules, 2004 provides for appointment and responsibilities of a Radiological Safety Officer (RSO) who shall be responsible for advising and assisting the employer and licensee on safety aspects aimed at ensuring that the provisions of the Atomic Energy (Radiation Protection) Rules, 2004 are complied with. The RSO shall also carry out routine measurements and analysis of radiation and radioactivity levels in the controlled area and report on all hazardous situations along with details of any immediate remedial actions etc.

Audit observed that the post of Radiological Safety Officer was not existing in the Department. Thus, due to non-availability of RSO in the Department, the unnecessary exposure either due to equipment malfunction or human error remained unnoticed which may be harmful for the patients as well as the staff operating the equipment.

The Chief Accounts Officer, Directorate of Health Services, Jammu and Dy. Director Health Services, Kashmir admitted (January 2025) that no post of Radiological Safety Officer is existing in the Department.

[23] DHs Ganderbal and Handwara
[24] Anantnag: four; Jammu: five and Kupwara: three
[25] Jammu: three; Kupwara: three and Ramban: two

8.7 Conclusion

The envisaged regulatory mechanism was not functioning effectively to ensure responsible provision of health services to the people. No targets for inspections under the D and C Act, 1940 were fixed. There was lack of mechanism where-under drug samples were to be referred to SDC for testing on regular basis. There was delay in issue of notification for nomination of MDTOs. No Apex body (UT Council) was constituted by the GoJ&K under Clinical Establishments (Registration and Regulation), Rules, 2020 to ensure that the appeals against cases of de-registration and other penalties levied by the District Registering Authority can be heard. For the registration and regulation of the clinical establishments, no survey was conducted to ascertain the actual number of CEs eligible for registration. There was disparity in rates of various pathological/ radiological tests. Requisite annual reports were not submitted by some of the healthcare facilities under BMW Management Rules, 2016 and authorisation was not obtained by the occupier or operator handling BMW.

8.8 Recommendations

In view of the audit findings, GoJ&K may consider:

- ***Fixing of targets for inspections under the D&C Act, 1940 to ensure adequate regulatory control;***
- ***Referring drug samples to SDC for testing on regular basis;***
- ***Issuing notification for nomination of MDTOs at the earliest so that the samples of medical devices are got tested from the notified MDTLs;***
- ***Constituting a UT Council as required under Clinical Establishments (Registration and Regulation), Rules, 2020 to ensure that the appeals against cases of de-registration and other penalties levied by the District Registering Authority can be heard;***
- ***Framing a mechanism to ascertain the actual number of CEs eligible for registration so that CEs operating without registration can be identified; and***
- ***Ensuring compliance with Bio-Medical Waste Management Rules by all healthcare facilities with regard to obtaining requisite authorisation, submission of annual returns etc.***

CHAPTER-IX
SUSTAINABLE DEVELOPMENT GOAL 3

CHAPTER-IX

Sustainable Development Goal 3

With the aim of taking forward the success of Millennium Development Goals, the United Nations (UN) General Assembly, in its 70th session held on 25th September, 2015 adopted the document titled "Transforming our World: the 2030 Agenda for Sustainable Development". The document consisted of 17 Sustainable Development Goals (SDGs) and associated 169 targets which came into force with effect from 1st January, 2016. India was also a signatory to the agenda.

In India, National Institution for Transforming India (NITI) Aayog is responsible for overall coordination of the SDGs and the Ministry of Statistics and Programme Implementation (MoSPI) is responsible for the formulation of the National Indicator Framework (NIF) to monitor the SDGs.

9.1 Formulation of State Indicator Framework and District Indicator Framework

On the analogy of National Indicator Framework, GoJ&K prepared (October 2019) UT Indicator Framework (UTIF) which was updated from time to time. At the national level
Goal-3 has 13 targets and 41 indicators. GoJ&K identified 12 targets[1] and 34 indicators under Goal 3 (Sustainable Development Goal 3, regarding "Good Health and Well-Being").

A brief description of the 12 targets and 34 indicators under Goal 3 is given in **Table 9.1**.

Table 9.1: Brief description of 12 targets and 34 indicators under Goal 3

Target No.	Brief description	Indicators adopted
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	4
3.2	By 2030, end preventable deaths of newborns and children under five years of age (with all countries), aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.	2
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	6
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.	1
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	2
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents.	1
3.7	By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and integration of reproductive health into national strategies and programmes.	6
3.8	Achieve universal health coverage including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.	5
3.9	By 2030, substantially reduce the number of deaths and illness from hazardous chemicals and air, water, soil pollution and contamination.	2

[1] Target 3.d 'Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks' was not adopted

Target No.	Brief description	Indicators adopted
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.	1
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha declaration on the agreement and public health, which affirms the right of developing countries to use to the full the provisions in the agreement on trade-related aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.	1
3.c	Substantially increase health financing and recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states.	3

(Source: Sustainable Development Goals-J&K Progress Report-2022)

A comparative analysis of indicators (Global Indicators Framework (GIF), National Indicators Framework and UTIF) proposed and adopted by the UT is given in ***Appendix 9.1***.

