B. Social Sectors

1. WOMEN AND CHILD DEVELOPMENT

INTRODUCTION

Human development as an objective is meant to embrace all sections of society. Accordingly, the Constitution of India guarantees equality to all citizens without any discrimination on the basis of race, sex, caste, creed, etc. Yet the ground reality is that women find it difficult to realize their Constitutional rights despite the commitment to work towards equality and social justice (Rajasthan Human Development Report, 1999).

The status of women and children is almost the same in all the states and union territories, where males dominate and females are accorded low status. Women's work has historically been excluded from accounting schemes of the male-dominated production process and male-constructed development discourse. Human development as a concept is incomplete without understanding the ways in which the 'situations are gendered' – whether at home, school, workplace or in the public sphere (The Madhya Pradesh Human Development Report, 1995).

Although in Indian cultural tradition it is the prime duty of the man to protect the child and woman, this social ethics is not conformed to in actual practice. The means of an average family is generally inadequate for the proper upbringing and care of children and women (Situation Analysis of Children and Women in Jammu and Kashmir, 1989).

Therefore, in order to present a balance-sheet of human development of Jammu and Kashmir, it is necessary to know the existing gender differentials in the state. Against this backdrop, this sub-section attempts to take stock of women's conditions in different settings, which can be analysed under the following heads:

1. Socio-economic security and livelihood issues;
2. Physical security, health and survival issues; and
3. Political security and participation in civil life.

SOCIO-ECONOMIC SECURITY AND LIVELIHOOD ISSUES

Education: Education is one of the key areas of the social service sector. It is a process by which people are subjected to the influence of a selected and controlled environment so that they can attain social competence and an optimum level of development. It allows people to stand on their own feet by enhancing their potential to work for the betterment of their own life and society at large.

It has been observed that the nations who have achieved their literacy targets are developing and progressing rapidly in every field of life as compared to those with a low literacy rate. This was true of Kashmir society where the literacy rate was very low especially among the women-folk. They were educationally very backward and lagged behind the rest of the population. Gradually the government and other organisations have made commendable efforts to improve education.

Education enabled Kashmiri women to secure an emancipated position in economic, social and political fields. As a result, women in the Kashmiri society are actively participating in all public and private sectors, governmental and non-governmental sectors, in the educational sector (as educationists, teacher and lecturers), in courts (as lawyers and judges), in the medical sphere (as doctors) and in other fields as engineers and architects.

The spread of education in the state has made great strides in the past few decades of planned development; considerable educational facilities are available even in remote hilly and backward areas. Table III.49 shows the number of institutions, teachers and students on roll.

Table III.49

Institutions, Teachers, and Students on Roll

Year	Institutions	No. of Students on Roll (Lakhs)			No. of Teachers		
		Male	Female	Total	Male	Female	Total
PRIMARY SCHOOLS							
1995-96	10461	3.71	2.6	6.31	13803	8952	22755
1996-97	10483	5.19	3.74	8.93	13888	8225	22113
1997-98	10366	5.68	4.43	10.11	15401	9351	24752
1998-99	10515	6.45	5.02	11.47	18341	10599	28940
MIDDLE SCHOOL							
1995-96	3082	2.54	1.80	4.85	14300	9572	23872
1996-97	3104	3.05	1.52	4.06	14538	8842	23362
1997-98	3613	2.41	1.64	4.05	15325	9649	24974
1998-99	3507	1.44	1.81	4.31	16803	11373	28176
HIGH SCHOOL/HIGHER SECONDARY SCHOOL							
1995-96	1359	2.50	1.53	4.03	16580	7544	24124
1996-97	1351	2.50	0.53	2.27	16501	7521	24022
1997-98	1431	1.78	1.15	2.93	17207	9350	26557
1998-99	1466	1.86	1.19	3.05	19976	10653	30629

Source: Digest of Statistics, 1999-2000, Government of Jammu and Kashmir.

The table clearly indicates that the number of primary schools went up from 10461 in 1996-97 to 10515 in 1998-99, indicating a very marginal increase of 0.51 per cent. Likewise, the number of students on roll in primary school and number of primary teachers witnessed an increase of 81.7 per cent and 27.1 per cent respectively (from 1996-97 to 1998-99). This shows that the number of students in primary schools has

gone up, but without a proportionate increase in the number of teachers. The number of middle and high and higher secondary schools has gone up, but students on roll have been declining. The number of teachers in middle and high schools has increased, but this does not indicate satisfactory development.

The data available from a number of institutions clearly shows a pyramid-like structure with a large number of primary schools, a few middle schools and very few high and higher secondary schools. This means that every higher order centre has some specialized facilities that are not present in the preceding lower order centre.

The analysis of the gender equation or the enrolment ratio reveals that the female enrolment ratio has remained lower than the males at all the three levels. The male-female difference was maximum at the primary level. Similarly the dropout rate was found to be higher among girls especially after the primary school, as is clear from Table III.49. Here it may be mentioned that the low enrolment ratio and high drop-out rates among girls shows that our social system first deprives the girls of educational facility like other important opportunities later in life *(Situation Analysis of Children and Women in Jammu and Kashmir, 1989).*

Although separate figures for drop-out rates in rural and urban areas are not available, it can safely be guessed that drop-out rates for girls in rural areas will be higher than the urban areas.

Table III.50
Drop-out Rates (1995-96)

Class	Boys	Girls	Total
I to V	53.13	41.48	48.36
VI to VII	50.10	72.40	59.24

Source: Godbole Report, 1998.

Factors responsible for non-enrolment, low enrolment and drop-out rates could be classified into the following:

1. Supply-related factors which include long distances to schools and/or dysfunctional schools.
2. Opportunity Costs including financial constraints, domestic work and participation in household activities, as well as participation in paid economic activity outside household.
3. Lack of interest among mothers to send their daughters to schools.

Income and Employment: The importance of women's economic independence for their overall dignity and even survival is brought out by the fact that there is a linkage between the physical survival of women and their entry into the workforce.

Data for women's occupation are not available for the state of Jammu and Kashmir. However, it can be generalized that due to limited knowledge, skill and resources at their disposal, they are engaged in informal and unorganized sectors where the wages are very low. Low income degrades their quality of life and lowers their standards of living. Their occupational categories are largely determined by their skill, level of education and knowledge. Broadly, their activities are classified under two heads:

- Activities that require less technical know-how;
- Intensive labour-oriented activities.

From these general facts it can be inferred that while females are vital productive workers in the state economy, they are under-valued by society because their work is generally unrecognized and un-rewarded. In addition to this, women lack access to resources and receive a smaller share of what is produced. Moreover, social attitudes view women only as supplementary income earners even when they contribute a large percentage of the family income. Women generally lack bureaucratic know-how that most men are able to acquire to make the system work for them. Thus the condition of females is characterized as *"They play by the rules but lose the game".*

PHYSICAL SECURITY, HEALTH AND SURVIVAL ISSUES

Physical Health: The status of health with respect to indicators like fertility, mortality and morbidity will be discussed in the following section on 'Health'. Here it may be mentioned that women and the girl child tend to get marginalized due to their low visibility and status and due to the fact that their health issues are confined within the domestic sphere.

The spheres of activities of women – social, biological and other related factors make women vulnerable to a myriad health risks. In addition to the specific health risks within each sphere of activity, women appear to be faced with the double or triple burden of risks as they fulfill multiple labour roles in social reproduction. (Social reproduction comprises activities related to functioning of family and household that takes place both within and outside the home).

During the reproductive span, females have to bear a great risk during frequent child births and that too at an early age. In addition, females have to perform a lot of

household chores like washing, cooking etc. This coupled with malnutrition (due to poverty) undermines their health and in the long run increases the morbidity rate among females. The situation becomes worse because the diagnostic and curative facilities acquire a gender bias in terms of use. A combination of external factors and self-neglect among females plays a significant role in increasing the health problems in the following ways:

- Low family income may result in fewer payments for medical care. The immediate consequence is the decreased quality of care and poorer quality of health care.
- The cost of bringing up the female child is comparatively lesser.
- Many areas may face a dearth of female doctors. Females may be shy to visit a male doctor, leading to self-neglect.
- It may also happen that the timings of the doctor may not be suitable for the females. Doctors may be available only for a short time. By the time the females complete their household work and make their journey to the hospital, the hospital may close down. Under such circumstances, a second trip to the hospital may be unlikely.
- It may be impossible for a female to visit a doctor without permission from their family members and she may be reluctant to share her specific problem with the members.
- Many diseases which occur during her lifetime, especially those which occur during pregnancy may be considered a part of the process and may not be reported.

In the light of the above facts, there is an urgent need to empower the women to improve the quality of life among women and children.

Violence against Women: The global campaign for the elimination of violence against women in the recent years indicates that the enormity and the seriousness of atrocities committed against women are being witnessed the world over. Development along with its progressive changes in personal lifestyles, living standards, varied economic growth caused by urbanization and changes in social ethos contribute to violent attitudes and negativity towards women which has resulted in an increase in crime against women. Such incidents are a matter of serious concern and it is necessary so that the women of India get their rightful share and live in dignity, freedom, and peace, free from crimes and aspersions. The battle against crime against women has to be waged by the various sections of society through campaigns and various programmes with social support along with legal protection safeguards and reforms in the criminal justice system *(Crime in India, 1999, National Crime Records Bureau).*

Despite all safeguards, the women in our country continue to suffer due to lack of awareness of their rights, illiteracy and oppressive practices and customs.

Crime rate in India and Jammu and Kashmir

According to the IPC, crimes against women are classified under the following heads:

1. Rape
2. Kidnapping and abduction
3. Dowry Deaths
4. Torture (Physical and Mental)
5. Sexual harassment
6. Importation of girls up to 21 years of age.

The state and UT-wise incidence of all the cognizable Indian Penal Code (IPC) crimes (violent and non-violent) along with the rank of criminality.

Table III.51

Rate of IPC Crimes in States during 1999

All India 178.9

State with crime rate (total IPC crimes) above all-India average			States with crime rate (total IPC crime) below all-India average		
S.No	**State**	**Rate**	**S.No**	**State**	**Rate**
1	**Rajasthan**	**317.7**	**1**	**Jammu & Kashmir**	**174.7**
2	**Kerala**	**294.4**	**2**	**Himachal Pradesh**	**167.8**
3	**Madhya Pradesh**	**261.3**	**3**	**Goa**	**166.0**
4	**Gujarat**	**261.1**	**4**	**Andhra Pradesh**	**160.5**
5	**Mizoram**	**238.7**	**5**	**Assam**	**143.5**
6	**Tamil Nadu**	**237.2**	**6**	**Orrisa**	**141.4**
7	**Karnataka**	**214.1**	**7**	**Sikkim**	**141.4**
8	**Haryana**	**202.2**	**8**	**Bihar**	**120.2**
9	**Maharashtra**	**196.2**	**9**	**Uttar Pradesh**	**103.6**
10	**Arunachal Pradesh**	**193.7**	**10**	**Manipur**	**100.0**
			11	**Punjab**	**86.7**
			12	**West Bengal**	**84.9**
			13	**Tripura**	**84.6**
			14	**Nagaland**	**75.7**
			15	**Meghalaya**	**72.2**

Source: Crime in India, 1999, National Crime Records Bureau, Ministry of Home Affairs.

The table clearly indicates that the crime rate is maximum in Rajasthan (317.7) and minimum in Meghalaya (72.2). There are 10 states which lie above the national average of 178.9, and 15 states below the national average. Jammu and Kashmir ranks 11th among the states and its rate is just below the national average (174.7)

The incidence (I) and rate (R) of cognizable crime (IPC) under different crime in India and Jammu and Kashmir is shown in Table III.52.

Table III.52

Incidence and Rate of cognizable crime (IPC) under different crime 1999

Crime	Jammu and Kashmir		India	
	Incidence	Rate	Incidence	Rate
Kidnapping & Abduction of women and girls	**473 (2)**	**4.8**	**14934 (4)**	**1.5**
Rape	**170 (4)**	**1.7**	**15031 (3)**	**1.5**
Dowry Deaths	**6 (6)**	**0.1**	**6564 (5)**	**0.7**
Molestation	**507 (1)**	**5.2**	**31640 (2)**	**3.3**
Sexual Harassment	**341 (3)**	**3.5**	**8673 (6)**	**0.9**
Cruelty by husbands and relatives	**39 (5)**	**0.4**	**43669 (1)**	**4.5**
Importation of girls	**0 (7)**	**0.0**	**1 (7)**	**0.0**
Total IPC Crime	**1542**	**15.8**	**135771**	**13.8**

Source: Crime in India, 1999, National Crime Records Bureau, Ministry of Home Affairs

Note: Crime Rate is defined as the incidence of crime per 1 lakh population. Figures in parentheses indicate rank.

The data for Jammu and Kashmir clearly indicates that the incidence of molestation has been maximum (507) followed by kidnapping and abduction of women and girls (473). Next ranks sexual harassment accounting for 341 incidents. Rape accounts for 170 incidents. Other crimes account for less than 10. There are very few cases of dowry deaths (6) and there was no case of importation of girls. District-wise incidence of cognizable crime (IPC) during 1999 is given in Table III.53.

Table III.53

District-wise Incidence of Cognizable Crime (IPC)

State/ District	Rape	Kidnapping & Abduction of		Dowry deaths	Molest-ation	Sexual harassment	Cruelty by husband & relative	Importation of girls	Total Cog. Crime under IPC
		Women & girls	Others						
Anantnag	5	9	49	0	50	7	0	0	883
Awantipore	4	11	3	0	11	2	0	0	377
Badgam	11	33	0	0	22	13	0	0	617
Baramulla	14	82	13	0	110	12	0	0	1850
Border	17	28	0	0	14	15	0	0	1412
Crime Jammu	0	0	0	0	0	0	0	0	16
Crime Srinagar	0	0	0	0	0	0	0	0	14
Doda	13	21	0	0	11	6	0	0	912
Ganderbal	1	29	0	0	24	0	0	0	303
Jammu	6	57	0	6	17	97	26	0	2657
Kargil	0	1	0	0	3	0	0	0	103
Kathua	10	7	2	0	7	10	4	0	692
Kulgam	6	4	29	0	6	3	0	0	437
Kupwara	6	30	4	0	51	3	0	0	803
Leh	1	1	0	0	0	0	0	0	159
Poonch	5	16	0	0	4	3	2	0	551
Pulwama	15	58	0	0	31	7	0	0	749
Railways	0	0	0	0	0	1	0	0	22
Rajouri	15	21	0	0	6	6	0	0	770
Srinagar	16	50	42	0	110	149	0	0	2379
Udhampur	25	15	8	0	30	7	7	0	1448
Total	170	473	150	6	507	341	39	0	17103

Source: *Crime in India*, 1999, National Crime Records Bureau, Ministry of Home Affairs.

These figures clearly indicate that women are victims of violence from their husbands and relatives as well as from outside the family, suffering from physical brutality as well as economic insecurity. Apart from the violence faced by women from within the family and from criminal elements outside, many women are also victims of systemic violence from within their own communities.

All the evidence points to the seriousness of the atrocities committed against women. Development along with its progressive changes in personal lifestyle, living standards and economic growth, caused by urbanization and changes in the social ethos contribute to a violent attitude and behaviour towards women. Such incidents are a matter of serious concern and their containment is a necessity so that the women of India attain their rightful share and live in dignity, freedom, and peace and free from crimes and aspersions.

A woman in terms of status and prestige is evaluated as one lacking in courage, who is submissive and docile and has to obey the orders of her husband and in-laws. Against this background, females and children become the target for all forms of violence. Consequent to discrimination in all spheres of life, females are subjected to both physical and mental trauma and anguish. Above all the stress of domestic work leaves them with little time for self-awareness or their psychological and physical needs. In addition, females bear the brunt of violence due to the following reasons:

1. Domestic violence within the four walls of the house in the absence of a witness. Even those who witness turn a blind eye to it, treating it as a purely personal and private matter that has to be sorted out within the family. These attitudes go a long way in legitimizing violence.
2. Reluctance among females to report cases due to fear of retaliation by their husbands or other members of the family and exposure of family quarrels in the community.
3. Many females find it difficult to register cases of violence against their husbands given their financial and social dependence on them.

Thus it may be inferred that violence against women is as common in Jammu and Kashmir as in other states.

POLITICAL SECURITY AND PARTICIPATION IN CIVIL LIFE

A study from Kashmir University revealed that when it comes to contesting of elections, women of Kashmir are nowhere in the picture. Today's educated women do not seem to be interested in joining politics. Kashmiri women looking for a career or a profession hardly look at politics as a desirable choice.

The mass political participation of women in early period of the 1930s in the Freedom movement nurtured a few prominent women political leaders and activists who highlighted the problems of women. This was the first time that the women of Kashmir participated in an organised manner. The women of Kashmir have been participating in the elections since then.

In a survey conducted by Kashmir University, nearly 68 per cent of the respondents were of the opinion that women should take part in politics and contest elections, holding the view that the "hands which rocks the cradle rules the world". Women have potential and can shoulder responsibilities in a more systematic way, can work better for problems related to women, resulting in their empowerment. About 32 per cent of the respondents felt that it was scandalous for to go for politics. Today's corrupt politics does not suit women who want to progress. Woman should take care of her home and children and not of the nation. Politics being a dirty game is unfit for women and they should keep away from it.

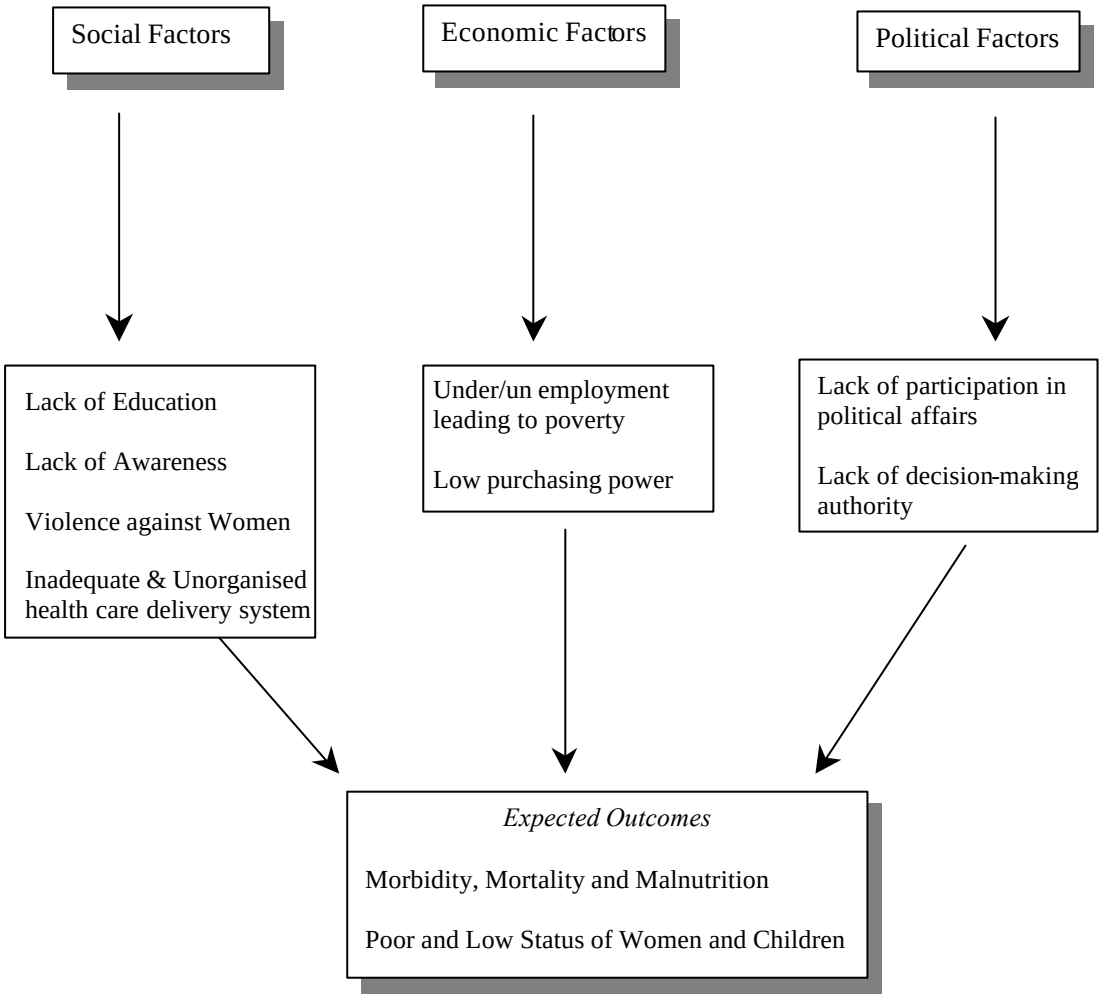
The data further revealed that the working Kashmiri women, on the other hand, were fully aware about political ups and downs. They wanted women to take part in politics and that the avenues for the younger generation be kept open. They were of the opinion that women's participation in political and social issues is needed for holistic development. Women's involvement on a significant scale should be made possible but the few working women who were aware about the sordid politics of today wanted that women should remain away from the political scenario.