District Indicator Framework (DIF) of Union Territory of Jammu and Kashmir was also prepared as a subset of UTIF.

9.1.1 Tier-wise indicator for SDG 3

The Global Indicator Framework (GIF) for Sustainable Development Goals developed by the Inter-Agency and Expert Group on SDG Indicators (IAEG[2]-SDGs) comprises 231 indicators. Based on the level of methodological development and the availability of data, all these indicators have been classified into three tiers (Tier[3] I, II and III) to facilitate implementation. As of 4th February 2022, there were 25 indicators under Tier I, 03 under Tier II for SDG 3. For Tier III, methodology and standards are yet to be specified.

Tier-wise analysis of indicators adopted in NIF and UTIF is given in **Table 9.2.**

Table 9.2: Tier-wise indicator for SDG 3

Tier	No. of indicators in GIF	NIF indicators from GIF	NIF indicators from GIF adopted in UTIF
I	25	22	16
II	3	1	1
Total	**28**	**23**	**17[4]**

(Sources: Global Indicator Framework, National Indicator Framework and Union Territory Indicator Framework)

It is evident from the above table that most indicators are under Tier I.

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2 Constituted by United Nations Statistical Commission and agreed upon at the 48th session of the United Nations Statistical Commission held in March 2017 and adopted by the General Assembly on 6th July 2017.

3 **Tier I:** Indicator is conceptually clear, has an internationally established methodology and standards are available, and data are regularly produced by the countries for at least 50 *per cent* of countries and of the population in every region where the indicator is relevant.
Tier-II: Indicator is conceptually clear, has an internationally established methodology and standards are available, and data are not regularly produced by the countries.
Tier-III: No internationally established methodology or standards are yet available for the indicator, but methodology/standards are being evolved.

4 The six indicators not adopted were (i) 3.3.4-Prevalence of Hepatitis 'B' per one lakh population, (ii) 3.4.1-Number of deaths due to cancer, (iii) 3.8.2-Proportion of population with large household expenditures on health as a share of total household expenditure or income, (iv) 3.a.1-Percentage of adults 15 years and above with use of any kind of tobacco, (v) 3.b.2-Budgetary allocation for Department of Health Research and (vi) 3.d.1-International Health Regulations (IHR) capacity and health emergency preparedness.

9.1.2 Sustainable Development Goal 3 and its adoption in J&K

SDG 3 envisions ensuring healthy lives and promotion of well-being for all at all ages. The Goal addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access to safe, effective, quality and affordable medicines and vaccines. In addition, the new National Health Policy (NHP) 2017 is set in the context of SDGs. GoJ&K set up (June 2018) a State/ UT Level Committee for achievement of SDGs under the chairmanship of the Chief Secretary.

9.1.2.1 Planning and mapping budget for SDG 3

The National Health Policy 2017 envisaged allocation of resources for healthcare in accordance with development and financial indicators in a State/ UT. Audit observed that expenditure on public health decreased from 2.95 in 2020-21 to 2.80 *per cent* in 2021-22 of the GSDP. However, no action plan for achieving SDGs was formulated by the Department.

Though NITI Aayog had mapped Centrally Sponsored Schemes with the SDG targets, as of March 2022, no information was provided by the Planning, Development and Monitoring Department[5] in respect of interlinkages between goals and targets and mapping of schemes to SDG 3 though called for by Audit. Due to non-availability of the requisite information, the extent of integration of SDG 3 into the accounting and budgeting framework could not be ascertained by Audit.

Department of Health and Medical Education, Government of Jammu and Kashmir constituted (August 2022) an Inter-Sectoral Committee[6] for setting up of "Institutional Framework for improvement of health services with special focus on Sustainable Development Goals (SDGs), District Good Governance Index (DGGI) and Vision JK@2047". The aim was to strategise the policies, programmes and standards for achievement of SDG 3 to improve important health indicators by aligning the policies/ action plans with mapping of various schemes. The Committee was to meet once in a month to review the progress made with quantifiable targets and achievements on SDG. Audit noticed that the first meeting of the Committee was held in December 2023 i.e. more than 15 months after its constitution.

9.2 Health Indicators

The SDG India Index and Dashboard of NITI Aayog tracks the progress of the country as well as the States and UTs compositely on all SDGs as well as on each individual SDG. Every year, the indicators are reviewed and updated in view of evolving availability of data, and the index is computed to capture the individual as well as collective momentum on implementation of SDGs at State/ UT and national levels.

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5 Being the nodal department for recording the progress/designing targets on all indicators set under SDGs.

6 Comprising of Mission Director, National Health Mission, J&K-Chairman, Director General, Family Welfare, MCH and Immunisation-Co-chairman, Chief Executive Officer, State Health Agency-Member, Director Health Services, Jammu/ Kashmir-Members, Director Planning, NHM, J&K-Member, Programme Manager HMIS, NHM, J&K-Member Secretary and Representatives of the GMCs to be nominated by the respective Principals as Members.

9.2.1 Analysis of SDG 3 indicators

A comparison between a few SDG health indicators of Jammu and Kashmir with all India average health indicators is given in **Table 9.3**.

Table 9.3: Comparison of few SDG health indicators[7] of J&K with all India SDG health indicators

Target number	SDG indicator	Unit	Year	JK Value	All India value
3.1	3.1.1- Maternal Mortality Ratio	Per one lakh live births	2014-16	97	130
			2015-17	96	122
			2016-18	85	113
			2018-20	77	103
3.2	3.2.1-Under five mortality rate	Per 1,000 live births	2015	28	43
			2018	23	36
			2019	21	35
			2019-21 (NFHS-5)^	18.5	41.9
	3.2.2-Neonatal mortality rate	Per 1,000 live births	2015	20	25
			2018	17	23
			2019	15	22
			2019-21 (NFHS-5)^	9.8	24.9
3.3	3.3.2-Tuberculosis incidence	Per one lakh population	2016	72	217
			2018	90	199
			2019	81	193
			2020	61	188
3.4	3.4.2-Suicide mortality rate	Per one lakh population	2015	3.0	10.60
			2018	2.50	10.20
			2019	2.10	10.40
			2020	2.20	11.30
3.6	3.6.1-People killed in road accidents	Per one lakh population	2015	7.48	11.81
			2018	7.34	11.54
			2019	7.46	11.57
			2020	5.48	9.84
			2021	5.98	11.38
3.7	3.7.3-Institutional deliveries	Percentage	2015-16	85.60*	78.90
			2019-21	92.40	88.60
3.8	3.8.1-Married women (15-49 years) who use any modern Family planning methods	Percentage	2015-16	46.10	47.80
			2019-21	52.50	56.50
3.c	3.c.1-Health worker density	Per 10,000 population	2015	15.85	40.41
			2018	17.16	48.80
			2019	16.91	49.45

(Source: Sustainable Development Goals-J&K Progress Report-2022 and National Family Health Survey-5)
****given as 85.50 in NFHS-4***
^NFHS-5 for Jammu and Kashmir: 2019-20, NFHS-5 for all India: 2019-21

It can be observed from the table above that Jammu and Kashmir fared better than the national average in most of the parameters except 3.8.1 (married women using modern family planning methods) and 3.c.1 (health worker density). However, the information in the table includes data for Ladakh (except for NFHS-5 data for target number 3.2) as

[7] Data also comprises of the information of Ladakh except for NFHS-5 and for the years 2020 and 2021.

the information covers the period prior to implementation of the Jammu and Kashmir Reorganisation Act, 2019.

9.3 Conclusion

UT of J&K adopted 34 indicators out of 41 indicators at the national level covering 12 targets at UT level out of 13 targets at national level. As of December 2023, the Inter-Sectoral Committee only met once since its constitution.

9.4 *Recommendation*

In light of the audit findings, GoJ&K may consider:

- ***Ensuring Inter-Sectoral Committee meetings are held at regular intervals to monitor the progress and achievements of targets under SDG.***

Srinagar/ Jammu
Dated: 21 October 2025

(K. P. Yadaw)
Principal Accountant General (Audit)
Jammu and Kashmir

Countersigned

New Delhi
Dated: 10 November 2025

(K. Sanjay Murthy)
Comptroller and Auditor General of India

APPENDICES

Appendix 1.1

(Reference Paragraph 1.7)