From the foregoing discussion it may be concluded that women are the major contributors to the survival of the family. In spite of shouldering the entire household activities and childcare responsibilities, social convention and gender ideology often deprives them of material assets. Socially, they are conditioned to a life of dependency. On accounting of the overall backwardness and lack of infrastructure, women and children get marginalized.

The condition of women and the girl child is depicted in the flow diagram in Figure 6. The diagram clearly shows the devaluation of women and girl child in every sphere of life. A woman is never viewed as a person in her own right, but always as someone's daughter, wife or mother. Women are always discriminated against in access to health, nutrition, education, etc.

Under such circumstances there is an urgent need to empower women and children. In the light of this, several programmes have been started. However, they have not achieved the anticipated positive impact on the status of women. The following section discusses the programme for women and child development.

Fig. 6: Major Components Affecting Women and Child Development



PROGRAMMES FOR DEVELOPMENT OF WOMEN AND CHILDREN

The Integrated Rural Development Programme comprises sub-schemes for poverty alleviation namely IRDP, TRYSEM and DWCRA.

1. *Integrated Rural Development Programme:* This programme was launched in the state on 2 October 1980, with the main objective of enabling identified poor rural families to cross the poverty line by taking up multifarious activities on income generation.

The said programme was taken up by on a 50:50 sharing pattern between state and central government. Under this scheme, subsidy is provided to small, marginal, scheduled castes, scheduled tribes, and educated unemployed youth at different rates. Assistance is provided mainly to families with an annual income below Rs.11000/-.

2. *Training of Rural Youth for Self-Employment (TRYSEM):* TRYSEM, a supportive component of IRDP started as a centrally sponsored scheme on a 50:50 basis. It aims at providing technical and entrepreneurial skill to rural youth belonging to families identified below the poverty line to enable them to take up income-generating activities.

3. *Development of Women and Child in Rural Areas (DWCRA):* This scheme was started in 1983-84 with the primary objective of focusing attention on women members of rural families below poverty line and providing them with opportunities for self-employment on a sustained basis.

Jammu and Kashmir Women Development Corporation* was incorporated in the year 1991 under the Companies Act of 1956 with an authorized share capital of Rs.5.00 crore. It started functioning w.e.f. the year 1994. The Corporation is implementing a number of developmental schemes for the socio economic upliftment of females with special focus on the upliftment of women in families below the poverty line and those women belonging to minorities, backward and other classes.

The Corporation arranges grant-in-aid, loans, etc., for eligible females/NGOs/societies working for the welfare and development of women from government of India/Apex Corporations through their various schemes. The Corporation has trained a number of women in different traditional and non-traditional trades, besides providing soft loans to various women for setting up their own income- cum-employment generating units. Jammu and Kashmir Women's Development Corporation has also done a commendable job. A brief description of the activities/schemes undertaken by the corporation is as follows:

(i) Norwegian Agency for International Development (NORAD): This is a centrally sponsored 100 per cent Grant-in-aid scheme under which training-cum-production-cum-employment generation centres are set up in different parts of the state of Jammu and Kashmir. The training is being imparted to women in different traditional and non-traditional trades; so far the Corporation has trained 5434/

* Source: Report obtained from the office of Jammu & Kashmir Women's State Development Corporation.

10,000 (2002) women through this scheme. After the completion of the training period, trainees work either with NGOs or have set up income-generating units by taking loans from Corporation. The proposal for setting up training-cum-employment generating units is submitted to the Government of India, Ministry of Human Resource Development Department of Women and Child Development after receipt of the same from reputed NGOs. The sanctions and grant-in-aid is received from Government of India and the same is released in favour of the NGOs for setting up of training centres which are monitored by the Corporation till their completion. The Corporation has recommended 95 proposals to Department of Women and Child Development, Government of India out of which 61 proposals have been considered in the Project Sanctioning Committee (NORAD). The training centres are functioning. The remaining proposals will be sanctioned in the next Project Sanctioning Committee meeting and are expected to receive Rs. 2.50 crore as grant-in-aid during the current financial year under this scheme.

(ii) National Minorities Development and Finance Corporation (NMDFC): The government of India has identified five communities, viz., Muslim, Buddhist, Sikh, Christian and Zoroastrians as minorities at the national level on the basis of the population census.

The National Minorities Development and Finance Corporation through the J&K Women's Development Corporation which is its channelising agency provides long-term loans at a concessional rate of interest to assist the poor segment of the minority population for setting up of income-cum-employment generating units. The Corporation lifts loans from NMDFC at a rate of 4.5 per cent rate interest and disburses the same to the beneficiaries among minority communities at 7 per cent. Till the end of March 2001, the Corporation had received an amount of Rs. 379.065 lakh from NMDFC out of which an amount of Rs. 379.065 lakh had been disbursed to 400 beneficiaries (for the financial year 2002-03). An amount of Rs.2 crore has being proposed. The loans are being secured according to the norms already fixed, i.e. 85 per cent will be contributed by National Minorities Development and Finance Corporation, 10 per cent by J&K Women's Development Corporation and 5 per cent by the beneficiary. The Corporation has contributed an amount of 46.00 lakh (amount met from share capital). During the current financial year, according to the action plan of the National Minorities Development and Finance Corporation, Rs.23.50 lakh would be contributed by the J&K Women's Development Corporation which needs to be earmarked.

(iii) Rashtriya Mahila Kosh (RMK): The State Women Development Corporation has been declared as channelising agency of Rashtriya Mahila Kosh for the women of

J&K state. This is also a centrally sponsored loan scheme. Under this scheme, micro loans are provided to the poorest of the poor women of the target group, i.e. those below the poverty level at an interest rate of 9.5 per cent as against an interest rate of 8 per cent charged by Rashtriya Mahila Kosh. The corporation could charge interest at 12 per cent per annum from the beneficiaries but keeping in view the economic condition of the poor women artisans of the state, the Board of Directors has fixed the same at 9.5 per cent. During the year 2002-03, the corporation proposed to lift and disburse an amount of Rs. 10.00 lakh to cover sixty women. An amount of Rs. 0.50 lakh needs to be earmarked as monitoring charges.

(iv) Support to Trainees and Employment Programme (STEP): The scheme envisages support to rural women for better training in socio-economic developmental activities in the agriculture and allied sectors, viz., dairy, handloom, etc. Under this scheme, the Government of India provides funds in the pattern of 90 per cent: 10 per cent per beneficiary to impart training to a cluster of minimum five hundred beneficiaries of a particular area to take up income-cum-employment generating activities. In the current year, the corporation has submitted a proposal for Rs. 2.50 crore to the Government of India through the administrative department in dairy development, handlooms, handicrafts and mushroom cultivation. The corporation has already got the area surveyed through the Department of Management and Studies, University of Jammu. After receiving the sanction for the same from Government of India, the Corporation intends to take up some more areas under this scheme. An amount of Rs. 25.00 lakh as 10 per cent share will have to be earmarked in this regard.

(v) National Backward Classes Finance and Development Corporation (NBCFDC): This is also a centrally sponsored loaning scheme wherein the loans are being lifted from the apex corporation, viz., National Backward Classes Finance and Development Corporation for assistance to the women of the backward and other classes. An amount of Rs.1 crore stands allocated to J&K Women's Development Corporation during the year 2002-2003; the corporation intends to lift the said amount as the case for government guarantee is under process in the administrative department. For this purpose an amount of Rs.10.00 lakh (10 per cent contribution) will have to be earmarked. The corporation has also released an amount of Rs.5 lakh under the micro financing scheme. The amount is to be disbursed through NGOs.

(vi) National Handicapped Finance and Development Corporation (NHFDC): Under this scheme, the apex corporation, viz., National Handicapped Finance and

Development Corporation provides loans for handicapped beneficiaries; the Corporation has already been declared as the state's channelising agency for receiving and disbursing the loans to the target groups and the Corporation proposes to lift and disburse an amount of Rs. 50 lakh. The government guarantee stands issued and an amount of Rs.5 lakh needs to be earmarked for this purpose.

(vii) Swyamsidha Women Empowerment Programme (SWEP): The J&K State Women's Development Corporation has been appointed as a nodal agency by the administrative department, viz., Social Welfare Department Government of Jammu and Kashmir to implement the scheme of Swyamsidha Women Empowerment Programme (SWEP) in J & K. It is an integrated scheme for women's empowerment and is basically designed for formation of women into Self Help Groups (SHGs) wherein awareness and confidence will be generated in them both economically and socially regarding their status, health, nutrition, education, sanitation, legal rights, upliftment, control over resources, saving habits, access to micro credit, involvement in local-level planning, etc. In this connection, the J&K State Women's Development Corporation proposes to cover one block of each district covering thirteen out of fourteen districts of J&K. In each block 100 SHGs will be formed. Training centres under NORAD will also be set up. Women will also be benefited in other schemes implemented by J&K Women's Development Corporation. It is proposed to implement the scheme after receipt of funds from Government of India. Under this scheme, funds will be allocated by Government of India under State Action Plan and Rs. 14.20 per Block (excluding Rs.4.00 lakh as Self Help Group contribution).

(viii) Exhibition/Marketing Assistance/Sales etc: The Corporation has participated in exhibitions and craft melas at different places within and outside the state in the previous year to provide marketing exposure to the women artisans, beneficiaries of NMDFC and trainees of the NORAD scheme. Up to now, the Corporation has been assisting NGOs and cooperative societies for participation in craft melas and exhibitions. The corporation also proposes to hold an exhibitions in Jammu & Kashmir in which northern States shall also participate. This will provide a marketing outlet for NMDFC beneficiaries who are being provided with loans by the corporation.

During the year 2002-2003, the corporation proposed to spend an amount of Rs.0.30 lakh, that is, 10 per cent, of its total grant, to be received from the NMDFC for holding an exhibition in the state and Rs.2.70 lakh for exhibitions outside the state. Thus a total Rs.3 lakh needs to be earmarked.

(ix) Awareness Generation Camps: The Corporation has been providing loans to the beneficiaries under different schemes and there has been quite a good response for these schemes. However, some of the beneficiaries who had taken loans have become defaulters. The Corporation has initiated legal action against them and that has given fruitful results and the cost of legal expenses ultimately has to be debited to the defaulting beneficiaries. Since the beneficiaries are living below the poverty level and it is not fair that they should be overloaded by such debts in these cases, awareness is required to be created among the women beneficiaries for which the camps/seminars and meetings need to be arranged. During the year 2002-2003 the Corporation proposed to conduct these camps in different parts/ districts of the State with a financial estimate of about Rs.1.00 lakh. Earlier, the Corporation was spending money from the Mahila Samridhi Yojna but according to the latest communication received from the Government of India, the amount released for the purpose of awareness camps is to be refunded to the Government of India as the scheme has been withdrawn by them.

*Ladakh:** The Women's Alliance of Ladakh (WAL) was formed in the early 1990s to counter the negative consequences of development and the increasing participation of Ladakh in global economy. This has been set up in the light of new economic pressures in Ladakh that have marginalised women. Women tend to be left behind on the farm when men and young people flock to the city for jobs or education. Consequently, women's decision-making power decreases while their workload increases.

WAL is a rural alliance whose primary aim is to encourage respect for women, farming and Ladakhi culture in general. The core representatives meet every month to discuss the problems raised by Ladakh's development and to strengthen and empower each other through group decision and group action. This has promoted deeper interaction between women in villages throughout Ladakh, and has further raised awareness of the implication of modernisation for Ladakhi culture, agriculture and the role of women.

With this perspective, the main aims and objectives of WAL are:

- To maintain respect for the ethical and spiritual values on which Ladakhi culture is based.
- To promote development in harmony with the aforementioned values, benefiting the entire community without harming nature or the heritage of future generations.
- To encourage a respect for Ladakhi culture and to counter the embarrassment that many young people feel about Ladakhi food, dress, language, song and dance.

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* Report obtained from the office of Women' Alliance of Ladakh, Ladakh.

- To highlight the importance of agriculture for Ladakhi economy and to counter the notion that farming is an inferior occupation; also to protect indigenous knowledge and seeds and warn against the dangers of cash cropping, chemical fertilizers, pesticides and hybridized seeds.
- To maintain respect for local knowledge, crafts and practical skills.
- To affirm and support extended families and strong communities.

In the new economy, political and economic power is even more centralised, as decisions affecting everyday life are made in remote government departments and corporate offices. The few jobs available are generally filled by men, while the women are left behind to do the agricultural work that was once shared by both. Even as their workload doubles, women's status has fallen: the traditional Ladakhi farmer, once the backbone of the economy, is increasingly considered backward and irrelevant, an impediment to progress. In addition, women who tend to have less formal schooling than men are looked down on as illiterate and ignorant.

Faced with such widespread challenges, WAL aims to promote development in harmony with the ethical and spiritual values based on Ladakhi culture. Such development should benefit the entire community. The broad programme of activities includes:

- Encouraging continuation of shared labour. Until recent years, the ploughing and harvesting was done on a co-operative basis, with families taking helping one another. Cash economy is breaking down this co-operative system, creating the need for expensive, hired labour. This imposes a financial burden on the household and threatens the viability of farming in Ladakh.
- Supporting and encouraging locally adapted agricultural methods, while at the same time raising awareness about the hazards of large scale industrial agriculture. In contrast to Ladakh's historically low input, flexible and ecologically sustainable farming methods, the forms of agriculture which are increasingly being promoted require even larger amounts of capital, fertilizers and chemical pesticides. A seed bank has also been instituted to preserve indigenous seed exchange programe and seed varieties adapted to Ladakh's unique ecology. New vegetable varieties have also been introduced to broaden the range of locally produced foods and to facilitate a subsidiary cash income through the sale of vegetables.
- Providing information regarding the nutritional superiority of locally grown fresh organic foods over imported mass-produced packaged foods, which have been transported over great distances at high environmental costs. The trend among the younger generation on processed food is particularly disturbing. WAL advertise messages by educating mothers and children about the benefits of locally grown food.

- Encourage members to retain their cultural identity by continuing to wear the unique Ladakhi dress. The rejection of Ladakhi clothing, particularly by the younger generations, is a disturbing symptom of the embarrassment and a sense of inferiority Ladakhis feel about themselves and their culture. WAL efforts are to make the community aware about the importance of wearing Ladakhi dress with pride.
- Organising educational programmes for Ladakhis and Westerners. Six Ladakhi women have been sent to the West to experience directly the negative aspects of western style of economic development. A cultural exchange programme brings Western tourists to Ladakh to stay with and get to know a local farming family.

Since the recommendations to improve the status of women and children is more or less the same as that of health, the combined suggestions have been given at the end of health section.

Box 1: **Empowering Women for Improved Health and Nutrition**

The complex socio-cultural determinants of women's health and nutrition have cumulative effects over a life-time. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child. Under-nutrition and micronutrient deficiency in early adolescence goes beyond mere food entitlements to those nutrition-related capabilities that become crucial to a woman's well-being, and through her to the well-being of children. The positive effects of good health and children on the labour productivity of the poor are well documented. To the extent that the women are over-represented among the poor, interventions for improving women's health and nutrition are critical for poverty reduction.

Impaired health and nutrition is compounded by early child-bearing, and consequent risk of serious pregnancy related complications. Women's risk of premature death and stability is highest during their reproductive years. Malnutrition, frequent pregnancies, unsafe abortions, RTIs and STIs all combine to keep the maternal mortality ratio in India among the highest globally.

Maternal mortality is not merely a health disadvantage, it's a matter of social injustice. Low social and economic status of girl and women limits their access to education, good nutrition, as well as money to pay for health care and family planning services. The extent of maternal mortality is an indicator of disparity and inequality of access to appropriate health care and nutrition services throughout a lifetime, and particularly during pregnancy and childbirth, a crucial factor contributing to high maternal mortality.

Programmes for safe motherhood, universal immunization, child survival and oral rehydration have been combined into an Integrated Reproductive and Child Health Programme, which also includes promoting management of STIs and RTIs. Women's health and nutrition problems can largely be prevented or mitigated through low cost interventions designed for low income settings.

The voluntary non-government sector and the private corporate sector should actively collaborate with the community and government through specific commitment in the areas of basic reproductive and child health care, basic education and in securing higher levels of participation in the paid workforce for women.

(Extracts from National Population Policy, 2000)

2. HEALTH

INTRODUCTION

Good health is the basic objective of any development effort. The concept of human development as defined by UNDP rests on three pillars: knowledge, health and livelihood. Health of the people has been recognized as a valuable national resource and the government's endeavour has been to improve the same and enable them to contribute to the enhancement of the nation's productivity.

Health is defined by World Health Organization (WHO) as a state of complete physical, mental and social well-being and not just avoidance of disease. Physical health implies the perfect functioning of the body (WHO 1948). It conceptualises health as a state in which every cell or organ is functioning at optimum capacity and is in perfect harmony with the rest of the body. Mental health implies not merely the absence of illness but the state of balance between the individual and the surrounding world, and a state of harmony between oneself and others, and co-existence between oneself and others and between the realities of self and that of other people and that of the environment (Sartorious, 1983). Social well-being implies the quality and quantity of interpersonal ties and the extent of involvement within the individual, between each individual and other members of the society and between each individual and the world in which he lives. Thus health is a multi-dimensional and a wholistic concept involving the well-being of the whole community.

STATUS OF HEALTH IN JAMMU & KASHMIR

Initially it was seen that the health status of the people was poor due to prevalence of diseases of various kinds resulting in morbidity and mortality. This was specially so with respect to women and children. The constraints in the improvement of health status of the people included lack of financial resources, dearth of technical staff, and inadequate health infrastructure. Therefore, in order to improve the health status and to achieve the objectives of "Health for All", the Government of India enunciated the National Health Policy in 1983. In response to this, the state government initiated a number of programmes and activities through which health and medical services could flow to the needy and gradually achieve the aims and objectives set under the national policy. As a result, some improvement was seen in the health status of the people.

While this is in itself a positive sign, the rates of change are far too slow for sustainable development and a better quality of life for the people. The state has not been able to keep pace with the national level achievement, in spite of giving due priority to the health sector while distributing state resources. Further, recent disturbances may also have worsened the condition. Consequently, the state till date has a considerable segment of population living below poverty line, with poor infrastructure amongst abundant resources. Under such conditions, women are the most affected, given the burden of child bearing in a patriarchal set up. Poverty coupled with poor social status, lack of access to social development, increases health problems.

Set in this background, this sub-section presents an intriguing picture of the health status in Jammu and Kashmir as measured by fertility, mortality and morbidity indicators. These vital indicators indicate the health status and well-being of the people in society, and give a broad idea of the issues related to health and nutrition.

Table III.54 gives a cursory glance at the health status as measured by three indicators, namely, crude birth rate, crude death rate and infant mortality rate in Jammu and Kashmir.

Table III.54
Comparison of Health Indicators of Jammu & Kashmir with India – 1998.