Number of Sampled Health Institutions

Tertiary Level		Secondary level		Primary level	
Sl. No.	**Hospitals providing specialised treatment**	**Sl. No.**	**District Hospitals**	**Sl. No.**	**Primary Health Centres**
1.	Govt. Medical College & Hospital (GMC&H), Jammu	1.	DH, Anantnag	1.	Achabal
2.	Sri Maharaja Gulab Singh Hospital, Jammu	2.	DH, Ganderbal	2.	Awoora
3.	Super Speciality Hospital, Jammu	3.	DH, Gandhi Nagar, Jammu	3.	B. Kalan
4.	Govt. Ayurvedic Hospital, Jammu	4.	DH, Handwara	4.	Dethu
5.	G.B.Pant Children Hospital, Srinagar	5.	DH, Ramban	5.	Kanalwan
6.	Sri Maharaja Hari Singh Hospital, Srinagar	6.	DH, Udhampur	6.	Kapran
7.	Super Speciality Hospital, Srinagar		Community Health Centres (CHC) /Sub-District Hospitals (SDH)	7.	Khayar
8.	Lalla Ded Hospital, Srinagar	1.	SDH Seer Hamdan	8.	Kullar
9.	Govt. Unani Hospital, Srinagar	2.	SDH Bijbehara	9.	Larkipora
		3.	SDH Shangus	10.	Larnoo
		4.	SDH Dooru	11.	Ari
		5.	SDH Kokernag	12.	Gund
		6.	SDH Achabal	13.	Gutlibagh
		7.	SDH Kangan	14.	Kondbal
		8.	SDH Akhnoor	15.	Shallabugh
		9.	CHC Jourian	16.	Tullamulla
		10.	SDH Bishnah	17.	Bain Bajalta
		11.	SDH Kot Bhalwal	18.	Bambyal
		12.	SDH Marh	19.	Bhagwati Nagar
		13.	CHC Khour	20.	Bharore
		14.	SDH R.S.Pura	21.	Bus Stand
		15.	CHC Sohanjana	22.	Dhanger
		16.	SDH Jagti	23.	Digiana
		17.	SDH Sarwal	24.	Domana
		18.	SDH Kupwara	25.	Gurah Manhasan
		19.	SDH Sogam	26.	Jaswan
		20.	CHC Kralpora	27.	Ashpora
		21.	SDH Tangdar	28.	Chiterkoote
		22.	CHC Zachaldara	29.	Chowgal
		23.	SDH Langate	30.	Gundishat
		24.	CHC Kralgund	31.	Kandi
		25.	CHC Gool	32.	Magam
		26.	CHC Banihal	33.	Monabal

Tertiary Level		Secondary level		Primary level	
Sl. No.	**Hospitals providing specialised treatment**	**Sl. No.**	**District Hospitals**	**Sl. No.**	**Primary Health Centres**
		27.	CHC Batote	34.	Mugalpora
		28.	SDH Ramnagar	35.	Nowgam
		29.	CHC Chenani	36.	Tarathpora
				37.	Alinbass
				38.	Dharmkund
				39.	Digdool
				40.	Miatra
				41.	Sangaldan
				42.	Sari Pura
				43.	Surrundi
				44.	Badhole
				45.	Chanauta
				46.	Chiryai
				47.	Garhi
				48.	Kawa
				49.	Latyar
				50.	Madha
				51.	Majalta
				52.	Marta
				53.	Sermanjala
					Sub-Centres (SCs)
				1.	Aru
				2.	Bewoora
				3.	Dandipora
				4.	Darigund
				5.	Karshangam
				6.	Kawarigam
				7.	Lisser
				8.	Nai Basti
				9.	Panzgam
				10.	Shankerpora
				11.	Akhal
				12.	Balapati Lar
				13.	Bandaybagh
				14.	Gagangeer
				15.	Kurag
				16.	Treesa
				17.	Bala
				18.	Barni
				19.	Challana
				20.	Chargali
				21.	Gurah pattan
				22.	Jagti
				23.	Kharian
				24.	Kudwal
				25.	N S pura

Tertiary Level		Secondary level		Primary level	
Sl. No.	**Hospitals providing specialised treatment**	**Sl. No.**	**District Hospitals**	**Sl. No.**	**Primary Health Centres**
				26.	Naryana
				27.	Baderkal
				28.	Batlan Gundgujran
				29.	Check Hayan
				30.	Checksarmerg
				31.	Gulnar
				32.	Gund Chowgal
				33.	Hatmulla
				34.	Jub Nachian
				35.	Kalas
				36.	Kashmiri Manigah
				37.	Amkoot
				38.	Bawa
				39.	Salballa
				40.	Dachan Gali
				41.	Gagarnag
				42.	Harra
				43.	Khari Trana
				44.	Parihinder
				45.	Phagmulah
				46.	Bari
				47.	Chak Rakhwalan
				48.	Darsoo
				49.	Dehari
				50.	Kela
				51.	Kheen
				52.	Majua
				53.	Muttal
				54.	Narore
				55.	Ossu
					AYUSH Dispensaries
				1.	A K Pora
				2.	Hapatnard
				3.	Hardturoo
				4.	Marahama
				5.	Ranipora
				6.	Vessu
				7.	Y K Pora
				8.	Akhal
				9.	Fatehpora
				10.	Ganderbal
				11.	Rayil
				12.	Abdullian
				13.	Bhantidi

Tertiary Level		Secondary level		Primary level	
Sl. No.	**Hospitals providing specialised treatment**	**Sl. No.**	**District Hospitals**	**Sl. No.**	**Primary Health Centres**
				14.	Bishnah Town
				15.	Gho-Manhasan
				16.	K.A.Singh
				17.	Khandwal
				18.	Kheri Raipur
				19.	Kuthar
				20.	Majoua
				21.	Marh Drabi
				22.	Aafan
				23.	Dardapora
				24.	Doolipora
				25.	Khurhama
				26.	Mushikjal
				27.	Sanzipora
				28.	Ashmaar
				29.	Mahu
				30.	Paprian
				31.	Tangar
				32.	Barigarh
				33.	Dhanwalt
				34.	G.S. Banj
				35.	Khail Seer Manjla
				36.	Nagrota Panjgrain
				37.	Thalora
				38.	Udhampur