(per 1000 persons)

HEALTH INDICATORS	J&K	INDIA
CRUDE BIRTH RATE	19.9	26.50
CRUDE DEATH RATE	5.4	9.0
INFANT MORTALITY RATE	45 *	72

Source: Registrar General of India, sample Registration Bulletin.
*Infant Mortality Rate is for three year period 1996-98

It is evident that all three indicators are far below their respective national averages. It may safely be guessed that owing to backwardness in terms of other socio-economic indicators, it may take a few years to achieve further reduction. This shows that a lot more has to be done to improve the health status.

As regards diseases, water-borne diseases including intestinal infections, worm infection, diarrhoea, jaundice, typhoid, etc., are found to be the most common. Other diseases of development, such as, hypertension, heart attack, etc., also exist.

Besides, there are imbalances in the spread of health institutions, physical facilities, equipment and availability of manpower. The health care delivery system is skewed in favour of urban areas. (The health care delivery system has been discussed in detail in subsequent sections).

MEASUREMENT OF HEALTH STATUS WITH RESPECT TO SELECTED INDICATORS

The development status of the region can be measured in terms of some basic indicators over a span of time of space. Literacy and health are the core of human resource development. The most common indicators of health are crude birth rate, crude death rate and infant mortality rate.

I. Fertility Indicators

Fertility indicators such as the crude birth rate, general fertility rate are crude summary measures of the rate at which the population is replacing itself. A more precise picture of fertility can be obtained by examining the age-specific fertility rate (ASFR) and total fertility rate, (TFR) because they are not affected by the age structure (National Family Health Survey, 1993-94).

Crude birth rate is defined as number of live births per thousand population. The number of live births per thousand population in Jammu and Kashmir is shown in Table III.55.

Table III.55
Trends in Live Births in Jammu and Kashmir

Year		No. of Live Births		
		Male	*Female*	*Total*
1995	T	85501	72443	157944
	R	47349	39457	86806
	U	38152	32986	71138
1996	T	95171	74442	169613
	R	53400	40778	94178
	U	41771	33664	75435
1997	T	94507	81243	175750
	R	57446	49676	107122
	U	37061	31567	68628
1998	T	98959	85384	184343
	R	59498	51610	111108
	U	39461	33774	73235
1999	T	99027	86207	185234
	R	61022	52907	113929
	U	38005	33300	71305

Source: *Registrar General of India, Sample Registration Bulletin.*

The trend clearly indicates that the total number of live births has consistently gone up from 1,57,944 in 1995 to 1,85,234 in 1999. This shows that there has been an increase of 14.73 per cent. The reason for this could be an improvement in medical facilities. Likewise the rural and urban areas too show a similar upward trend.

Table III.56 shows the trend in birth rate in India and Jammu and Kashmir.

Table III.56
Annual Birth Rate per Million

Year	Jammu and Kashmir	India
1986	33.40	32.60
1987	30.40	32.00
1988	32.60	31.30
1989	31.10	30.60
1990	31.40*	29.90
1998	19.90	26.50

Source: Registrar General of India, sample Registration Bulletin.
* Figure is based on the average of the previous three years since no half-yearly survey was conducted.
Since SRS was out of order from 1990 to 1998, no information is available for the years 1991-1997.

It is evident from the trend line, that both in Jammu and Kashmir and in rest of India, the annual birth rate has shown a declining trend. In Jammu and Kashmir, the annual birth rate fluctuated between 30 per million and 34 per million. After 1990, there was a sudden decline and it fell to nearly 20 per million, while in India the decline has been gradual.

Another point which emerges from the table is that up to 1990 the birth rate in Jammu and Kashmir had remained only slightly higher than that of India. In 1998, a drastic difference is found between Jammu and Kashmir and India.

A break-up of rural and urban areas indicates that birth rate in rural areas (20.8) has remained higher than in the urban areas (16.1) in 1998. The same pattern is seen in the rest of India too.

Age-specific fertility rate is another important indicator which follows the expected pattern. Fertility peaks in the 15-25 age group. This is true for both rural and urban areas. After 25, a steady decline in the fertility rate is noticed, which reaches very low levels for women in their forties. The same trend could be ascertained in the case of Jammu and Kashmir.

The low fertility rates for women in the highest age groups may be because many women in these ages have been sterilised or are menopausal. Moreover, terminal absence from sexual intercourse is commonly practised once the daughter attains menarche or once any of the children gets married and has a child (National Family Health Survey, 1992-93).

Other important indicators of fertility and fertility preference is given in Table III.57:

Table III.57
Indicators of Fertility and Fertility Preferences 1999

Total fertility rate (for the past 3 years)	2.71
Mean number of children ever borne to women in the age 40-49	4.79
Median age at first birth among women age 20-49	NA
Per cent of births [1] of order of 3 and above	50.30
Mean ideal number of children [2]	2.70
Per cent of women with 2 children wanting another child	30.90
Per cent never married among women age 15-19	91.50
Median age at marriage among women age 20-49	18.70

1. For births in the past three years. 2. Excluding women giving non-numeric responses.
Source: Population Studies Centre, Jammu and Kashmir.

MORTALITY INDICATORS

This section provides a comprehensive picture of the prevalence of mortality rates. This information is required for demographic assessment of the population and for planning health policies and programmes. Mortality indicators are helpful in identifying the sectors of population that are at high risk and in need of health care service. Some of the important indicators of mortality are as follows

A. Crude Death Rate

Crude death rate is defined as the number of deaths per 1000 people. Among the Indian states, Jammu and Kashmir accounts for only a small percentage of mortality in India and is well below the national average of 9.0.

A comparison of rural and urban areas shows that the rural death rate is higher than the urban, both at the state as well as at the national level.

Table III.58
Death Rate in Rural and Urban Areas, 1998 (Per 1000 persons)

State/Country	Death Rate		
	Rural	Urban	Combined
India	9.7	6.6	9.0
Jammu and Kashmir	5.6	4.6	5.4

Source: Sample Registration System, Registrar General of India.

Table III.59
Annual Death Rate Trends

(Per million)

Year	Jammu and Kashmir	India
1986	9.00	11.10
1987	8.00	10.80
1988	8.30	10.90
1989	7.60	10.30
1990	7.90 *	9.60
1998	5.40	9.00

Source: Registrar General of India
*Figures are based on average of the previous three years since no half yearly survey was conducted. Since SRS was out of order from 1990 to 1998, no information is available for the years 1991-1997.

It is evident that the annual death rate has been declining in both Jammu and Kashmir and rest of India. In Jammu and Kashmir, the annual death rates fluctuated between 5 per million and 10 per million. After 1990 a sharp decline from 7.90 (1990) to 5.40 (1998) is noticed in J&K, while in the rest of India the decline has been gradual.

Another conspicuous feature that emerges from the table is that the death rate in Jammu and Kashmir has remained lower than that of the rest of India. A break-up of rural and urban areas indicates that the death rate in rural areas has remained higher than in urban areas. Higher death rates in rural areas highlight economic deprivation, lack of access to resources and infrastructure that assure survival.

Table III.60
Trends in Number of Deaths

Year	T/R/U	Male	Female	Total
1995	T	16698	12673	29371
	R	11595	9856	21451
	U	5103	2817	7920
1996	T	17930	13761	17393
	R	13120	10076	23196
	U	4810	3685	8495
1997	T	17393	15174	32567
	R	12964	11417	24381
	U	4429	3757	8186
1998	T	19774	17296	37070
	R	12890	11431	24321
	U	6884	5865	12749
1999	T	20039	17552	37591
	R	13743	12188	25931
	U	6296	5364	11660

Source: Directorate of Economics and Statistics, Jammu and Kashmir.

A trend in the number of deaths from 1995 to 1999 shows that the number of deaths has gone up from 29371 (1995) to 37591 (1999), i.e., an increase of 27.98 per cent.

Table III.61
Death rate by Sex and Residence

(Per 1000 people)

State	Death Rate by Sex			Death Rate by Residence	
	Total	Male	Female	Rural	Urban
Jammu & Kashmir	5.4	5.8	5.0	5.6	4.6
India	9.0	9.2	8.8	9.7	6.6

Source: Sample registration system, Registrar General of India.
Note: Estimate of Death Rates for Jammu & Kashmir is not reliable due to inadequacy of returns.

B. Infant Mortality Rate

The infant mortality rate is the most widely used indicator of child survival and a proxy indicator of health status. It measures the number of infant deaths in the 0-1 age group per 1000 live births.

Table III.62
Infant Mortality Rate – 1994 and 1998

(Per 1000 persons)

State/Country	1994	1998
J&K	45	45
India	72	72

Source: Sample Registration System, Registrar General of India.

Table III.62 clearly indicates that Jammu & Kashmir has made absolutely no progress in 1994 and 1998 to reduce the infant mortality rate as it has remained the same in both the years. The break-up of infant mortality rate is evident in Table III.63.

Table III.63
Break-up of Infant Mortality Rate by sex and residence 1998

(Per 1000 persons)

State/Country		Total	Male	Female
Jammu & Kashmir	Total	45.4	39.5	52.1
	Rural	45.5	37.9	54.1
	Urban	45.1	48.1	41.7
India	Total	71.6	69.8	73.5
	Rural	77.4	76.0	78.9
	Urban	44.9	41.5	48.7

Source: Sample Registration System, Registrar General of India.
Note: Estimates of Infant Mortality Rates for Jammu & Kashmir is not reliable due to inadequacy of returns.

A comparison of infant mortality rate in the rest of India with Jammu and Kashmir shows that the IMR in Jammu and Kashmir is far below the national average of 71.6 per thousand. Even the rural-urban and male-female break-up for Jammu and Kashmir is below the national average. This indicates a very positive signal for the state towards reducing infant deaths. The state is as such devoid of problems of infanticide and feoticide.

However, when we analyse the data at the state level, it is evident that there are glaring differences between male-female and rural-urban infant mortality rates. It is clear that the infant mortality among females is still high, especially in rural areas. There are wide variations in male and female infant mortality rate in rural areas as

37.9 for males and 54.1 for females. The difference tends to be lower in urban areas as 48.1 for males and 41.7 for females.

Possible reasons for Infant Mortality Rate

The persisting rate of infant mortality is a manifestation of the inadequate care given to the child during adolescent age, and the mother during pregnancy and after childbirth. The quality of antenatal and post-natal care influences the survival of infants. This is reflected in the high incidence of pre-mature birth as being the significant cause of infant mortality.

Low birth weight including premature birth is one of the major causes for infant mortality as this increases their susceptibility to infection. Respiratory infections, water-borne diseases, poor immunity of neonates and infants, unclassified conditions peculiar to infancy, anemia and unclassified fevers are the major causes of infant mortality, reflecting poor nutritional and hygiene standards. Other causes peculiar to infant deaths are cord infection, congenital malformation and birth injuries. Thus a combination of poor nutrition, and inadequately treated infections causes preventable mortality during early childhood.

The Table III.64 shows the infants deaths, maternal deaths and still births by sex and residence in the districts of Jammu and Kashmir.

A cursory glance at the state-level figures indicates that the total number of infant deaths for Jammu and Kashmir is 2919. This figure is very high compared to the total maternal deaths accounting for 405 and still births accounting for 875.

At the district level it is evident that out of 14 districts, 11 districts have infant mortality rates exceeding 100. In all instances, urban male infant mortality rates are lower than rural female infant mortality rates. Maternal deaths are also found to be lower in urban areas as compared to rural areas. Women who have many children at short birth intervals almost certainly tend to live in rural areas, which raises mortality risks to their children independent of their childbearing behaviour.

Though the figures for still births account for 857, it is found that it is concentrated in just two districts, namely, Srinagar (629) and Jammu (228).

For social and biological reasons, infant mortality is co-related to mother's age at childbirth. It is generally seen that children of both very young and very old mothers are at a higher risk of dying than children whose mothers are in the prime reproductive ages. It may also be noted that infants born to young mothers are more likely to be of low birth weight, which could probably contribute to neonatal

mortality. Similarly, children born to mothers above age 30 are at higher risk of experiencing congenital malformations. The same general trend could be ascertained for Jammu and Kashmir also.

Table III.64
Number of Infant Deaths, Maternal Deaths and Still Births by Sex and Residence, 1999

District	R/U	Infant Deaths			Maternal Deaths	Still Births		
		Male	*Female*	*Total*	*Total*	*Male*	*Female*	*Total*
Srinagar	T	109	93	202	25	320	309	629
	R	71	60	131	14	0	0	0
	U	38	33	71	11	320	309	629
Budgam	T	124	107	231	31	0	0	0
	R	78	67	145	24	0	0	0
	U	46	40	86	7	0	0	0
Anantnag	T	136	116	252	31	0	0	0
	R	94	80	174	15	0	0	0
	U	42	36	78	16	0	0	0
Pulwama	T	124	104	228	48	0	0	0
	R	82	69	151	31	0	0	0
	U	42	35	77	17	0	0	0
Baramulla	T	144	123	267	33	0	0	0
	R	98	84	182	17	0	0	0
	U	46	39	85	16	0	0	0
Kupwara	T	135	115	250	19	0	0	0
	R	86	73	159	14	0	0	0
	U	49	42	91	5	0	0	0
Leh	T	44	37	81	19	0	0	0
	R	30	26	56	17	0	0	0
	U	14	11	25	2	0	0	0
Kargil	T	32	28	60	15	0	0	0
	R	32	28	60	15	0	0	0
	U	-	-	-	-	-	-	-
Jammu	T	116	99	215	28	125	103	228
	R	76	64	140	15	0	0	0
	U	40	35	75	13	125	103	228
Kathua	T	132	112	244	40	0	0	0
	R	94	80	174	25	0	0	0
	U	38	32	70	15	0	0	0
Udhampur	T	138	118	256	31	0	0	0
	R	99	85	184	16	0	0	0
	U	39	33	72	15	0	0	0
Rajouri	T	127	108	235	34	0	0	0
	R	90	77	167	24	0	0	0
	U	37	31	68	10	0	0	0
Doda	T	134	114	248	29	0	0	0
	R	97	82	179	20	0	0	0
	U	37	32	69	9	0	0	0
Poonch	T	81	69	150	22	0	0	0
	R	51	44	95	15	0	0	0
	U	30	25	55	7	0	0	0
J & K	T	1576	1343	2919	405	445	412	857
	R	1078	919	1997	262	0	0	0
	U	498	424	922	143	445	412	857

Source: Directorate of Economics and Statistics, Jammu and Kashmir.

Specific factors responsible for maternal mortality as identified by various studies are pregnancy wastage caused by abortions and still births. Such foetal wastage prevails more in low-income groups. Much of the pregnancy loss and perinatal mortality (number of still births plus deaths of infants of less than seven days per 1000 live births plus still births during the year) is caused by premature births and malnutrition. Perinatal mortality and still birth results from premature births, itself a consequence of maternal malnutrition, particularly iron deficiency during pregnancy. Another reason for infant and maternal mortality relates to high birth disorders. Frequent pregnancies cause protein malnutrition of the mothers.

C. Other Indicators: Other indicators considered to assess the health status include neo-natal mortality, post neonatal mortality, child mortality and under-5 mortality. These indicators give a clearer picture of the degree of the vulnerability of an infant at different stages of infancy. Neonatal mortality and post neonatal mortality rate are good indicators of availability, accessibility and use of maternal and child health services and use of obstetric care.

Table III.65
Health Indicators

(Per 1000 persons)

Indicators	Jammu and Kashmir	India
Neonatal mortality [1]	40.3	43.4
Post neonatal mortality [2]	24.7	24.2
Child mortality	16.1	29.3
Under 5 mortality	80.1	94.9
Infant mortality	65.0	67.6

Source: Towards Equality – The Unfinished Agenda – Status of Women in India 2001.

Note: Post neonatal mortality has been calculated as the difference between the infant and neonatal mortality rates

1. Neonatal mortality rate refers to the number of deaths in the first four weeks per 1000 live births during the year
2. Post neonatal mortality rate refers to number of deaths in the subsequent 48 weeks per 1000 live births in a year
3. Data is for the 5-year period preceding the survey (1998-99)

It is evident from the Table III.65 that all the five indicators are well below the national average. When all the five indicators are analysed, it is found that U5 mortality rate is the maximum accounting for 80 per thousand. This is closely followed by infant mortality rate (65 per thousand). Other indicators account for less than 50 per thousand.

The neonatal mortality rate of 40.3 for Jammu and Kashmir indicates the critical importance of the first four weeks in child survival. Post-neonatal mortality rate of 24.7 indicates that there has been some success in reducing the percentage of deaths in the post neonatal stage. Important causes for neonatal and perinatal mortality are low birth

weight, tetanus, congenital malformation, and birth asphyxia. Among the associated factors are unsafe motherhood, unmet women's reproductive health needs, lack of health care delivery system and other environmental and socio-economic factors.

NUTRITION

The National Nutrition Policy (NNP) has considered poverty in terms of a self-perpetuating vicious circle: causative sequential links being low intake of food and nutrition – under nutrition with attendant nutrition related diseases and infections – faltering growth of children – small body size of adults – impaired productivity – low learning capacity — back to poverty.

According to NNP, the problems of nutrition have to be addressed in terms of an overall development strategy, nutrition being tackled both independently and along with other development issues. Direct interventions are required in the short term for expanding the safety net, reducing the incidence of severe and moderate malnutrition, reaching the adolescent girls, ensuring better coverage of expectant women, fortification of essential goods, popularisation of low-cost nutrition food, and control of micro-nutrient deficiencies among vulnerable groups *(Towards Equality – The Unfinished Agenda, Status of Women in India 2001, Sarala Gopalan, NCW, Government of India).*

Indices of Nutrition Status: The following Table III.66 shows the indices of nutritional status in Jammu and Kashmir. The table clearly shows that more than 75 per cent of women in the state are anaemic. The data also shows the level of undernourishment, both chronic and acute among children, leading to stunting and wasting.

Table III.66
Indices of Nutritional Status

Percentage of women with anaemia [1]	58.70
Percentage of women with moderate/severe amaemia [1]	19.40
Percentage of children aged 6-35 months with anaemia	71.10
Percentage of children with moderate/severe amaemia	42.00
Percentage of children chronically undernourished (stunted) [2]	38.80
Percentage of children acutely undernourished (wasted) [2]	11.80
Percentage of children underweight [2]	34.50

Source: Population Studies Research Center, Economics Department, University of Kashmir

1. Anaemia – haemoglobin level < 11.0 grams/deciliter (g/dl) for children and pregnant women and < 12.0 g/dl for non-pregnant women. Moderate/severe anaemia – haemoglobin level <10.0 g/dl
2. Stunting assessed by height-for-age, wasting assessed by weight-for-height, underweight assessed by weight-for-age.

Undernourishment manifests itself in the stunting of height and wasting of height for both boys and girls, leading to problems of protein energy malnutrition, iron deficiency, iodine deficiency, vitamin A deficiency and low birth weight of children. People in hilly areas have special nutrition problems. (According to the National Nutrition Monitoring Bureau, at the age of five years, there is a deficit of stature of 8 to 9 cms, at the age of 20, of 12 to 13 cms, and at 55 years of age there is a height loss of 2 cms due to osteoporosis).

Adolescents undergoing rapid growth and development are one of the nutritionally vulnerable groups who have not received the attention they deserved. In under-nourished children, rapid growth during adolescence may increase the severity of under-nutrition. Low dietary intake is the most important cause of under-nutrition. Early marriage and pregnancy further perpetuate both maternal and child under-nutrition.

Other major factors responsible for under nutrition in children are poor infant feeding practices, infections due to poor sanitation, lack of safe drinking water and poor access to health care, gender discrimination in breast-feeding, and feeding patterns of baby girls.

MORBIDITY PATTERN AND CAUSATIVE FACTORS IN ILL-HEALTH

According to Prof. Titmus, the termination of an individual's life "is a product of an enormous number of complex and inter-related forces, from government policy in international affairs to the local methods of refuse disposal and from a coal owner's decision to close the pits to a mother's intake of calcium". Narrowing down this diversity to identify, to pinpoint the causes of poor health in the community, two factors are operative, namely poverty and insanitary urbanisation.