Appendix-4.1

(Reference Paragraph 4.4.1)

Details of 42 test-checked cases of Annual Rate Contract of allopathic drugs/ medicines, AYUSH drugs/ medicines and machinery/ equipment

Sl. No.	Category of items for which NIT issued	Date of NIT	Date of Technical Evaluation committee (TEC) meeting	Time taken for holding of TEC meeting from the date of issuance of NIT	Date of Financial Evaluation Committee (FEC) meeting	Time taken for holding of FEC Meeting from TEC meeting	Date of State Level Purchase Committee (SLPC) meeting	Time take for holding of SLPC meeting from the date of holding of FEC	Time taken for holding of SLPC from the date of issuance of NIT	Date of Issuance of Rate Contract	Time taken for issuance Rate contract from holding of SLPC meeting
Allopathic drugs and medicines											
1	JKMSCL/Tend/drug & Med/05/2017	02-02-2017	29-06-2017	147	20-09-2017	83	05-10-2017	15	245	15-11-2017	41
2	JKMSCL/Med/2018-19/287 (for medicine)	09-04-2018	16-07-2018	98	21-07-2018	5	08-08-2018	18	121	27-08-2018	19
3	JKMSCL/Med/2018-19/302 (for the procurement of Drugs & IV Fluids)	03-01-2019	27-03-2019	83	30-03-2019	3	10-04-2019	11	97	11-05-2019	31
4	JKMSCL/Med/2019/322 (supply for drugs)	04-06-2019	14-10-2019	132	16-10-2019	2	20-11-2019	35	169	06-01-2020	47
5	JKMSCL/Med/2019/361(for the procurement of essential drugs)	19-09-2019	06-01-2020	109	15-01-2020	9	18-01-2020	3	121	13-03-2020	55
6	JKMSCL/Med/2019/366(for the procurement of essential drugs)	08-11-2019	17-01-2020	70	18-01-2020	1	18-01-2020	0	71	04-02-2020	17

Sl. No.	Category of items for which NIT issued	Date of NIT	Date of Technical Evaluation committee (TEC) meeting	Time taken for holding of TEC meeting from the date of issuance of NIT	Date of Financial Evaluation Committee (FEC) meeting	Time taken for holding of FEC Meeting from TEC meeting	Date of State Level Purchase Committee (SLPC) meeting	Time take for holding of SLPC meeting from the date of holding of FEC	Time taken for holding of SLPC from the date of issuance of NIT	Date of Issuance of Rate Contract	Time taken for issuance Rate contract from holding of SLPC meeting
7	JKMSCL/Allop. Medicines/2020/402 (For the procurement of Allopathic Medicines)	23-06-2020	18-11-2020	148	20-11-2020	2	28-11-2020	8	158	07-12-2020	9
8	JKMSCL/Drugs for NHM/2020/433	02-12-2020	17-12-2020	15	30-12-2020	13	27-01-2021	28	56	04-02-2021	8
9	JKMSCL/Emergency/ Drugs/2021/440	05-01-2020	15-01-2021	376	02-03-2021	46	16-03-2021	14	436	16-04-2021	31
10	JKMSCL/Surfactant 4ml 2021/453	06-03-2021	23-03-2021	17	08-04-2021	16	29-05-2021	51	84	03-06-2021	5
11	JKMSCL/Drugs for PHCs & Sub Centres/2021/454	09-03-2021	24-03-2021	15	29-05-2021	66	16-06-2021	18	99	30-06-2021	14
12	JKMSCL/Allop. Med/2021/447	14-01-2021	24-02-2021	41	29-05-2021	94	28-06-2021	30	165	01-07-2021	3
AYUSH Drugs and Medicine											
1	JKMSCL/Ayd/Unani/ Med/2017/130	27-01-2017	18-11-2017	295	22-11-2017	4	22-12-2017	30	329	02-01-2018	11
2	JKMSCL/Ayd/Unani/ Med/2017/285	16-03-2018	08-06-2019	449	08-06-2019	0	01-08-2019	54	503	14-09-2019	44