When the pattern of morbidity and mortality is examined, it is found that the above statement is meaningful even today. The state has now become a major foci for a combination of diseases of under-development (malaria, diarrhoea, cholera, measles) together with those of development (cardiovascular and other chronic respiratory diseases). Lack of basic facilities leads to proliferation of some disease vectors, which increases the possibility for transmission of infectious diseases. Thus, people live under unhealthy conditions with differential patterns of morbidity and mortality. Besides this, a new pattern of disease is emerging with arrival of AIDS and dengue on the one side and resurgence of once eradicated or controlled diseases, such as plague, cholera, etc. on the other. Failure of municipal services (such as sanitation and garbage collection) to keep pace with the growing population increases health hazards. Likewise, declining access to health care delivery system to keep up with

the growing population may magnify the health problems of those afflicted with the diseases.

In order to have a generalised and simplified picture, the disease pattern has been identified according to the prevailing environmental, economic, social and cultural conditions in which the people live.

Environmental Factors and Health: Outbreak of diseases in Jammu and Kashmir is closely related to environmental degradation traceable to inadequacy of urban civic amenities. Municipal services are either virtually non-existent or woefully lacking. The major components of environment are: safe drinking water, sanitation and garbage disposal and housing quality.

Water: Among the basic amenities, provision of safe drinking water is a primary requirement for good health. However, the process of urbanisation and haphazard growth has degraded the quality of water beyond permissible safety levels. Like some other states, in Jammu and Kashmir too the demand for water outstrips supply; it has affected the comfort and health of the people and has led to the spread of several water- borne diseases. Pipes carrying drinking water are seen immersed in drains full of foul smelling discharge. Since pipes are not maintained properly, they suck in the sewage from these drains.

In many 'problem villages', the shortage of piped potable water forces people to use alternate sources such as rivers, rivulets and streams which are highly contaminated because of unsanitary latrines erected on their banks.

The poor quality of water has resulted in the outbreak of water-borne infection. Nearly 80 to 90 thousand cases of diarrhoea and dysentery are reported monthly between June and September. Even during the low prevalence months they represent a major chunk of disease. During April 2002, six districts of the valley reported 10800 cases of diarrhoea, 900 cases of giardiasis and 1200 cases of typhoid fever. Water-borne jaundice (Viral hepatitis A and B) is endemic in most parts of the state. In addition to a continuous simmering presence, there are seasonal flare-ups of water-borne diseases. True epidemics occur sometimes.

Sanitation and Garbage Disposal: Sanitation is one of the trunk infrastructural network which covers all aspects of waste management without endangering human safety. It includes choked drains, sub-standard toilet facilities, unclean garbage collection centers, etc.

Human excreta and cow dung, which attract disease-spreading organisms, are found littered everywhere. Drains are clogged and open; the lack of an appropriate sewerage system causes every household to discharge sewage out into open. Garbage and refuse are also carelessly thrown around. All organic waste has the potential of breeding germs. The defecation by children, old and sick in fields attracts flies and other insects which transmit disease-producing germs far and wide. At the same time, torrential rains wash off human excreta or cow dung onto the streets and nearby water resources, deteriorating the situation further.

This has resulted in the outbreak of food and water-borne diseases like cholera, jaundice, dysentery and diarrhoea, which are caused due to ingestion of food and water contaminated by flies found in already existing dirty surroundings. Malnutrition often occurs both as a cause and effect of water and food-borne diseases.

Housing Quality: Poor quality of housing, i.e. small and ill-ventilated, is responsible for indoor pollution, resulting in respiratory diseases such as asthma and TB. High density of persons in a room (room crowding) leads to close physical contact between members of the family. Thus even if one member contracts an infection, others become highly susceptible to it. Besides this, smoke produced by the use of cow dung, firewood, etc, for cooking increases the chances of respiratory diseases especially among females.

Economic Factors and Health: Economic factors, mainly poverty, eliminate or seriously limit the chances of securing proper and timely medical attention and good nutritious food. They are directly responsible for malnutrition and various deficiency diseases.

The most widespread disease caused due to malnutrition is anaemia. A child born to an anaemic and malnourished mother is bound to be chronically anaemic. Thus the ailments of infants bear a relationship to their mothers. Any amount of medicines to cure the disease from which the child is suffering does not help much, because in such cases, the disease is only a symptom of causes, which lie in the poor health of the mothers. This relationship is rarely correctly understood by the uneducated. (Mishra, 1970). Therefore, lack of education is also an important contributory factor.

A malnourished population falls easy prey to infection of all kinds. Repeated attacks of infection reduce the resistance of the body. The body reduced to a state of weakness is required to put in several hours of physical labour every day. The net result is that the body is unable to defend itself against various diseases. All these factors also contribute to food and water-borne diseases.

Socio-cultural Factors and Health: Socio-cultural values, conventions and beliefs also influence outbreak of disease. Certain socio-cultural factors act as a hindrance to proper identification and treatment of diseases. The failure to understand the scientific theories of disease causation leads people to neglect disease.

Others: Besides these, lack of personal hygiene, especially during menstruation, unsafe methods of contraception, childbirth and abortion is responsible for various gynaecological problems and reproductive tract infections, such as STDs like chlamydial, gonorrhoea, syphilis. *(Towards Equality – The Unfinished Agenda, Status of Women in India 2001, Sarala Gopalan, NCW, Government of India)*

REPRODUCTIVE HEALTH AND FAMILY PLANNING

Safe motherhood and reproductive and child health: The reproductive and child health programme in India aims at providing pregnant women with at least three antenatal check-ups, two doses of tetanus toxoid vaccine, and iron and folic acid supplementation during pregnancy for the last three months. In addition, the programme encourages institutional deliveries attended by a trained medical professional, and three postpartum visits. Table III.67 shows the state of family planning and reproductive health in Jammu and Kashmir.

Table III.67
Safe Motherhood and Women's Reproductive Health, 1999

Percentage of births [1] within 24 months of previous birth	24.9
Percentage of births [2] whose mothers received:	
Ante-natal check-ups from a health professional	83.0
Antenatal check-ups in first trimester	47.9
Two or more tetanus toxoid injections	77.7
Iron and folic acid tablets of syrup	70.80
Percentage of births [2] whose mothers were assisted at delivery by:	
Doctor	33.8
Nurse/midwife	6.70
Traditional birth attendant	50.0
Percentage [3] reporting at least one reproductive health problem	60.5

Source: Population Studies Research Centre, Department of Economics, Kashmir University.

1. For births in the past five years.
2. For births in the past three years.
3. Among currently married women aged 15-49.

The table shows that 83 per cent received the required components of antenatal care. Nearly 50 per cent received check-ups in the first trimester. This shows that the antenatal check-up facilities are easily accessible and satisfactory. Another aspect which emerges from the table is that only a small proportion of births are attended by trained professionals. About 50 per cent of the births are attended by traditional

birth attendants. This remains a major lacuna in the health system for women. It is clear that women in villages are socially and economically disadvantaged with little or no access to health care facilities, hence are less likely to deliver in institutions or to have health professionals present at the time of delivery.

The major health service for women has been in the area of contraception. Among the modern methods, female sterilization is the most predominant method in use. Other methods, namely, oral pill, conventional contraceptive methods, IUD, condom, etc constitute a very low percentage. The use of these methods has a significant effect on health and about 9 per cent of the users complained of side-effects.

Table III.68

Current Contraceptive Use [1]

(Percentage)

Any method	49.1
Any modern method	41.7
Pill	3.3
IUD	3.0
Condom	4.8
Female Sterilisation	28.0
Male Sterilisation	2.7

Source: Population Studies Research Centre, Department of Economics, Kashmir University
1. Among currently married women aged 15-49

HEALTH CARE DELIVERY SYSTEM*

Jammu and Kashmir state, as in some other developmental fields, inherited a primitive health care system at the time of Independence. Due to difficult terrain and lack of infrastructural facilities, no breakthrough could be made during the earlier times. Thus, there were only a few hospitals and dispensaries, mostly located in the cities and urban areas. As a result, most of the people particularly in rural areas remained dependent on the indigenous system of medicine.

Realising the importance of health, this sector also got priority at the time of annual plan resources distribution. The percentage outlay under health and medical education against total state plan went up from 3.5 per cent during the First Five-Year Plan to 6.56 per cent during the Ninth Plan. Thus various developmental programmes were undertaken to increase the number of health institutions to 3190 by the end of the year, i.e., 2001.

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* Details of Health Infrastructure were not available for Lakakh Division, hence the information pertains only to Leh District.

The substantial expansion taking place under the health and medical education sector, was only namesake. Most of these remained devoid of requisite infrastructure like buildings, equipments/machinery, ambulatory services etc. Appropriate medical care facilities were not available to patients.

The network of health institutions throughout the state is given in Table III.69.

Table III.69
Number of Health Institutions

Health Institutions	Numbers
Sub centers	1798
Medical Aid centers	280
Allopathic Dispensaries	250
Primary Health Centres	333
Sub District Hospital/Emergency Hospital	59
District Hospital	14
Associated Hospitals of Medical Colleges	13
Medical Colleges	2
Dental Colleges	1
SKIMS	1
Nursing Training Schools in 2 Medical Colleges	2
Ayurvedic Hospitals	1
Ayurvedic/Unani centers	437

Source: Office of the Joint Director, (Planning) Health, Government of Jammu and Kashmir.

Health Care Infrastructure in Jammu

During the past few decades, the state has been making efforts to expand the existing health facilities in terms of quality, quantity, distribution and integration, to serve the people, in particular the socially and economically disadvantaged. To meet this ambitious goal, a hierarchical system of health unit, i.e., sub-centre, primary health centers (PHCs) and community health centres (CHCs) has been designed to provide various kinds of services. The state is also trying to develop effective referral linkages between PHCs, district and teaching hospitals. In other words, the PHC is expected to play a pivotal role in the total health care system of Jammu and Kashmir. The cornerstones of such an approach are the establishment of health delivery system within the reach of the vulnerable sections and providing vertical linkages with referral services at a higher level, which would lead to a reduction in morbidity and mortality rates.

The infrastructure of medical institutions spread over in various districts of Jammu division ending March 1994 is given in Table III.70

Table III.70
District-wise Break-up of Health Institutions

Category	Jammu	Udh	Kathua	Doda	Rajouri	Poonch	Total
District Hospital	1	1	1	1	1	1	6
Sub-Distt. Hospital	4	3	3	3	2	2	17
Sarwal Hospital	1	-	-	-	-	-	1
Leprosy Hospital	1	-	-	-	-	-	1
Emer. Hospital	-	-	-	3	-	-	3
Pry. H. Centres	28	24	20	21	17	13	123
Sub. H. Centres	3	-	-	2	1	1	7
Rural A.Ds	20	24	20	44	21	18	157
Urban H. Units	8	1	-	-	1	-	10
M.A.C	13	31	18	65	13	11	151
Sub-Centers	244	144	121	134	109	85	837
P.P. Centres	2	1	2	2	2	-	9
Rural P. Centres	-	-	-	-	-	-	-
D.T.C.	1	1	1	1	1	1	6
STD Clinics	-	-	-	-	-	-	-
I.C.U	1	2	1	1	1	-	6
Lep. SET Centers	-	-	-	-	-	-	-
Distt. Hosp. covered Under visual Imp.	-	1	1	1	1	1	-

Source: Draft Ninth Five-Year Plan, 1997-2000, September 1997, Planning and Development Department, Jammu and Kashmir Government, Srinagar.

ANNUAL PLAN 1995-96: DISTRICT COMPONENT:

1. *Primary Health Centres (PHC):* As per the norms laid down by the Government of India, a PHC has to be provided for 20,000 population in hilly and backward areas. As against the requirement of 180 primary centres, only 131 primary health centers were available by the end of 1995.

2. *Sub-Centres:* 837 Sub-centres are functioning in Jammu division which have been established in accordance with the national norms of providing one sub-centre for population of 3000 in Jammu division being hilly and backward.

3. *Community Health Centers:* At present, there are 17 community health centres (Sub-District Hospital) which have been established at tehsil headquarters with specialist services in the disciplines of medicine, surgery, gynaecology, obstetrics. and pediatrics.

4. *Rehbar I Sehat:* Under this scheme, 52 blocks were covered up to end of July 1994. Three blocks were proposed to be covered during 1995-96 and 150 teachers proposed to be trained. The scheme was implemented with 50 per cent Central scheme.

5. *Rural Allopathic Dispensaries:* No new allopathic dispensary was proposed to be established during 1994-95/1995-96.

6. *Urban Health Units:* Ten Urban Health Units were established in different districts and the requested amount proposed for their maintenance during 1995-96.

7. *District Hospitals:* All the district hospitals of Jammu division have a bed strength of 100 beds each, except the District Hospital, Poonch, where the number of beds was raised from 50 to 90 during 1993-94. Adequate staff and equipment is not available in these hospitals and all possible efforts are being made to provide additional staff to the district hospital, viz., ENT specialist, etc. together with other technical and non-technical staff including nursing staff.

8. *Implementation of Plan:* Planning and statistics have been strengthened in order to monitor all states/centrally sponsored schemes effectively.

9. *District Hospital Udhampur:* A new district hospital is being constructed at Udhampur.

10. *District Hospital Kathua:* The emergency Block of a new district hospital at Kathua has come up.

11. *District Hospital Doda:* In view of the shortage of space and other problems in the existing building, it has been decided to construct a new hospital at Doda for which the land has been acquired.

12. *Emergency Hospital at Ramban/Banihal:* The government has planned to establish emergency hospitals at Ramban and Banihal and also upgrade the SK memorial hospital at Batote for providing prompt medical attention to victims of accidents on National Highway.

HEALTH INFRASTRUCTURE IN KASHMIR DIVISION

1. *Ambulances*: Owing to the hilly terrain, the inadequate number of health institutions and non-availability of specialized services, the valley has increased the demand for referral services at the district level. In the light of this a number of ambulances were proposed to be purchased between 2001 and 2003.

2. *X-Ray Plants*: According to the norms fixed, each primary health centre is to be provided with an x-ray plant. There are at present 61 units against a total requirement of 129.

3. *Drugs*: A large segment of the population is living below poverty line and is entirely dependent on government medical institutions. Therefore, the demand for augmenting funds for drugs in the hospital is increasing.

4. *Primary Health Centres*: The existing allopathic dispensaries are strengthened by diagnostic discipline and the institutes are designated as primary health centres.

5. *Sub-district Hospitals/CHCs/Emergency hospitals*: This scheme envisages upgradation of old PHCs to the status of CHCs by providing specialised services like medicine, surgery, gynaecology, obstetrics and pediatrics.

6. *Sub-Centre/IPP-VII*: This is an important scheme which aims at delivering basic health care to the people at the grassroots. The expansion programme of establishing sub-centres has been suspended for the time being. Strengthening and construction programme continues.

7. *Allopathic Dispensaries*: This is an ongoing scheme and the normal activities shall continue to be carried on.

8. *Rehbar-I-Sehat:* This is an alternative scheme of 'Village health guide' of government of India that aims at delivering basic health care facilities to the rural masses through school teachers.

9. *District Hospitals*: It covers urban areas and caters to the referral services of the rural areas of the district as well. The main hospitals under this are:

   - JLNM Hospital/Leper Hospital
   - District Hospital Budgam
   - District Hospital Pulwama
   - District Hospital Anantnag
   - District Hospital Baramulla
   - District Hospital Handwara.

Health infrastructure in Leh*

During the past few decades drastic changes have taken place in the health care delivery system in Leh. During the 9th Five-Year Plan, an improved health care system was successfully implemented in all corners of the district. The 9th Five-Year Plan is called the *"Golden Period of Health Department"*. Simultaneous development has taken place in all the four components of the services: preventive, promotive, curative and rehabilitative.

At present there are 192 different high and small health institutions in the district, details of which are given in Table III.71

* Details of Health Infrastructure was not available for Ladakh Division, hence the information pertains only to Leh district.

Table III.71
Health Institutions in Leh

Sl. No	Name of the Institute	Number	Place	Bed Strength	Future Expansion (10th FYP)
1	District Hospital	1	Leh	150	300
2	S.D.H	1	Nubra	50	2
3	C.H.C	1	Skurbuchan	15	1
4	P.H.C	6		10	10
5	A/Ds	8			
6	M.A.C	63			20
7	Sub centres (Health)	53			
8	Family Planning Centers	2			
9	Sub-centre (FW)	22			
10	Amchi Centre	40			10
11	CHW	30			20
12	RST	129			150

Source: Office of the Chief Medical Officer, Leh.

At present there are services of different specialties, i.e., 8 in S.N.M hospital, Leh, but 11 specialists services shall be available by the 10th Five-Year Plan. The sub-district hospital at Nubra – a 50 bedded centrally heated hospital is likely to be commissioned any time with three specialists. By the end of 10th Five-Year Plan two new SDH at Nyoma and Khalsi shall be commissioned. All the 8 A/Ds shall be converted into Primary Health Centres and five more new PHCs shall be opened during 10th Five-Year Plan.

All the block HQs are provided with at least 2 ambulances each for referring of patients to District HQs and one ambulance is also kept at remote places like Chushool, Turtukan and Skurbuchan to refer patients to block HQs.

Diagnostic facilities at District Headquarters

Besides basic investigation facilities like X-ray, ultrasonography sophisticated equipments like the endoscope, colonoscope, colposcope, blood auto-analyser are also available. Moreover, the services of a woman doctor at the entire block HQs with a proper labour room and basic labour equipment are available.

To provide medical facilities to the needy people of the far-flung and cut-off areas, the department arranges frequent medical camps engaging all specialists.

Under unique system, each Ladakhi has been provided with a health card andhis/her health check up is done by qualified doctors. About 99 per cent of the population has been covered under this scheme.

EXPENDITURE ON HEALTH*

The 9h Five-Year Plan for the health and medical education sector was approved by the government of India at Rs. 656.00 crore with the following break-up:

Table III.72
Break-up of Health Expenditure

(Rs.in crore)

Revenue	312.45
Capital	343.55
Total	656.00

As is evident, the revenue component constitutes 48 per cent and capital 52 per cent approximately. However, during the course of the first four years of 9th Five-Year Plan, the position of allocation in terms of revenue and capital has almost over turned due to various reasons. During 2000-2001, out of an allocation of Rs. 105.95 crore, revenue component constitutes 88 per cent of the outlay and capital component only 12.25 per cent. Against the total expenditure of Rs. 125.37 crore during 1999-2000, an amount of only Rs. 105.95 crore was earmarked for the health and medical education sector during the year 2000-2001. As a result of these changes in the Plan resources and subsequent lesser allocation of the capital component, the department has not been in a position to do justice to the ongoing work, supply of drugs and medicines to health institutions, purchase of ambulances, etc., although it did take up a massive construction programme in order to make up the deficiencies in terms of the construction of new buildings and augmentation of accommodation of existing buildings. Presently, the department needs approximately Rs. 198.00 crore for the execution of 85 ongoing projects. In spite of the increase in workload in health institutions, hike in cost of drugs and medicines and awareness about health-related issues amongst public, we are still following the norms devised in the late 1980s.

While projecting the requirements of 2001-02, it was decided to follow the strategy for health care system development as laid down under the 9th Five-Year Plan. However, although no further expansion has been proposed, priority has been given to strengthening the existing infrastructure of health institutions.

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* *Source:* Report obtained from the office of the Joint Director (Planning) Health, Government of J&K.

ALTERNATE SYSTEM OF MEDICINE*

Due importance as per guidelines of government of India was proposed to be given during 2000-2001 to Indian System of Medicine (ISM) sector by way of strengthening the research field, identification of herbal and medicinal plants available in the state and establishment of herbal gardens. No expansion has taken place for the past 15 years under the said sector. Even the Unani Hospital, a longstanding commitment of the government, could not be established due to the ongoing financial squeeze.

The Central Government has been requested to come to the rescue of the state in this context and has subsequently released Rs. 4.00 crore, the estimated cost of the construction of the Unani Hospital at Srinagar.