Sl. No.	Category of items for which NIT issued	Date of NIT	Date of Technical Evaluation committee (TEC) meeting	Time taken for holding of TEC meeting from the date of issuance of NIT	Date of Financial Evaluation Committee (FEC) meeting	Time taken for holding of FEC Meeting from TEC meeting	Date of State Level Purchase Committee (SLPC) meeting	Time take for holding of SLPC meeting from the date of holding of FEC	Time taken for holding of SLPC from the date of issuance of NIT	Date of Issuance of Rate Contract	Time taken for issuance Rate contract from holding of SLPC meeting
3	JKMSCL/Ayd/Unani/ Med/2019/383	14-03-2020	20-08-2020	159	24-08-2020	4	08-09-2020	15	178	28-09-2020	20
Machinery/ equipment and other items											
1	NIT/JKMSCL/MACH/ BSL/2016-17/56	25-11-2016	20-12-2016	25	19-08-2017	242	07-11-2017	80	347	11-04-2018	155
2	NIT/JKMSCL/MACH/ 2016-17/275	04-09-2017	19-01-2018	137	01-02-2018	13	15-03-2018	42	192	11-04-2018	27
3	NIT/JKMSCL/MACH (II)/2017/280	18-11-2017	12-10-2018	328	13-10-2018	1	26-10-2018	13	342	28-12-2018	63
4	NIT/JKMSCL/MACH/ BSL/2017/283	20-12-2017	24-12-2017	4	07-03-2018	73	15-03-2018	8	85	21-04-2018	37
5	NIT/JKMSCL/MACH/ 2017/296	14-07-2018	20-09-2018	68	29-12-2018	100	12-01-2019	14	182	28-02-2019	47
6	NIT/JKMSCL/MACH/ 2017/300	23-10-2018	28-12-2018	66	25-01-2019	28	08-02-2019	14	108	28-02-2019	20
7	NIT/JKMSCL/MACH/ 2017/301	03-01-2019	08-06-2019	156	08-06-2019	0	14-06-2019	6	162	19-07-2019	35
8	NIT/JKMSCL/MACH/ 2017/317	15-05-2019	08-07-2019	54	03-01-2020	179	18-01-2020	15	248	28-02-2020	41
9	NIT/JKMSCL/MACH/ 2017/319	23-05-2019	28-08-2019	97	21-09-2019	24	25-09-2019	4	125	11-11-2019	47

Sl. No.	Category of items for which NIT issued	Date of NIT	Date of Technical Evaluation committee (TEC) meeting	Time taken for holding of TEC meeting from the date of issuance of NIT	Date of Financial Evaluation Committee (FEC) meeting	Time taken for holding of FEC Meeting from TEC meeting	Date of State Level Purchase Committee (SLPC) meeting	Time take for holding of SLPC meeting from the date of holding of FEC	Time taken for holding of SLPC from the date of issuance of NIT	Date of Issuance of Rate Contract	Time taken for issuance Rate contract from holding of SLPC meeting
10	NIT/JKMSCL/MACH/2017/348	25-07-2019	06-09-2019	43	12-06-2020	280	19-08-2020	68	391	19-09-2020	31
11	NIT/JKMSCL/MACH/2017/399	15-06-2020	06-08-2020	52	05-08-2021	364	10-08-2021	5	421	23-09-2021	44
12	NIT/JKMSCL/MACH/2017/405	11-07-2020	07-09-2020	58	28-11-2020	82	28-11-2020	0	140	02-12-2020	4
13	NIT/JKMSCL/MACH/2017/434	09-12-2020	09-01-2021	31	16-03-2021	66	16-03-2021	0	97	08-04-2021	23
14	JKMSCL/dressinf material/2018-19/291	20-04-2018	29-08-2018	131	13-10-2018	45	12-01-2019	91	267	11-02-2019	30
15	JKMSCL/dressinf material/2019-21/313	24-01-2019	13-09-2019	232	24-09-2019	11	25-09-2019	1	244	17-12-2019	83
16	JKMSCL/SURGICAL DISPOSABLE/2015/105	23-11-2015	07-04-2016	136	12-04-2016	5	26-04-2016	14	155	04-05-2016	8
17	JKMSCL/SURGICAL DISPOSABLE/2017/234	11-04-2017	15-09-2017	157	13-06-2018	271	04-07-2018	21	449	31-07-2018	27
18	JKMSCL/MED/2021/444	11-01-2021	23-06-2021	163	21-09-2021	90	25-09-2021	4	257	08-10-2021	13
19	JKMSCL/COMMONITEMS/2016/28	27-07-2016	24-09-2016	59	03-02-2017	132	04-07-2018	516	707	03-08-2018	30

Sl. No.	Category of items for which NIT issued	Date of NIT	Date of Technical Evaluation committee (TEC) meeting	Time taken for holding of TEC meeting from the date of issuance of NIT	Date of Financial Evaluation Committee (FEC) meeting	Time taken for holding of FEC Meeting from TEC meeting	Date of State Level Purchase Committee (SLPC) meeting	Time take for holding of SLPC meeting from the date of holding of FEC	Time taken for holding of SLPC from the date of issuance of NIT	Date of Issuance of Rate Contract	Time taken for issuance Rate contract from holding of SLPC meeting
20	JKMSCL/BLOODBAGS&KITS/2016/01	20-02-2016	28-05-2016	98	01-08-2016	65	16-11-2016	107	270	21-12-2016	35
21	JKMSCL/BLOODBAGS/2017/1473	23-11-2017	25-05-2018	183	13-06-2018	19	04-07-2018	21	223	04-09-2018	62
22	JKMSCL/MED/2021/449	18-01-2021	05-10-2021	260	02-12-2021	58	22-12-2021	20	338	10-01-2022	19
23	JKMSCL/FURNITURE/2015/110	28-11-2015	18-01-2016	51	11-03-2016	53	14-03-2016	3	107	18-03-2016	4
24	JKMSCL/HOSPITALFURNITURE/2017/233	07-04-2017	15-09-2017	161	13-06-2018	271	04-07-2018	21	453	07-08-2018	34
25	JKMSCL/HOSPITALFURNITURE/2019/309	16-01-2019	26-04-2019	100	01-07-2019	66	01-08-2019	31	197	19-12-2019	140
26	JKMSCL/HOSPITALFURNITUR/2019/311	17-01-2019	17-07-2019	181	24-07-2019	7	01-08-2019	8	196	13-12-2019	134
27	JKMSCL/HOSPITALFURNITURE/2021/439	02-01-2021	03-05-2021	121	06-05-2021	3	29-05-2021	23	147	05-06-2021	7

Appendix 9.1

(Reference Paragraph 9.1)

Statement of Indicators for Sustainable Development Goals 3

(Ensure healthy lives and promote well-being for all at all ages)

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 1,00,000 live births	I	3.1.1 Maternal mortality ratio	1. Maternal Mortality Ratio	Adopted	1. Maternal Mortality Ratio (Per 1,00,000 live births)
		I	3.1.2 Proportion of births attended by skilled health personnel	2. Percentage of births attended by skilled health personnel. (Period 05 years)		2. Percentage of births attended by skilled health personnel. (Period 05 years)
				3. Percentage of births attended by skilled health personnel. (Period 01 year)		3. Percentage of births attended by skilled health personnel. (Period 01 year)
				4. Percentage of women aged 15−49 years with a live birth, for last birth, who received antenatal care, four times or more. (Period 05 years/ 01 year)		4. Percentage of women aged 15−49 years with a live birth, for last birth, who received antenatal care, four times or more. (Period 05 years/ 01 year)
3.2	By 2030, end preventable deaths of newborns and children under 05 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	I	3.2.1 Under-5 mortality rate	1. Under-5 mortality rate.	Adopted	5. Under-5 mortality rate per 1,000 live births
		I	3.2.2 Neonatal mortality rate	2. Neonatal mortality rate.		6. Neonatal mortality rate per 1,000 live births.
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and	I	3.3.1 Number of new HIV infections per 1,000 uninfected population, by	1. Number of new HIV infections per 1,000 uninfected population	Adopted	7. Number of new HIV infections per 1000 uninfected population

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
	neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases		sex, age and key populations.			
		I	3.3.2 Tuberculosis incidence per 1,00,000 population	2. Tuberculosis incidence per 1,00,000 population	Adopted	8. Tuberculosis incidence per one lakh population
		I	3.3.3 Malaria incidence per 1,000 population	3. Malaria incidence per 1,000 population		9. Malaria incidence per 1,000 population
		I	3.3.4 Hepatitis B incidence per 1,00,000 population	4. Prevalence of Hepatitis "B" per 1,00,000 population		
		I	3.3.5 Number of people requiring interventions against neglected tropical diseases			
						10. Percentage of HIV Prevalence rate. (*UT specific*)
				5. Dengue: Case Fatality Ratio (CFR)		11. Dengue: Case Fatality Ratio (CFR)
				6.The proportion of grade-2 cases amongst new cases of Leprosy		12. The proportion of grade-2 cases amongst new cases of Leprosy
				7. Percentage of blocks reporting < 01 Kala Azar case per 10,000 population out of the total endemic blocks		
				8. Percentage of districts reporting < 1 *per cent* Microfilaria rate (MF) out of Targeted Endemic districts		
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases	I	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	1. Number of deaths due to cancer		

Targets		Indicators				
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		Tier	**Indicators**			
	through prevention and treatment and promote mental health and well-being	I	3.4.2 Suicide mortality rate	2. Suicide mortality rate	Adopted	13. Suicide mortality Rate (per 1,00,000 population.
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	II	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	1. Number of persons treated in de-addiction centres		14. Number of persons treated in de-addiction centres.
		I	3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	2. Percentage of population (men15-49 years) & women (15-49 years) who drink alcohol about once a week out of total population (men15-49 years) & women (15-49 years) who drink alcohol.		
				3. Percentage of population (men (15-54 years) and women (15-49 years)) who consume alcohol		15. Percentage of population (men 15-54 years) and women (15-49 years)) who consume alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents	I	3.6.1 Death rate due to road traffic injuries	1. People killed / injured in road accidents.	Adopted	16. People killed/injured in road accidents per one lakh population
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration	I	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	1. Percentage of currently married women (15-49 years) who have their need for family planning satisfied with modern methods.		17. Percentage of currently married women aged (15-49 years) who have their need for family planning satisfied with modern methods
						18. Total Fertility Rate (*UT specific*)
				2. Percentage of currently married women (15-49 years) who use any modern		19.Percentage of currently married women (15-49 years) who use any modern