In spite of the fact that medical science has advanced tremendously in various parts of the country and over the whole world, our health institutions, particularly in rural areas, lack basic minimum requirements. They need to be strengthened and fully equipped urgently, to be at par with those in other parts of the country in view of the poverty of the people, lack of communication facilities, and a number of other problems prevalent in the state.

PROGRAMMES FOR IMPROVEMENT OF HEALTH*

There are as many as 12 centrally sponsored schemes extended by the government of India to J&K. The funding pattern varies from scheme to scheme and the maximum schemes are being fully funded by the government of India. The main schemes and their financial and physical achievements for the past five years are as under:

1. *Family Welfare Programme:* This programme had a meagre start in J&K in the year 1957-58 with the creation of two family welfare centres, one each at SMGS Hospital Jammu/SMHS Hospital Srinagar. It was given a fillip by the opening of 15 Rural Family Welfare Centres in the year 1964 and subsequently adopted as a national programme of topmost priority as elsewhere in the country. Initially, it was a target-oriented programme during which the achievement figures in terms of sterilisation operations and users of conventional methods showed a substantial upward trend. However, the programme changed its nomenclature from family planning to family welfare with the objective of converting it into a 'people's movement'. For better results the programme was made more broad-based by

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* *Ibid*.

integrating it with a package of services under maternity and child health. The department has been helping to provide immunisation cover to children against the six dreaded diseases of polio, diphtheria, purtessis, tetanus, TB and measles in addition to prophylaxis against the vitamin A deficiency.

The main objective of the programme is to provide better health services and to check the rapid growth of population especially in rural and semi-urban areas. Different policies and decisions were framed to upgrade the programme. The infrastructure of the programme was considerable but it has suffered a great deal during the past decade of turmoil in the state. Irregular flow of funds and paucity of funds from the government of India has affected not only the work but the overall progress of the programme. For the past seven years adequate funds have not been provided by Government of India as per the requirements and proposals of the state government. Due to non-availability of funds, no furniture, drugs and equipments could be purchased. The rent liability of the buildings occupied by the family welfare department has also accumulated to crore of rupees. However, as a remedial measure, various steps have been initiated to gear up the monitoring system of family welfare department within the available resource. The annual physical and financial performance of the programme is given below:

Table III.73
Physical Achievements

Item	1996-97	1997-98	1998-99	1999-2000	2000-2001
I FAMILY WELFARE					
Sterilization (No.)	15388	10766	11471	11040	14863
I.U.D. cut (No.)	9551	9952	9988	13537	12990
C.C.U pieces No.)	7469	8899	9352	12312	852576
O.P.U cycles (No.)	3031	3119	4503	5270	61050
II IMMUNIZATION					
D.P.T 3rd Dose (No.)	206409	21207	236449	248032	262028
Polio Dose (No.)	209792	214159	238023	250564	261658
B.C.G (No.)	226592	244574	258536	279115	295789
Measles (No.)	167710	180115	201980	211740	227632
TT/P Women 2nd & Booster dose (No.)	125429	122003	164107	200910	196742
FINANCIAL ACHIEVEMENTS					
Amount Received (Rs. in Lakh)	7.79	9.98	12.90	21.14	19.14
Expenditure Incurred (Rs. in Lakh)	12.16	12.73	13.74	18.51	19.14 (Anticipated)

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

2. *National Programme for Control of Blindness:* The national programme for control of blindness was started with central assistance in the state from the year 1977-78 and the scheme was strengthened by integrating World Bank assisted Cataract Blindness Control Project in 1994. According to the National survey conducted in the year 1986-89, the position of prevalent rate of blindness was found to be 1.94 per cent, recording the highest prevalence of blindness in the country. Under the programme, 60 health institutions including primary health centres, community health centres and district hospitals have been asked to provide necessary eye care facilities and conduct cataract operations. However, the state has also extended the programme to 50 health institutions out of state resources. Furthermore, District Blindness Societies stand established in all the 14 districts of the state headed by respective District Development Commissioner. A state programme officer of the rank of Joint Director has also been posted to monitor the programme at the state level. The liability of all the centrally established centres under the programme was to be transferred to the state government by the end of 8th Five-Year Plan. The physical and financial achievements are as follows:

Table III.74
Physical and Financial Performance

	Physical Performance	Financial Performance (Rs.in lakh)	
Year	Cataract Operations performed	Amount Received	Expenditure
1996-97	6332	--	--
1997-98	7109	2.79	20.60
1998-99	10646	7.74	17.47
1999-2000	8314	28.65	33.16
2000-2001	10092	88.50	55.78

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

An amount of Rs. 55.00 lakh was released to the implementing agencies during 2000-01 for the construction of operation theatres/eye wards, besides Rs. 10.00 lakh for furnishing and renovation of operation theatres/eye wards established under the programme. Action has also been initiated for the registration of blind persons in the state and funds have been released for the purpose.

3. *National Leprosy Eradication Programme*: The state falls in the non-endemic zone of leprosy and NLEP is being implemented here since 1963 in accordance with the guidelines of the Government of India. The following infrastructure has been established with state/central assistance during the implementation of the programme. Table III.75 shows the availability of infrastructure.

Table III.75
Availability of Leprosy Infrastructure

Infrastructure	Numbers
Leprosy Hospitals	2
Urban Leprosy Centers	2
Leprosy Control Units	9
Modified Leprosy Control Units	2
Temporary Hospitalisation Wards	2
Survey, Education and Treatment Centres	44
Leprosy Rehabilitation and Promotion Unit	1
Mobile Leprosy Control Unit	14
Leprosy Control Societies (Reg.)	14
Leprosy Colony	1

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir

All the institutions are functional and most of the staff is in position. In spite of disturbed conditions the performance has been encouraging because of efforts made by state government with the assistance of government of India to identify and treat leprosy patients. Details of both physical and financial achievements for the last five years are given below:

Table III.76
Physical and Financial Achievements

Physical				Financial (Rs. in Lakhs)	
Year	Cases Detected	Cases Treated	Cases Discharged	Amount Received	Expenditure Incurred
1996-97	432	432	323		
1997-98	735	708	975	43.45	8.54
1998-99	888	2810	936	1.36	15.75
1999-00	467	1832	992	31.50	36.00
2000-01	897	1815	1003	18.00	25.36 (Anticipated)

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

However, a lot needs to be done to achieve the goal of below one case per 10 thousand population by the target date which was 2000. The state needs more time for elimination of leprosy and it is recommended that funds be released timely and directly by Government of India to the Administrative Department J & K, as the funds routed through the Finance Department take a lot of time in reaching the implementing agencies.

The modified leprosy elimination campaign launched in the State from 1998-99 proved fruitful for the identification of leprosy patients and has been brought under the purview of treatment in order to ensure success and achievement of target by the desirable time limit. Monitoring of the programme has been streamlined. The

programme is now reviewed at both divisional and state levels, besides by district development commissioners and chief medical officer at the district level. The leprosy hospital at Digyana is being strengthened by augmenting its bed capacity. An amount of Rs. 41.38 lakh stands released for the purpose during 2000-01. It is also proposed to shift the leprosy patients from Leprosy hospital, Nageen Lake to their original place of birth as they have been fully cured now.

4. *National TB Control Programme*: The National TB control programme is being implemented in J&K state in accordance with the guidelines of the Government of India. There are two chest disease hospitals, one each at Srinagar and Jammu which cater to the indoor requirements of the patients suffering from TB in addition to the other diseases of the chest. Besides, there are 10 district TB centres and one TB demonstration centre in the state. Action has been initiated to upgrade three chest clinics of the valley and the TB hospital Kargil to the level of District TB centres. All the centres provide short-course chemotherapy; the quota of drugs for sputum cases is being supplied by government of India and other drugs from state resources.

In order to provide better facilities to patients, a survey is being conducted to ascertain HIV positive prevalence of patients of TB in the state. All the TB patients admitted to the hospital are being examined for HIV positive. In view of the various activities carried out under National TB Control Programme, the physical achievements have been encouraging, as shown in Table III.77

Table III.77
Physical and Financial Achievement

Year	Physical			Financial (Rs. in lakh)	
	Cases detected	Sputum examination	Found positive	Amount received	Expenditure incurred
1996-97	12100	22904	1541	--	--
1997-98	10236	16486	932	21.15	11.75
1998-99	10643	37379	1368	24.45	11.15
1999-2000	10085	44691	1224	35.00	30.42
2000-2001	8844	58008	2011	30.87	30.87 (anticipated)

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

All necessary measures have been taken to ensure timely supply of drugs and medicines to patients and to develop better health care facilities in this context. However, inadequate and late receipt of funds from government of India and the state finance department hamper smooth functioning of the programme. X-ray machines are also required to be supplied to PSC's/CSC's who do not have them. Besides, vehicles are required for the four proposed district TB centers.

5. *National AIDS Control Programme*: Though a full-fledged war against AIDS was started in the 1980s the AIDS Control Programme as a 100 per cent centrally sponsored scheme was initiated in 1992 to arrest and eradicate the disease. An AIDS cell was established under the charge of a Senior Health Officer. In J&K, the programme actually took off in the year 1993-94 when an AIDS control cell was established. The department initiated all necessary measures to control the spread of this dreaded disease. J&K being a tourist state, with a population of soldiers, truck drivers, traders, etc., who are mobile poses problems; therefore some specific steps were initiated by the government.

The State AIDS Control Society, the main agency for the actual implementation of the programme, in the state is headed by the Chief Secretary. The recruitment of staff for office of Project Director is complete. The society is establishing eight new STD clinics at the cost of Rs. 1.00 lakh each in various districts of the state and existing blood banks in Medical college, Jammu, SMGS Hospital Jammu, SMHS Hospital Srinagar and Sher-I-Kashmir Institute of Medical Sciences, Srinagar will be strengthened. Consumables and services of Laboratory Technicians are being provided where these services are not available. The main activities carried out in phase –II of AIDS control programme for the period (1999-2004) are given below:

- Intervention programme for truck drivers through NGOs.
- School AIDS education programme.
- Family health awareness programme.
- Information, education and communication.
- Telephone hotline facilities to be established to have any information on HIV/ AIDS on telephone no. 1097 at Jammu and Srinagar.
- Voluntary testing and counselling facilities at Medical College Jammu and SKIMS Srinagar.
- For blood safety programmes, eight new blood banks will be established within an estimated cost of Rs. 50.72 lakh in Rajouri, Poonch, LD Hospital, Srinagar, Bone and Joint Hospital Srinagar, Gandhinagar Hospital Jammu, District Hospital Baramulla, SDH Ramban, District Hospital Anantnag under the programme. Equipments worth Rs. 30.00 lakh will also be purchased for these blood banks.

Furthermore, blood component separation facility unit at the cost of Rs. 30.00 lakh will be established in Kashmir by the society with the help of NACO and World Bank. Thrice Elisa readers have been provided to the Government Medical College, Jammu, SKIMS Srinagar and Command Hospital. As many as 316 Elisa kits have been provided to blood banks. Besides rapid kits to voluntary testing counselling

centers, drugs for opportunistic infection and post-exposure prophylaxis will be provided in medical colleges and SKIMS. Surveillance activities are being undertaken at various sentinal sites in Gandhinagar Hospital Jammu, LD Hospital Srinagar, Leh, SMHS Hospital Srinagar and SMGS Hospital Jammu.

An amount of Rs. 30.00 lakh has been released for various training programmes, because without training NACO – II could not be implemented effectively in the state. A total of 600 doctors and 14000 para-medicos have been trained since May 2000 and this process will continue till the project period ends.

The funds released by Government of India under National AIDS Control have not been spent within the specific time in full. The position of releases and corresponding year-wise expenditure is shown in Table III.78.

Table III.78
Release of Expenditure

(Rs. in lakh)

Year	Amount Received	Expenditure
1992-93	2.80	0.024
1993-94	37.32	1.797
1994-95	12.35	13.930
1995-96	--	14.704
1996-97	25.00	18.323
1997-98	25.00	20.380
1998-99	--	--
1999-2000	50.25	24.00
2000-2001	201.00	152.25

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

As is evident, the funds have not been utilised fully due to late receipt of funds from Government of India and subsequent late release by State Finance Department covering the programme.

6. *National Malaria Eradication Programme*: Prevalence of malaria in J&K state is confined to six districts of the Jammu province and a portion of district Baramulla and Kupwara in Kashmir Valley. It has been observed that Jammu, Kathua and Udhampur have been recording malaria continuously. However, no district is perceived to be a malaria-prone district. In order to bring the disease under control, a task force under the chairmanship of Director Health Services, Jammu has already been set up in the state. Apart from entomological control, surveillance activities are also undertaken in rural areas. The overall activities of the programme include:

- Intensified IEC activities to seek people's effective co-operation and participation in Malaria Vector-Borne diseases.
- Intensified surveillance for early case detection and administrative/radical treatment to malaria fever cases.
- Intensified ante-larval operations in UMPC.
- Intensified vector surveillance to identify factors and to keep watch on their density during the incidence period of the disease.

The state is not in any way lagging behind in any activity, including surveillance. Staff strength sanctioned under the programme has been engaged and staff of NMEP does not suffer on that account.

However, the state is facing some problems with regard to shortage of spray material. Therefore the activities of the NMEP and spraying were restricted to high-risk areas only. Details of spray operations are given in Table III.79.

Table III.79
Spray operations for Malaria Eradication

(Population coverage in lakh)

Year	Target	Achievement
1995	5.38	4.36
1996	12.00	9.17
1997	16.87	11.33
1998	16.99	10.66
1999	4.63	3.29
2000	15.25	

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

As regards the financial aspects of the scheme, the position of expenditure is given in Table III.80.

Table: III.80
Year wise Expenditure and Amount Received

(Rs. in Lakh)

Year	Amount Received	Expenditure
1997-98	14.39	12.79
1998-99	87.45	72.12
1999-2000	103.52	89.26
2000-2001	108.46	99.78

Source: Report obtained from the Office of the Joint Director (Planning) Health, Government of Jammu & Kashmir.

7. *Strengthening Drug and Food Testing Laboratories:* The drug and food control organisation is supposed to ensure availability of standard drugs and pure food articles to the people of the state. In order to achieve the goals under various acts as also the guidelines form the Government of India, wide-ranging activities have been carried out by the organisation. Four laboratories, two each for testing of drugs and food articles have been established in Jammu and Kashmir provinces. These laboratories receive samples lifted by Inspectors of the organisation from the dealers/retailers, and also cater to the needs of local bodies, municipalities, etc. In view of the growing trend of the various diseases, the department tried to strengthen these laboratories but could not succeed due to the financial squeeze prevailing in the state for a couple of years. However, the Government of India has come to the rescue to the state government of extended following CSS programmes for betterment of the public:

- Strengthening of drug testing laboratories.
- Strengthening of food testing laboratories.

Due to administrative and other reasons, the scheme has not taken off fully in the state. However, action has been initiated for its implementation. An amount of Rs. 57.43 lakh has been released by the Government of India against which only Rs. 10.00 lakh stands released by State Finance Department. The said amount has also been placed at the disposal of implementing agencies for purchase of equipments in accordance with the instructions of Government of India.

WOMEN AND CHILD DEVELOPMENT AND HEALTH

Synthesis and Recommendations

The preceding two sections examined several issues that have emerged over the past few decades or so. They are not single self-contained phenomena, but are in many ways inter-linked syndromes. They broadly include the environmental syndrome, economic-debt structure syndrome and infectious disease syndrome. Under these conditions, the most vulnerable group is the women and children who bear the brunt of discrimination in the family and society. Women are accorded low status in society, with glaring gender differentials in all spheres of life – health, education, income, political participation, etc. Under such conditions, females become the target for all forms of discrimination. Consequent to discrimination in all spheres of life, females are subjected to both physical and mental trauma and anguish. Above all the stress of domestic work leaves them with very little time for self-awareness and their psychological and physical needs.

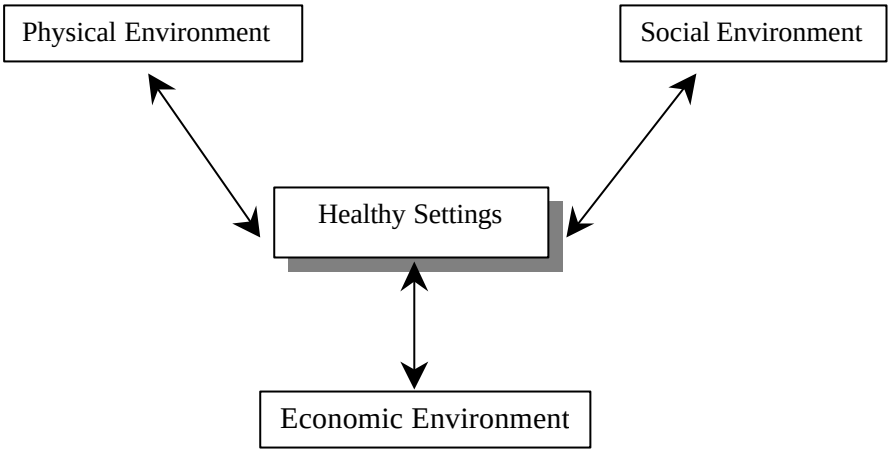
Besides this, the bottled-up feelings resulting from prolonged exposure to the

problems of militancy in the long run lead to psychological problems like depression and mental disorders. Mental trauma and physical injury have severe repercussions on women's psychological and physical health and behaviour. Children are also directly or indirectly affected by adverse socio-economic conditions, causing malnutrition and other health problems. If this situation continues, the region will become, to borrow T.S. Elliot's phraseology, *"A paralysed force, a shape without form and colour, and gesture without motion."*

It has now been fully recognised that bio-medical and other models have not been very successful in treating diseases and several other health problems such as malnutrition, drug abuse, etc., especially in the low-income groups. The work of Prof. T. Mckeown revealed that improvement in health in UK and other developed countries in the 19th and 20th centuries was achieved not due to advances in medical care but due to improvements in physical, social and economic conditions. D. Achone's (1991) analysis also led to similar findings that advances in health has been associated with improvement in physical, social and economic environment than mere advances in the field of medicine. Thus, in areas where people are free to exercise their choice in housing, employment, food, health, etc., health conditions are more favourable. By contrast, where the choice of the people is restricted owing to various socio-economic factors such as poverty, illiteracy, etc., health is adversely affected.

Thus, the overall condition of women and children depends not only on good health services, but on the supportive environment (Figure 7)**.** Supportive environment refers to the physical, social and economic aspects of the surroundings in which people live and work. This implies that health is influenced by non-medical factors. It follows that health, including the socio-economic conditions, has to be addressed by all sectors of the society. This calls for a distinct public health approach which recognises the role of environmental, social and economic factors in affecting health and the role of community in creating healthy settings.

Fig. 7: Supportive Environment for Healthy Setting



Source: WHO

Therefore the solution lies in catering to the most basic human needs including providing them with all civic amenities to improve their lot, which will in the long run enhance the quality of life of the people and contribute to overall human development. A determined and concerted effort is needed from the government and other organisations to break this vicious circle.

Any effort to eradicate ill-health cannot succeed in isolation. Nor can the problems be tackled in an adhoc manner as this would only distort the magnitude of the problem. The problems have to be tackled very systematically and the task can best be achieved by advanced planning and effective implementation at various levels. Best results can be achieved through integrated development which means that all sectors — social, environmental and economic – should contribute to the development of health and consequently to a healthy neighbourhood. Each sector can provide different sets of solutions for each problem to fit into the range of problems that exist within society. In other words, the long-term solution to solve health problems lies in socio-economic and environmental development. An improvement in these spheres will automatically engender an improvement in the health status of the community.

In view of the fact that the government's assistance is not very forthcoming, it is suggested that the local people form local associations. The associations can adequately look after and implement their own welfare measures. In the light of this, some suggestions have been put forth to improve the health and socio-economic conditions of the community, especially women and children.