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
	of reproductive health into national strategies and programmes			family planning methods		family planning methods
		I	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	3. Percentage of women aged 15-19 years who were already mothers or pregnant.		20. Percentage of women aged 15-19 years who were already mothers or pregnant.
				4.Adolescent birth rate (aged 15-19) per 1,000 women in that age group		21. Adolescent birth rate (aged 15-19) per 1,000 women in that age group
				5. Percentage of Institutional Births. (05 years/ 01 years)	Adopted	22. Percentage of institutional deliveries/births. (period 05 years/ 01 year)
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	I	3.8.1 Coverage of essential health services	Not adopted		
		I	3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income	1. Proportion of population with large household expenditure on health as a share of total household expenditure or income.	*Monthly per capita out-of-pocket expenditure on health as a share of Monthly Per capita Consumption Expenditure (MPCE)	
				2. Percentage of currently married women (15-49 years) who use any modern family planning methods.		23. Percentage of currently married women (15-49 years) who use any modern family planning methods

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
				3. Percentage of people living with HIV currently receiving ART among the detected number of adults and children living with HIV		24. Percentage of people living with HIV currently receiving ART among the detected number of adults and children living with HIV
				4. Prevalence of hypertension among men and women age 15-49 years 2015-16 (in percentage).		25. Prevalence of hypertension among men and women age 15-49 years.
				5. Percentage of population in age group 15-49 who reported sought treatment out of total population in that age group having diabetes.		
				6. Percentage of women aged 15-49 who have ever under gone Cervix examination.		26. Percentage of women aged 30-49 years who have ever under gone a screening test for Cervical cancer.
				7. Percentage of TB cases successfully treated (cured plus treatment completed) 21 among TB cases notified to the national health authorities during a specified period		27. Percentage of TB cases successfully treated (cured plus treatment completed) among TB cases notified to the national health authorities during a specified period
				8.Total physicians, nurses and midwives per 10,000 population		
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	I	3.9.1 Mortality rate attributed to household and ambient air pollution	1.Proportion of men and women reporting Asthma in the age group 15-49 years.		28.Proportion of men and women reporting Asthma 15-49 years
		I	3.9.2 Mortality rate attributed to	Not adopted		

Targets		Indicators				
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		Tier	**Indicators**			
			unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)			
		I	3.9.3 Mortality rate attributed to unintentional poisoning	1. Mortality rate attributed to unintentional poisoning		29. Mortality rate attributed to unintentional poisoning per lakh population.
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	I	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older	1. Percentage of adults 15 years and above with use of any kind of tobacco (smoking and smokeless)		30. Percentage of women aged 15 -49 years and men aged 15-49 years with use of any kind of tobacco.
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, 23 in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use	I	3.b.1 Proportion of the target population covered by all vaccines included in their national programme	1. Proportion of the target population covered by all vaccines included in their national programme	Adopted	31. Percentage of children aged 12-23 months fully immunised.

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
	to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all					
		I	3.b.2 Total net official development assistance to medical research and basic health sectors	1. Budgetary allocation for department of Health Research		
		II	3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	Not adopted		
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	I	3.c.1 Health worker density and distribution	1. Total physicians, nurses and midwives per 10,000 population	Adopted	32. Health worker density per 10,000 population
				2. Percentage of government spending (Current and Capital)		33. Percentage of government spending (Current and Capital

Targets		Indicators				
Global Target No.	**Targets of SDG 3**	**Global Indicators Framework for SDG of the 2030 Agenda and their Tier-wise classifications**		**National Indicator Framework (Version-3.0) developed by MOSPI as of 31.03.2021**	**Indicators adopted in India SDG Index 20-21**	**Indicators adopted by Jammu & Kashmir**
		Tier	**Indicators**			
				in health sector to GDP.		expenditure) in health sector to GDP
						34. Percentage of government spending (Current and Capital expenditure) in health sector to total spending.
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	I	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness		
		II	3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	Not adopted		
Total	**13**	**Tier I = 25 Tier II = 3**	**28**	**41**	**9 + 1* different from NIF@**	**34**

@ NIF: National Indicators Framework developed by Ministry of Statistical Programme Implementation (MOSPI), GOI.

(Source: Global Indicators Framework, National Indicators Framework (Version-3.0), India SDG Index 20-21)

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