1. Water Supply

A. In order to eliminate water-borne diseases, one of the most significant causes of ill health in the region, it is necessary to provide safe drinking water to its people. Regular water surveillance and water purification through cost-effective methods should be implemented.

B. Since *"water saved is water made"*, every effort should be made to conserve water. Better leak detection methods should be found. Repair of malfunctioning taps and/or replacement of stolen taps can be overcome by making use of local resources including knowledge, management capacity and labour. The concerned association can take most of the work which would otherwise be taken up by external contractors. Investment in better leak detection, maintenance and repair of water system can improve the supply of water to a large extent. This will improve personal hygiene and reduce the occurrence of skin and other diseases.

2. Unemployment

In order to solve the problem of unemployment, it is suggested that cottage industries be set up. For this, females can be given special training in the preparation of products in demand, e.g., candle, envelopes, pickle, jam, fruit juices, etc. However, care should be taken that eatables are prepared in a hygienic way so that they are uncontaminated and can be easily marketed. This will make the females economically self-reliant and independent.

3. Health Education

Informal health education can begin at home, where family members can impart basic education on sanitation, hygiene, etc., to their young children. Educated representative from the local population can approach the target groups and provide them with information on various aspects of environmental sanitation, personal hygiene, disposal of excreta, etc. Information can also be disseminated through mass media by drama, plays, and anti-commercials on negative aspects of sanitation, etc., at peak viewing hours.

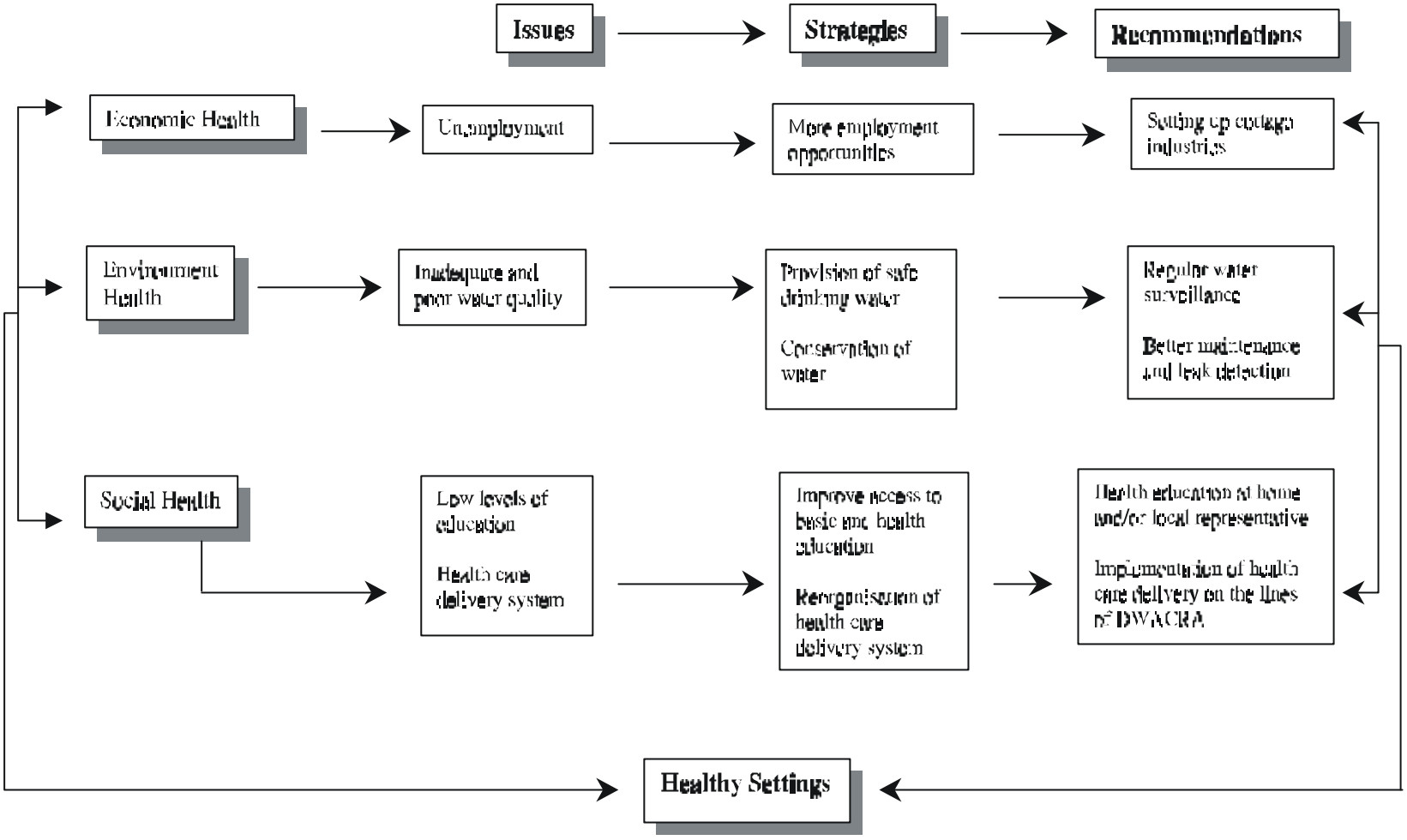
4. Health Care Delivery System

Representatives from the neighbourhood population can be chosen to provide preventive and promotive health care to the people. For preventive health care, the representative may be given training in first-aid and basic knowledge about treatment of minor ailments such as common cold, headache, minor injuries etc. More serious

problems can be referred to qualified doctors. Health care can be promoted on the lines of DWCRA (Development of Women and Children in Rural Areas). Accordingly, a representative would keep track of all the young married women who are eligible for family planning and give them appropriate advice on various aspects of family welfare such as personal hygiene, nutritional requirements, maternal and child health, etc.

The measures suggested are not directly related to health and medicine, because medicine alone is not sufficient to solve health problems. The cause of ill-health lies in a combination of physical, social and economic factors which can be overcome only by the socio-economic transformation of the society (Figure 8).

Fig. 8: Health, Women and Child Development



3. EDUCATION

> "Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory…. Education shall be directed to the full development of human personality and to the strengthening of respect for human rights and fundamental freedoms."
>
> *– Universal Declaration of Human Rights, Article 26*

Jammu and Kashmir, one of the 10 educationally backward states of the country, has remained so due to a variety of reasons. At the time of Independence, there were very few educational institutions in the state which were largely concentrated in the major towns. The state of affairs, as far as literacy is concerned, was such that the literacy rate of the state was only five per cent at that time. This low level of literacy forced the state government to take serious note about the existing state of affairs and promote education in the state. Initially, the state government decided to provide free education from the primary to university level.

This effort paid off as the literacy rate started to rise in the years that followed. In 1961 it rose to 11.03 per cent. In 1981 it was 32.68 per cent as against national average of 43.67 per cent and the projection for 1991 was 45 per cent in the absence of census data. According to the latest data available, it stood at 54.46 per cent for 2001.

From time to time, the state government takes steps to improve the education scenario. It provided educational facilities throughout the state to achieve the target of universal elementary education. Various initiatives by the different authorities concerned have led to the achievement of satisfactory results in the state.

PRE-SCHOOL EDUCATION

There is no provision for pre–school education, the informal schooling system provided by the government. But private initiative is there in a very big way; the government's initiative is only limited to Anganwadis and Balwadis for pre-school going children. But in these institutions the emphasis again is only on nutrition and not the overall development of the child. In very few government primary schools, children are enrolled for nursery classes but their reach, once again, is very limited. The private sector provides the pre-schooling facilities to a large number of children. However, they are mostly concentrated in the cities and towns. This is an all-India phenomenon and J&K is no exception.

However, going by the prevalent trend, the government of Jammu & Kashmir (J&K) has decided to stress the need for formulating policies for pre-schooling. According to the Annual Report of Education Department of J&K, "it is increasingly felt that the burgeoning number of nursery schools which are ill-equipped to handle such a vital and delicate concept of education at the pre-primary level need to be given a fresh orientation." It further states that Board of School Education, with the help of experts, has prepared a plan for pre-school education where emphasis will be on playful activities to promote creativity, sense of participation and originality among children. When this becomes effective, it would become mandatory for all the private pre-schools to register themselves with the Education Department of the state.

PRIMARY EDUCATION

Primary school education is of utmost importance for the growth of a child. It is imperative that all the children are provided with a conducive atmosphere to grow and progress with the system. In fact, the primary level is one level which needs to be very attractive for children, as at this level, the enrolment rate should be very high and dropout rates should be minimal. Many a time it happens that despite having schooling facilities within walking distance, the children do not attend schools. At times the children from socially and economically backward areas do not attend school or drop out at the primary level itself. In such cases it becomes important to implement such schemes that would help in the retention of children in schools and also ensure higher enrolment.

This is a problem in J&K and various steps have been taken to counter it by the state government. One of them is formation of committees at the village level to spread awareness about enrolment in the schools. According to a report of the education department, "village level committees have been given a participatory role in ensuring 100 per cent enrolment and effective management of various activities." With the sustained efforts of the department, the enrolment ratio saw an increase of nearly 13 per cent within two years from, 1996-97 to 1998-99. Table III.81 gives a clearer picture:

Table III. 81
Enrolment Ratio: I-V

Year	Boys	Girls	Total
1996-97	84	53.1	67.6
1998-99	93.38	66.63	79.95
2000-01*	104.05	80.11	91.79

Source: Annual Report on Educational Profile (School Stream) of J&K for 2000-2001. Education Dept.
*: Selected Educational Statistics 2000-2001, Planning, Monitoring & Statistics Division, Dept. of Secondary & Higher Education, MoHRD, GOI, New Delhi, 2002.

Like ensuring higher enrolment, retaining the children in schools is a major task. The goal of universalisation of elementary education cannot be achieved till the dropout rate is brought down to the minimum level possible. As mentioned earlier, children from certain sections tend to drop out more quickly because of economic as well as social compulsions. To overcome the problem of a high dropout rate, the education department implements a number of incentives like free textbooks and uniforms, merit scholarship, etc. The dropout rate has also come down in the same period when enrolment ratio increased. It saw a decrease of around 12 per cent within a very short span of time. Table III.82 below depicts the picture of dropout rate in the past couple of years.

Table III. 82
Dropout Rate: I-V

Year	Boys	Girls	Total
1996-97	34.4	33.63	34.08
1998-99	24.01	20.20	22.39
2000-01*	34.35	31.67	33.18

Source: Annual Report on Educational Profile (School Stream) of J&K for 2000-2001. Education Department.
*: Selected Educational Statistics 2000-2001, Planning, Monitoring & Statistics Division, Dept. of Secondary & Higher Education, MoHRD, GOI, New Delhi, 2002.

Keeping the universal of elementary education as the thrust area for the coming years, it becomes imperative to have a strong support base in terms of school infrastructure, etc., to achieve desired goals.

In the Five-Year Plans, expenditure on primary education has been increasing. As mentioned earlier, the education department has taken several steps to ensure better enrolment in schools. In the 9th Five-Year Plan, steps were taken by the state government to improve the conditions in primary schools. The opening of new primary schools and upgradation of existing ones is part of it. According to the 9th Plan assessment, the state government had set up 10,000 primary schools but there

were still some places where schools were required. "During 9th Plan it was proposed to cover 1,000 school-less habitations in a phased manner by opening 200 schools every year."

The effort to improve the conditions in primary schools is not limited only to the opening up of new school buildings but to improving the existing infrastructure. In the past years, i.e., during the 8th and 9th Plans, the emphasis was on converting all the primary schools from single-teacher schools to two-teacher schools. Schools have been opened in the remotest of areas in the state. As per the Sixth All-India Educational Survey, approximately 92 per cent of the population has primary stage schooling facility within a radius of one kilometre and around 86 per cent of the population has access to a middle school within a radius of 3 km.

SECONDARY EDUCATION

Secondary education is another important area of our education system. It is another level where a major chunk of students drop out for various reasons. In most of the areas primary schools are close by but not secondary schools. So, many children, especially girls, drop out after the primary level. It is necessary that secondary schools also be opened at the nearest distance possible. With the conceptualization of an enrolment drive, the ratio for this level also increased within two-three years. Table III.83 below gives a clearer picture:

Table III. 83
Enrolment Ratio: I-VIII

Year	Boys	Girls	Total
1996-97	77.8	51.8	55.5
1998-99	79.79	49.99	65.22
2000-01*	93.04	73.23	83.01

Source: Annual Report on Educational Profile (School Stream) of J&K for 2000-2001. Education Dept.
*: Selected Educational Statistics 2000-2001, Planning, Monitoring & Statistics Division, Dept. of Secondary & Higher Education, MoHRD, GOI, New Delhi, 2002.

Keeping this in mind, the government of J&K also emphasized upgrading the schools or the opening of new secondary schools. But this measure did not succeed much as the minimum infrastructure required for these schools was not provided. In the Ninth Five-Year Plan, the emphasis was not only on upgrading the schools from primary to secondary but also on improving the infrastructure such as better laboratories, libraries, science kits, etc.

The role of teachers in school education, especially at the primary level is very crucial. The state government from time to time also emphasises the performance of

teachers at both primary as well as secondary level. Although the number of teachers has gone up substantially in the past, it is still inadequate. The shortage of teachers in the state forced the state government to open new institutes to fulfill the gaps. During the 8th Five-Year Plan, 14 District Institute of Educational Training (DIETs) were opened to overcome the shortage of teachers at the primary level.

Table III.84 below gives a comprehensive picture of the primary as well as the secondary schools in terms of enrolment, teachers and institutions in the state:

Table III. 84
Institutions, teachers and students on roll

Sl. No.	Year	Number of Institutions			Number of Students on roll (lakh)			Number of Teachers		
		Males	Females	Total	Males	Females	Total	Males	Females	Total
I	PRY. SCHOOLS									
1	1950-51	940	175	1115	0.57	0.07	0.64	1948	214	2162
2	1960-61	2314	545	2859	1.11	0.37	1.48	3654	750	4404
3	1974-75	3798	1979	5777	1.24	0.66	1.9	5123	3060	8183
4	1980-81	4725	2681	7406	1.62	1.06	2.68	6482	4177	10659
5	1986-87	5513	1953	7466	2.28	1.59	3.87	7835	5369	13204
6	1990-91	6200	3042	9242	2.55	1.79	4.34	9835	6605	16440
7	1994-95	7283	3061	10344	3.62	2.63	6.25	13888	8225	22113
8	1998-99	7535	2980	10515	6.45	5.02	11.47	18341	10599	28940
II	MIDDLE SCHOOLS									
1	1950-51	102	37	139	0.14	0.05	0.19	869	309	1178
2	1960-61	461	72	533	0.52	0.13	0.65	2139	273	2412
1	1974-75	1366	476	1842	1.38	0.53	1.91	7268	2994	10262
2	1980-81	1509	537	2046	1.76	0.81	2.57	8779	4449	13228
3	1986-87	1676	520	2196	2.53	1.34	3.87	11447	5644	17091
4	1990-91	1855	583	2438	2.47	1.49	3.96	11515	6484	17999
5	1994-95	2398	626	3024	2.92	1.94	4.86	14538	8824	23362
6	1998-99	2819	688	3507	2.50	1.81	4.31	16803	11373	28176
III.	HIGH/H.S. SCHOOLS									
1	1950-51	48	7	55	0.19	0.02	0.021	835	86	921
2	1960-61	204	46	250	0.70	0.21	0.91	2760	754	3514
3	1974-75	567	147	714	1.58	0.69	2.27	8540	3772	12312
4	1980-81	640	173	813	1.83	0.90	2.73	10010	4858	14868
5	1987-88	852	211	1063	2.52	1.28	3.80	12987	6015	19002
6	1990-91	997	223	1220	2.69	1.51	4.20	14928	6622	21550
7	1996-97®	1171	188	1359	2.50	1.53	4.03	16580	7544	24124
8	1998-99	1212	254	1466	1.86	1.19	3.05	19976	10653	30629

Source: Department of Education.

In the year 1980-81, the number of teachers at the primary level was 10,659 which increased to 16,440 in the year 1990-91. For the year 1998-99, the figure stood at

28,940. The number of students on roll during the same period was 2.68 lakh, 4.34 lakh and 11.47 lakh respectively. The number of teachers in high/higher secondary schools was 14,860 in 1980-81 which rose to 21550 in 1990-91 and in 1998-99 the number stood at 30,629. The number of students on roll for the same years stood at 2.73 lakh, 4.20 lakh and 3.05 lakh respectively.

HIGHER EDUCATION

Better schooling facilities and a higher pass percentage automatically leads to a greater demand for more institutions. Jammu & Kashmir is no exception to this rule. The demand for degree colleges and universities has been increasing in the state. Despite the fact that many more colleges have been opened, they are not able to cope with the ever-increasing demand for more institutions. According to Draft 10th Five-Year Plan, colleges are also facing an acute financial crunch. During the 9th Five-Year Plan no new colleges were opened. In such circumstances, it was left to the existing colleges to accommodate all the students, leading to an additional burden on the already existing precarious infrastructure. To accommodate more students in the colleges, evening shifts were also started. The number of colleges, teachers and students on roll is given in Table III.85

Table III. 85
Number of Colleges, Teachers and Students Enrolled

	1970-71	1990-91	1994-95	1996-97
No.of colleges	14	30	32	32
No. of teachers	897	1,254	1,223	1,427
Enrolment	21,071	23,924	32,263	62,000

Source: Department of Education, J&K.

It is clear from the Table that the number of colleges in 1990-91 was 30 which rose to 32 in 1996-97 while the enrolment rose from 23,924 to 62,000 which is a difference of 38,076. In other words, it was more than double.

In the Draft Tenth Five-Year Plan, opening of five new colleges, within the Plan period, has been proposed to cope with the increasing number of students seeking admission in colleges.

VOCATIONAL/TECHNICAL EDUCATION

Other than these colleges, the state also has Industrial Training Institutes (ITIs) and polytechnics, both private as well as government for vocational education. These institutes provide training courses for electricians, motor mechanics, plumbers, etc. At present there are four government polytechnics in the state, out of which two are

exclusively for women. According to the data available from the Department of Education, their number in the state stands at 37. There are approximately 52 courses available for students pursuing their training from these institutions.

Table III. 86
Number of Polytechnics and ITIs

Year	No. of Polytechnics	Enrolment	No. of ITI's	Enrolment
1970-71	2	160	7	1430
1980-81	2	1520	18	2414
1990-91	4	860	35	2726
1994-95	4	380	37	3102
2000-01*	12	375	37	4455

Source: Godbole Report. (Department of Education, Govt. of J&K)
* Selected Educational Statistics 2000-2001, Planning, Monitoring & Statistics Division, Dept. of Secondary & Higher Education, MoHRD, GOI, New Delhi, 2002.

By looking at Table III.86, one can see that enrolment in polytechnics in 1990-91 came down to almost half of that in 1980-81. The reason for this is related to the militancy factor in the state. Militancy had a direct effect on the enrolment, especially that of girls, which has witnessed a complete scaling down in the past few years.

In the recent past the infrastructure facilities in the polytechnics have been upgraded. New equipment has been provided; computer labs have been fitted with brand new computers with assistance from the World Bank.

As far as ITIs are concerned, a visit to two of them in Srinagar led the team to conclude that they are far behind in terms of using the latest technology. In fact, one of the ITIs visited does not have computer facility despite the fact that it is otherwise one of the better ITIs in terms of performance.

In the Draft Tenth Five-Year Plan, there is a proposal to upgrade the existing infrastructure in ITIs. As mentioned earlier, there is a dire need to upgrade the facilities in these institutes as they have to compete with polytechnics and other private institutions which provide training in latest technology.

ADULT EDUCATION

Although from time to time various steps have been taken to strengthen the literacy rate in the state, it has still remained below the national average. Moreover, there is a significant gap between the literacy of males and females. To enhance the literacy rate in the state, the government has taken many initiatives, one of which is adult education. But, like in many parts of the country, adult education is not very

successful in the state as well. Though no data is available, the general perception is that educators do not take it very seriously.

According to 9th Five-Year Plan document, the state continued the scheme on the old pattern of center-based approach but tried to shift the focus to a total literacy programme. In the draft of the 10th Five-Year Plan, a token of Rs. one crore has been kept for adult literacy programme for illiterates.

GOVERNMENT INITIATIVES FOR IMPROVEMENT OF EDUCATION SCENARIO

As mentioned earlier, the government keeps taking various initiatives from time to time to improve the education system. The government runs many centrally and state supported schemes especially for the backward/underprivileged sections of the society so that they are not deprived of education. The first and foremost step taken by the government of J&K is providing free education up to the degree level.

Special attention is being given to the nomadic population for whom mobile institutions are provided. The children in backward regions, especially those dominated by Gujjars and Bakerwals, are provided with free uniforms, books, etc., to ensure that their poor economic conditions should not become a constraint in getting education. The deserving students at primary and other higher levels are given scholarships, free books, uniform, etc. To fill the gaps created by vacancy for teachers in the remote villages, the state government started a very innovative scheme called Rehbar-e-Taleem under which a local person selected through a committee fills a vacancy and only meritorious candidates are chosen. Later, they are trained with a provision for promotion. The teachers so appointed are also regularised after a period of five years.

Other than this, in the 9th Plan, the stress was also on upgrading the existing infrastructure. Some of the centrally sponsored schemes are*

1. *Provision of Science Kits:* As per norms laid down by the NCERT, kits are being provided to primary and upper primary classes.
2. *Upgradation of Science Labs:* High and Higher Secondary Schools are covered for strengthening of science laboratories by equipping them with latest/modern equipments/kits.
3. *Supply of Library Books:* Text/reference books are provided to Higher Secondary/Senior Higher Secondary Schools.
4. *Training of Teachers:* **N**ecessary training is being given through the State Institute of Education for in-service teachers to develop resource persons.

5. *Strengthening of DIETs:* Construction/renovation of DIETs is being taken care of.

6. *Sarva Shiksha Abhiyan:* A proposal for Pre-project activities has been sanctioned by government of India in all the districts. A survey has been conducted in all the districts where this project will be implemented. As and when findings of the survey are made available by the district, the SSA plan of each district will be formulated.

PRIVATE INITIATIVES

The role of the private sector in education is very important. Though the reach of private sector is limited as compared to that of the government, the former's role cannot be underestimated in providing quality education. According to the Annual Report of the Education Department, around 2000 privately-run schools are operating in the state; there are a significant number of privately-run technical institutes, etc.

However, their participation is limited only to cities and towns. The reach of private schools in villages is almost insignificant. To encourage greater participation of this sector in villages and fill gaps in several areas, the Directors of School Education have been vested with the powers to recognise schools up to the primary level. There is also a proposal to give powers of recognising higher secondary schools to the Directors, School Education, in the future.

However, the picture of private education is not all that rosy. It has its own problems. The proliferation of private institutes without any checks forced the state government to pass a bill so that unwanted growth can be stopped (see Box 2). The Education department is now in a position not only to check but also derecognize some of the institutes that do not fulfill the minimum standards. This is to ensure that students should not suffer because of the profit-oriented policies of private sector where they charge high fees but have inadequate and ill-equipped staff. In spite of all its problems, the private sector is still better placed as compared to the government sector. Not only is their pass percentage higher than that of government schools, they also impart training in the latest technologies. Henceforth, it is important to recognise their efforts and with some government control, they can perform very well.

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* *Source:* Brief note on Plan proposal for centrally sponsored schemes prepared by Department of Education, Government of Jammu & Kashmir.

Box 2: New law forces 'education shops' to run for cover

All unauthorised computer institutes, college to face severe action.

The 'Education Shops' running in thousands in Jammu and Kashmir and fleecing students by promising awards of many foreign and prestigious Indian Universities at the door steps may now no more be able to mint money as state government is determined to see their bags packed.

The Jammu and Kashmir state legislatively assembly has passed a bill, The Jammu and Kashmir Private Colleges (Regulation and Control) Act, 2002, on the regulation and control of private colleges imparting education beyond 10+2 without adhering to standard infrastructure and faculty specifications.

The Education Department, after passing of this bill is now armed with the powers to order closure of any institution and slap a penalty of Rs.50,000 if one is found running without its permission. The action on the unscrupulous elements will be taken within a short notice of one month, though after giving the owner a reasonable opportunity to being heard.

According to the Education Minister, the Act "will ensure a proper monitoring of courseware, infrastructure, validity of degrees/diplomas, etc., so that none of these institutions can fleece the innocent students.

However, institutions affiliated with the Universities of Jammu and Kashmir, other private institutions affiliated with Mata Vaishno Devi University, Indira Gandhi National Open University (IGNOU), Department of Electronics Accreditation of Computer Course Society (DOEACS) and other autonomous societies of similar nature have been kept outside the purview of this Act. But these institutions will also have to seek formal permission from the state government.

As per the new Act, franchise institutions sponsored by or affiliated to non-governmental organisations based within or outside the state shall also be treated as unauthorised institutions.

The Education Department is to formulate the rules in consistence with the Act. The notification to this effect is likely to be issued in short time and thereafter will follow a crackdown on the unscrupulous institutions.

Source: The Kashmir Times, 10 April 2002.

Having discussed the education scenario and its present status in the state, it can be concluded that the reasons for illiteracy and educational backwardness in the state are more or less the same as anywhere in the country, viz., non-performance of teachers, unattractive syllabus in schools especially at the primary level leading to

higher drop-out ratio, etc. That is why the state government has started schemes like Rehbar-e-Taleem to improve education.

There is still a lot required to be done in this sphere. There is also a need to look at all the three regions, i.e., Jammu, Kashmir and Ladakh from different perspectives. Each region has unique features that cannot be ignored. All three regions have different mediums of instruction in the government schools. Future policies should be formed keeping this uniqueness in mind. There is also a need to take more strict measures for improvement in education. Recently, the state government has amended its Education Bill where, among other things, it added a clause according to which it is obligatory on the part of the guardian to send their children to school. In case of failing in his duty, the guardian can be fined up to two hundred rupees for the first offence and five hundred rupees for every subsequent offence. Before implementing this rule there is a serious need on the part of state government to sincerely assess whether there is adequate infrastructure available for schoolchildren.

RECOMMENDATIONS

In order to improve the education scenario in the state, several steps are to be taken:

1. J&K has suffered a lot due to militancy that was at its peak for almost a decade. Although the situation is now becoming normal day-by-day, loss of property and other infrastructure has left educational institutions in a very fragile situation. In addition, some of the policies of the state government have proven very costly in the long run. There is a need to rationalize the scheme of providing free education at all the levels in the state. It is essential to reconsider its decision of providing free education at the university level. As higher education is directly related to the employment sector, it becomes imperative to link it with the changing market scenario. The stress should not be on acquiring higher degrees only but on vocational education, which will help a person in the job market. The need of the hour is to learn about the latest technologies available. The government institutes need to be equipped with the latest infrastructure so that students are better trained.

2. School buildings destroyed in remote areas need to be reconstructed immediately. The other major problem is that security personnel are currently occupying many school buildings. For instance, in Jammu alone, the figure is around 500. Such schools should be handed over to school authorities, so that they do not have to run schools in open and/or in rented buildings.

3. The education of girls is still in the doldrums. Their enrolment is low and the dropout ratio is very high. There is need to take serious account of this situation and steps to ensure a higher ratio of enrolment among girls. In many places, there is a dearth of teachers, especially science and mathematics teachers. The existing infrastructure is also not sufficient to handle the pressure. To overcome this problem, adequate infrastructure should be provided. In fact, some of the schools even face shortage of training/learning material like black/ white boards, chalks, etc. This situation needs to be rectified.

4. The quality of education in the government sector is very poor. The need is all the more at the primary and secondary levels which are the base for higher education and/or other type of technical training. The private sector should be encouraged but checks and balances from the government need to be in place so that exploitation is minimal.

5. Going by the need of the hour, locally employed teachers should be encouraged to minimize absenteeism in schools, especially in remote areas. The Government of Madhya Pradesh has associated village panchayats with supervision of functioning of schools in the villages. This experiment has met with considerable success and led to sharp reduction in absenteeism on the part of teachers. The Government of J&K could follow their example.

4. URBAN DEVELOPMENT

INTRODUCTION

An urban settlement is a complex entity and its complexity increases with growth in its population and functional specialization. Urban settlements provide space for the various activities of the people during their life cycle. They are the centres for art and culture. They are the mirrors of society. They represent the achievements, way of life, deviation in the form of crime and the contrasts – the riches and poverty, planning and development. As a consequence of the rapid growth of population that large cities are unable to contain, thereby degrading their environment and affecting the quality of life.

Over the past two decades, the number of people living in India has increased from 683 million in 1981 to 1027 million in 2001. As per the Census of 2001, the urban population is 285 million, i.e., 28 per cent of the total population living in urban areas spread over 5545 (5161towns, 384 UAs) towns and cities. The people living in urban areas have increased from 23 per cent to 28 per cent and towns from 3347 to 5545 between 1981 and 2001. The main reason for this high growth (78.95 per cent between 1981-2001) is the inordinate concentration of capital investments in favourable nodes at the relative expense of a vast majority of other settlements.

The Indian metropolises are growing at an enormous pace. The number of million cities has increased from 12 in 1981 to 27 in 2001, thus indicating more than a two-fold increase. Population density has been increasing and older parts of some of the largest cities are bound to intensify, further leading to the worst kind of urban congestion. The problem of congestion is compounded by serious shortages of infrastructure such as water supply, sewerage, drainage and electricity. Transportation facilities are inadequate. Prices of land have skyrocketed because of which people's access, especially that of the urban poor, to serviced land is extremely limited. The metropolitan planning efforts in India have succeeded only in a limited way in taking some functions away from the core and deflecting them to surrounding centres in big cities. Urbanisation is thus becoming more and more pronounced, therefore it is very necessary to work out a stringent microscule policy to optimize the size of the city populations.

GROWTH IN NUMBER AND POPULATION OF URBAN SETTLEMENTS

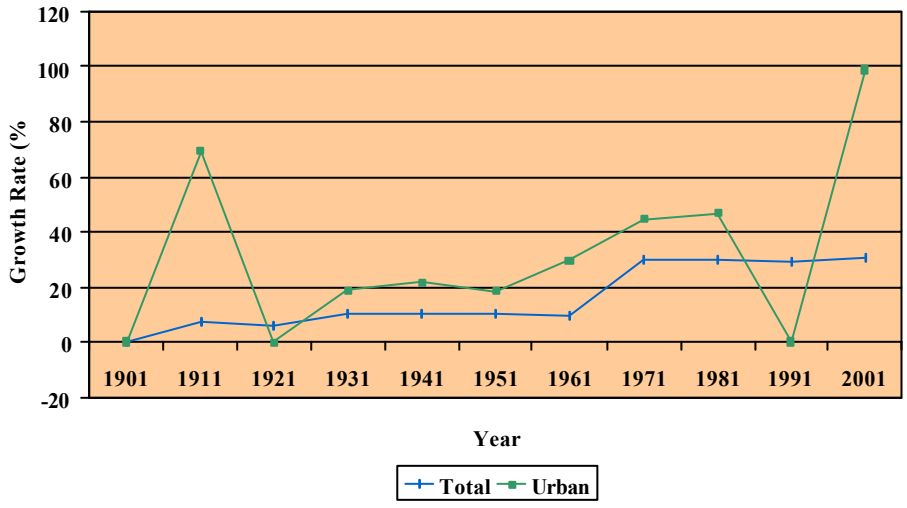
The urban population of Jammu and Kashmir as per the 2001 census is 2505309, which accounts for 24.88 per cent of the state's population. Low level and slow pace of urbanisation in the state can be adjudged from the fact that as late as 1961 more than

Table III.87
Growth of Urban Population in Jammu and Kashmir. 1901-2001

Year	No. of Towns	Population		Per Cent Urban	Growth Rate of Population	
		Total	Urban		Total	Urban
1901	2	2139362	158748	7.42	--	--
1911	45	2292535	268518	11.71	7.16	69.15
1921	29	2424359	267754	11.04	5.75	-0.28
1931	31	2670208	317805	11.90	10.14	18.69
1941	32	2946728	386565	13.12	10.36	21.64
1951	25	3253852	457213	14.05	10.42	18.28
1961	43	3560976	593315	16.66	9.44	29.77
1971	45	4616632	858221	18.59	29.65	44.65
1981	58	5987389	1260403	21.05	29.69	46.86
1991	No Census	7718700	No Census	No Census	28.92	No Census
2001	75	10069917	2505309	24.88	30.46	98.77

Source: Census of India, 1981, & 2001.

Fig. 9
Growth Rate of Total and Urban Population in Jammu and Kashmir, 1901-2001



83 per cent of the population was living in rural areas. Since then, as is clear from Table III.87 urban population has increased. In 1971, 18.59 per cent of the total

population was living in the urban areas and in terms of growth between 1961-71 it was 44.65 per cent which increased to 46.86 per cent in 1971-81. Between 1981 and 2001 the growth rate of urban population was as high as 98.77 per cent.

Unlike the trend in the proportion of urban population, trend in the growth rate shows a different pattern, being characterized by a rapid increase in one decade followed by a decline in the next decade, then a sharp increase. Moreover, the growth rate of urban population has been consistently higher than the growth rate of total population of the state. This gap is due to the gaps both in the rate of natural increase of urban and total population as well as due to the movement of people from rural to urban areas. But the available information is not adequate to ascertain how much of this gap is due to the difference in the rate of natural increase and how much is due to the movement of population.

VARIATION IN SIZE CLASS COMPOSITION OF NUMBER OF TOWNS AND URBAN POPULATION

As revealed in Table III.88, most of the urban population of the state is concentrated in big towns and cities, which is generally the case. Not only is more than 60 per cent of the urban population of the state concentrated in class I towns, but net addition to the population of these towns has been the highest. The proportion of population living in other size class towns is much lower, so is the net addition of urban population to these towns during the past twenty years.

Table III.88
Urban Population distribution by Size Class of towns in Jammu and Kashmir, 1981-2001

Size Class	No. of UA, Cities, & Towns		Absolute Population 2001	Population addition (1981-2001)	Percentage Addition
	1981	2001			
I	2	2	1578999	749636	60.21
II	--	4	368270	368270	29.58
III	5	7	97543	-50485	-4.05
IV	7	20	251032	174439	14.01
V	20	23	146656	9068	0.72
VI	24	19	62809	-6022	-0.48
Total	58	75	2505309	1244906	100.00

Source: Census of India, J&K 2001.

As indicated by Table III.88, in 2001, there were 75 towns in Jammu and Kashmir of which 2 fall in class I, 4 in class II, 7 in class III, 20 in class IV, 23 in class V and 19 in class VI categories. The two capital cities Srinagar and Jammu have not changed their status and continue to retain their respective position as class I towns since 1961. There was no class II town in 1981, whereas in 2001 the towns

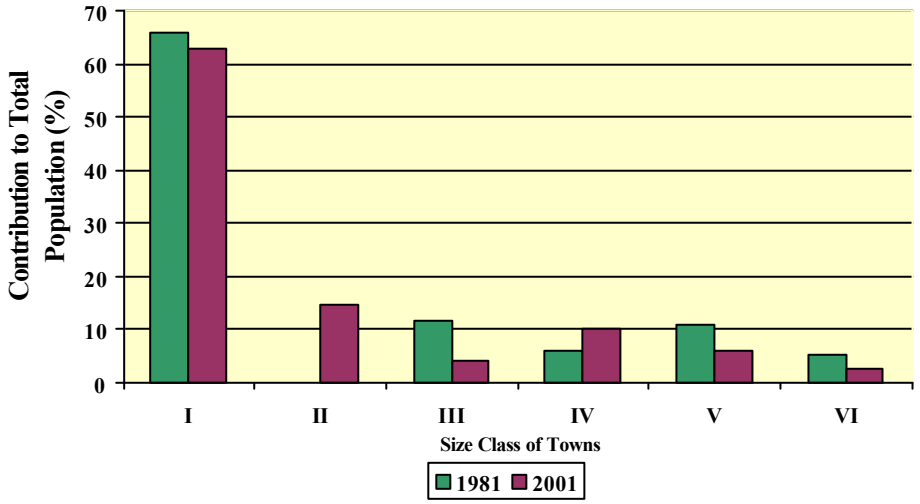
of Anantnag, Baramulla, Sopore and Udhampur attained the status of class II town on the basis of population from their previous position of class III category town. Seven urban areas of Bandipore, Leh, Punch, Rajauri, Bari Brahmana, Jammu C.B and Kathua T.C have qualified as class III category from their previous position of class IV. Similarly 20 towns have been categorized as class IV against 7 towns in 1981 census, while 23 towns have been classified as class V against 20 in 1981, the number of class VI categories town have been reduced to 19 from 24 in 1981.

Table III.89
Urban Population Growth by Size Class of Towns

Size Class	Contribution to total population		Growth Rate
	1981	2001	1981-2001
I	65.80	63.03	90.39
II	0.00	14.70	0.00
III	11.74	3.89	-34.11
IV	6.08	10.02	227.75
V	10.92	5.85	6.59
VI	5.46	2.51	-8.75
Total	100.00	100.00	98.77

Source: Census of India, 1981 & 2001

Fig. 10
Distribution of Urban Population According to Size Class, 1981 & 2001



As far as the growth rate of urban population of different size class towns is concerned, class I towns accounted for 90.39 per cent of the growth between 1981-2001 while class IV towns returned the highest rate of growth at 227.75 per cent (Table III.89). For the first time class II towns emerged in 2001 with a total

population of 368270. This phenomenon of increasing concentration of urban population in cities implies that the economic activities are getting localized in such places as well as in the surrounding areas of such places.

INTER-DISTRICT VARIATIONS IN URBANIZATION

District-level statistics on urban population are presented in Table III.90 and summarized for the year 2001 in Table III.91.

Table III.90
District wise Distribution of Urban Population in Jammu and Kashmir, 1951-2001

(Percentage of Urban Population)

S. No.	Districts	1951	1961	1971	1981	2001
1	Kupwara	0.00	0.00	1.95	2.95	3.96
2	Baramula	9.05	14.63	11.95	13.40	16.98
3	Srinagar	64.15	66.31	72.90	80.50	78.59
4	Badgam	0.00	1.51	4.41	14.13	11.66
5	Pulwama	4.56	4.67	7.28	8.98	10.72
6	Anantnag	6.07	8.47	9.91	10.71	14.40
7	Leh	8.76	8.53	10.64	12.75	23.39
8	Kargil	0.00	0.00	4.48	5.34	8.63
9	Doda	3.15	5.90	5.71	5.92	7.50
10	Udhampur	5.74	6.30	8.29	9.53	16.00
11	Poonch	6.37	6.60	8.08	6.32	6.31
12	Rajauri	1.87	3.59	3.86	5.23	6.98
13	Jammu	20.12	24.90	26.40	29.64	44.45
14	Kathua	5.16	7.37	9.03	11.38	14.21
Jammu and Kashmir		44.78	16.66	18.59	21.05	24.88

Source: Census of India, 1981 & 2001.

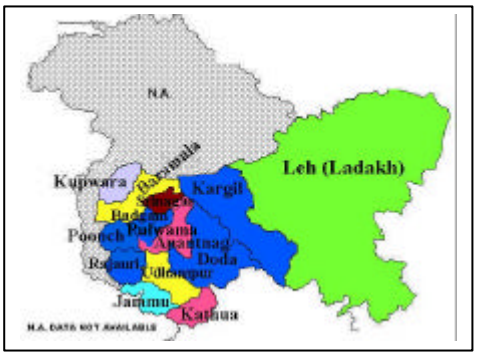
Table III.91
Distribution of Districts according to the proportion of urban population to total population , 2001

Proportion (Percentage)	Districts	
	Number	Name
79.54	1	Srinagar
44.45	1	Jammu
20-25	1	Leh
15-20	2	Baramula, Udhampur
10-15	2	Anantnag, Kathua
5-10	6	Badgam, Pulwama, Kargil, Doda, Poonch, Rajauri
< 5	1	Kupwara

Source: Compiled from Table III.90.

Distribution of Urban Population, 2001

Fig. 11



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79.54	44.45	20-25	15-20	10-15	5-10	<5

The urban population is spread over the districts of the state. However, there are signs of urban population concentration in districts of Srinagar, Jammu, Leh, Baramulla and Udhampur. All these districts have metropolitan cities and divisional administrative headquarters. The metropolitan cities of Srinagar and Jammu have also been the traditional growth centres since the past. The pull factors associated with these cities appear to be primarily responsible for the concentration of urban population in these towns and in these districts. As depicted in Figure 11, the highest proportion of population is in Srinagar and Jammu districts. Despite the high level of urbanization in these two districts, as observed from Table III.90, urban population continues to grow. Both Srinagar (summer) and Jammu (winter) being state capitals are the hub of the political, social and economic activities of the state. The level of infrastructure development in and around the city of Srinagar and Jammu and the attraction of living in the state capital along with diverse nature of opportunities available at the central place, appear to have attracted large number of people from the surrounding districts. With an increasing trend in the urbanization process, and substantial increase in the urban population in few districts, there is need for the initiation of an urban planning policy in these districts of the state.

The concentration of urban population in some districts is revealed from the growth rate in the number of towns as well. Table III.92 shows the growth in the number of towns. It is to be noted that during 1981 there were only two Urban Agglomerations (UAs) viz., Srinagar and Jammu. In 2001, the following five town also qualified as UAs on the strength of their population and urban overspill;

Baramulla, Sopore, Anantnag, Udhampur, and Kathua. Srinagar UA with the population of 971,357 has the highest urban population in the state spread over two neighbouring districts, viz, Badgam and Pulwama. Next is Jammu UA, which has population of 607,642, confined to its district territorial limits only. Moreover, 17 new urban areas were notified after 1981. Table III.93 shows the new towns added between the period 1981 and 2001.

Table III.92
Districtwise Growth in the Number of Towns in Jammu and Kashmir, 1951-2001

S. No.	Districts	1951	1961	1971	1981	2001
1	Kupwara	0	0	1	2	2
2	Baramula	3	9	5	6	6
3	Srinagar	2	2	2	3	3
4	Badgam	0	1	0	1	5
5	Pulwama	2	2	3	4	6
6	Anantnag	2	4	6	8	8
7	Leh	0	0	1	1	1
8	Kargil	0	0	1	1	1
9	Doda	2	6	6	6	6
10	Udhampur	4	4	5	6	7
11	Poonch	1	1	2	1	1
12	Rajauri	1	2	2	4	4
13	Jammu	5	7	7	9	13
14	Kathua	2	4	4	6	6
Jammu and Kashmir		24	42	45	58	69

Source: Census of India, 2001.

Table III.93
Urban areas notified after 1981

S. No.	District	Newly created urban areas
1	Baramulla	1. Hajin
		2. Sumbal
2.	Badgam	3. Kunzer 1. Magam 2. Beerwah
		3. Badgam
		4. Khan Sahib
3.	Pulwama	1. Khrew
4.	Anantnag	2. Awantipora 1.Duru-Verinag
5.	Udhampur	1. Talwara (C.T)
		2. Kud
6.	Jammu	1. Jourian
		2. Khore
		3. Gurah- Salathian (C.T) 4. Ramgarh 5. Gho Manhassan

Note: All the towns except two are Notified Area Committees (NAC).
Source: Census of India J & K 2001, Paper –2 of 2001, Rural-Urban Distribution of Population.

NATURAL INCREASE AS A CONTRIBUTING FACTOR TO URBAN POPULATION GROWTH

There are three components of urban population growth: natural increase, increase due to migration, and reclassification. In simple terms, natural increase is the addition made by the excess of births over deaths. Net in-migration is the excess of in-migration over out-migration. Reclassification refers to the change in urban population due to emergence of new towns, declassification of existing towns and alteration in the territorial justification of towns.

NATURAL INCREASE

Table III.94 shows the rate of natural increase in the state between 1980 and 1998. The rate of natural increase shows an increasing trend till the 1990s. In 1998 the rate has shown a decline. This means that rural–urban net migration since the 1990s to the major towns has cut into the role of natural increase in the state.

Table III.94
Natural increase in Urban Population in 1980-1998

Year	Annual BR/1000	Annual DR/1000	Natural Increase
1980	21.40	5.60	15.8
1984	26.20	9.60	16.6
1986	25.40	8.70	16.7
1988	23.60	5.90	17.7
1990	24.00	6.30*	17.7
1998	16.10	4.60	11.5

Note: * Figures are based on average of the previous three years since no half yearly survey was conducted.
Source: Registrar General of India, quoted in Digest of Statistics, 1999-2000.

Table III.95
District-wise Natural increase of Urban Population, 1980-1999

S. No.	Districts	1980		1985		1990		1995		1999	
		Births	Deaths	Births	Deaths	Births	Deaths	Births	Deaths	Births	Deaths
1	Kupwara	34	17	110	47	103	14	289	314	707	401
Natural increase		17		63		89		-25		306	
2	Baramula	842	200	1986	374	1774	89	3677	504	3080	671
Natural increase		642		1612		1685		3173		2409	
3	Srinagar	11406	1190	17040	3196	19784	963	40694	2364	32676	3537
Natural increase		10216		13844		18821		38330		29139	
4	Badgam	-	-	48	19	21	5	184	124	479	255
Natural increase		-		29		16		60		224	
5	Pulwama	502	153	340	141	364	65	530	206	1042	558
Natural increase		349		199		299		324		484	
6	Anantnag	2094	372	2437	360	1636	106	3136	355	3418	695
Natural increase		1722		2077		1530		2781		2723	
7	Leh	-	-	60	30	51	8	45	57	183	77
Natural increase		-		30		43		-12		106	
8	Kargil	-	-	-	-	-	-	-	-	-	-
9	Doda	149	62	235	94	223	951	425	232	928	270
Natural increase		87		141		-728		193		658	
10	Udhampur	859	122	913	137	785	17	2073	226	3172	479
Natural increase		737		776		768		1847		2693	
11	Poonch	51	22	217	56	275	18	214	166	412	299
Natural increase		29		161		257		48		113	
12	Rajauri	189	35	143	48	206	16	347	147	598	185
Natural increase		154		95		190		200		413	
13	Jammu	6112	1461	8296	1457	20706	38	15784	3034	19406	3991
Natural increase		4651		6839		20668		12750		15415	
14	Kathua	559	76	586	167	2051	71	3740	191	5204	242
Natural increase		483		419		1980		3549		4962	
Jammu and Kashmir		22797	3710	32411	6126	47979	2361	71138	7920	71305	11660

Source: Directorate of Economics and Statistics Jammu & Kashmir.

Fig. 12
Districtwise Natural increase in Population 1980-1999

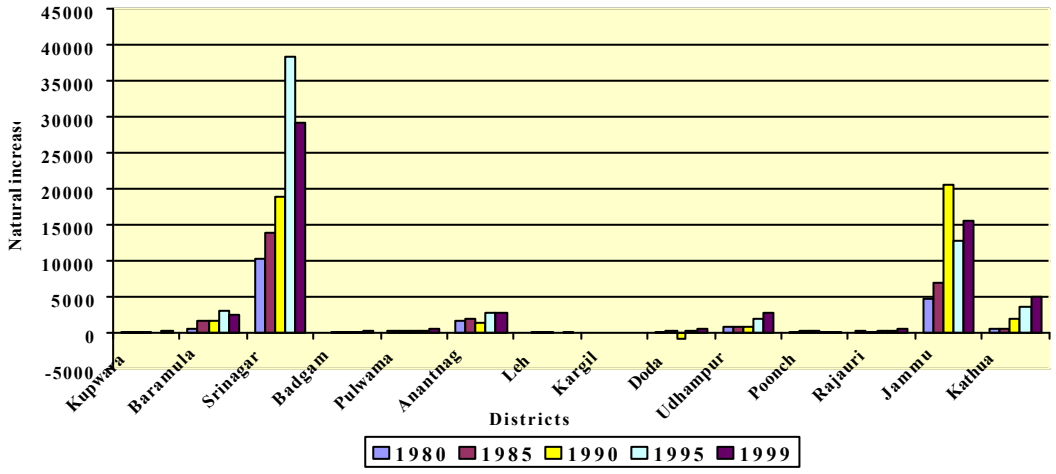


Table III.95 shows that the rate of natural increase is maximum in the two most urbanised districts of Srinagar and Jammu. Nearly 15,000 to 30,000 populations are added every year by way of natural increase in the two important cities. In Srinagar both migration and acquisition of villages within the city limit, i.e., reclassification is responsible for the increase in population. The new Master Plan 2000-2021 for Srinagar city will cover 126 villages within the city limits, thereby increasing the area of the city from 236 sq. km to 416 sq. km. The villages will be taken from Srinagar, Baramula, Budgam, and Pulwama right from Narbal, Shalbug, Mujgund, Soibug and Wathora to Galander.

EFFECTS OF URBANIZATION

Though it is an undeniable fact that urbanization, being an integral part of the development process, brings in its wake more opportunities and new possibilities, yet the attendant problems are be very acute and complex in nature. In Jammu and Kashmir, although most of the population lives in rural areas, the increasing concentration of population in the urban areas has created the usual problems such as the shortage of houses, inadequate supply of drinking water and problems of drainage and sewerage, pollution, unemployment, poverty, etc. The following paragraphs analyse some of the effects of urbanization in the state.

i) Housing

The major problem related to urbanization is the problem of habitation. The significance of this problem was also realised in the main theme address in the Second UN Conference on Human Settlements (Habitat II) held in Istanbul in 1996 which emphasized adequate shelter for all and sustainable human settlement development in an urbanising world.

Table III 96
Number of Occupied Residential Houses/ Number of Households in Urban Areas

Districts	No. of Occ Res Houses		No. of Households		Population		Av. Size of the HH		Percentage Growth	
	1971	1981	1971	1981	1971	1981	1971	1981	ORH	HH
Kupwara	N.E	1171	N.E	1458	N.E	9585	0	6.6	0	0
Baramula	7081	9457	9829	13056	66943	89766	6.7	6.9	33.32	33.14
Srinagar	43270	60794	60067	82793	423253	570195	7.0	6.9	40.50	37.86
Srinagar UA	*43270*	*64863*	*60067*	*87722*	*74234*	*606002*	*1.2*	*6.9*	*49.90*	*46.06*
Badgam	N.E	5951	N.E	7256	N.E	51585	0	7.1	0.00	0
Pulwama	N.E	4237	N.E	5354	N.E	36279	0	6.8	0	0
Anantnag	8267	7853	10942	10428	74234	70286	6.8	6.7	-4.64	-4.70
Leh	1573	1735	1959	2162	7909	8713	4.0	4.0	13.45	3.70
Kargil	N.E	572	N.E	735	N.E	3527	0	4.8	0	0
Doda	3137	4118	3377	4419	19636	25174	5.8	5.7	31.27	30.86
Udhampur	5362	8508	5777	8725	28419	43247	4.9	5.0	58.67	51.03
Poonch	2536	2633	2658	2648	13456	14171	5.2	5.4	3.82	-0.38
Rajauri	1626	2803	1756	2918	8397	15833	4.8	5.4	72.39	65.23
Jammu	29115	39218	33459	48396	191342	279514	5.7	5.8	34.70	44.64
Jammu U A	*24355*	*29867*	*25807*	*35537*	*164207*	*223361*	5.7	5.8	22.63	*35.76*
Kathua	4590	7328	4775	7440	25085	41990	5.3	5.6	59.65	55.81
Jammu & Kashmir	106566	156338	134629	197365	853221	1260408	6.4	6.4	47.17	46.97

Source: Census of India,1971, Vol. I, India, Part IIA (ii) Union Primary Census Abstract. and Census of India, 1981, Series 8, Jammu and Kashmir, Part IIB, Primary Census Abstract.
Note: N.E Not Existed, ORH Occupied Residential Houses, HH Households.

Fig.13
Average Size of Household 1971-81

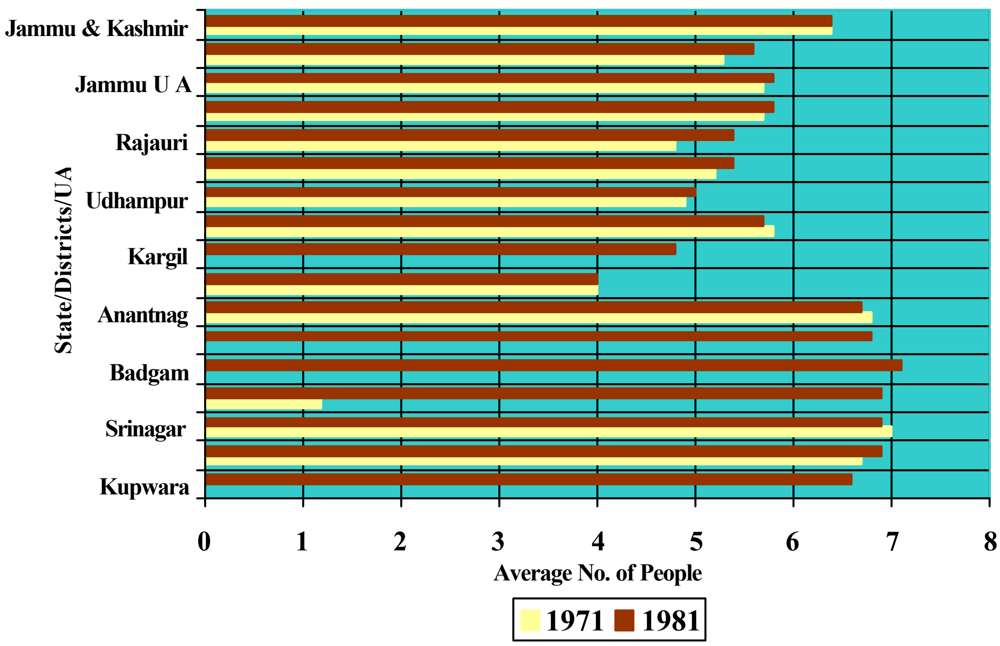
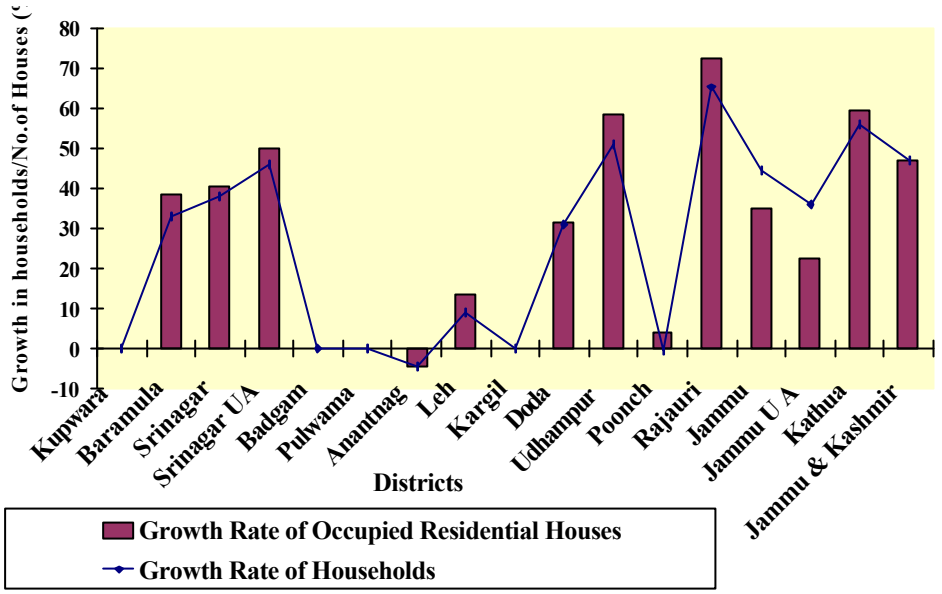


Fig. 14
Growth of Households and Number of Houses 1971-81



The continuous growth of population pressurizes the housing market, raising the demand for more houses. By the 9^{h} Five-Year Plan the total housing shortage in the urban areas of the state was estimated to be to the tune of 1.63 lakh dwelling units. Table III.96 shows the average size of households, percentage growth of residential houses and households. The same is depicted in Figures 13 and 14. The average size of the household has not changed during the years 1971 and 1981. Therefore the ratio of occupied residential houses to the number of households also remained the same at 100: 126. Due to the limitation of availability of the current data, the analysis is not complete. But the pressure is clear from the fact that Srinagar Development Authority (SDA) have been given the challenging task for providing housing facilities and better civic amenities to the people as the available land resources are limited. To overcome the dearth of land in Srinagar city, a propsal for creating a land bank under the control of SDA is under active consideration of the government. For this purpose, about 5000 kanals of land are being acquired within the limits of the proposed greater Srinagar city under the new master plan.[1]

Moreover, the mushrooming growth of private housing colonies, which are either ill planned or un-planned, has created various problems for urban local bodies in providing basic amenities to these colonies. Most of these colonies have turned into

1. The official Website of Jammu & Kashmir Government, India, *Newsline*, 09 July, 2001

slums which have caused various problems in the Srinagar city, stated the Minister for Housing and Urban Development, Mr. Ghulam Mohi-ud-Din Shah, while presiding over 66th meeting of Board of Directors of Srinagar Development Authority (SDA). He also underlined the need for involving private agencies in the housing sector owing to the growing demands of housing facilities in urban areas. It was also decided to transfer 1500 kanals of land at Mujgund to SDA by the Revenue Department by October 2001.[2]

Ghulam Mohi-ud-Din Shah also said that in order to cater to the needs of the people, it has become necessary to carve out new wards under local bodies for an efficient and transparent administration of these institutions. For example, in Jammu city 48 wards are being carved out of the existing 23 wards with a population of 7500 in each ward and in Srinagar 59 from the existing 33 wards.

With the demand for houses having increased, the quality and condition of housing has received much less attention. According to the NSS 49th round (Jan—June 1993), of the 80.82 per cent of the households living in pucca houses, 1.36 per cent lived in bad condition. The situation was worse for those living in semi-pucca and kutcha houses. According to the survey, 13.41 lived in bad condition among 14.98 per cent of the semi-pucca households and 19.57 per cent among 4.20 per cent of the households living in kutcha houses. According to the 50th round of NSS, 65 per cent of the households lived in their own houses while 32 per cent in rented houses and 3 per cent in others.

The 50th round of the NSS found that 99.6 per cent of the urban households had electricity connection, but no information about the supply of power is available so as to know the interruption in it.

It is also important to note here that only 64.7 per cent of the households in the urban areas (NSS 49th round) of the state had toilet facilities.

Slums are also a new phenomenon in the state. In 1999, the lake colony was the only slum on water in Srinagar. There were no slums on land. Unlike other cities where people encroach on land, in Srinagar they encroached on water.[3] With the fast trend of urbanization and concentration of population in big towns, slums have come up in Jammu and Kashmir. The 2001 census recorded 5 towns with a slum population of 2,70,084, which accounts for 18.60 per cent of the total population staying in these 5 towns.

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2. The official Website of Jammu & Kashmir Government, India, *Newsline*, 20 August, 2001
3 Of Shikaras and Slums, *Down to Earth*, Vol. 8, No.8, 15 September, 1999.

ii) Supply of basic civic amenities

Like housing, other facilities are essential for urban life. These include water supply, sewerage, disposal of solid waste, power supply, etc.

• *Water Supply*

Water supply and distribution is an important lifeline in any urban area. Inadequate and unhygienic water supply has been a perennial problem in Indian cities and a major factor responsible for periodic water-borne epidemics. Millions of city dwellers do not have access to a safe water supply source. According to the 1981 census, 14 per cent of the urban population did not have access to safe water supply, although much progress has been made. For the state as a whole, in 1981, 60 per cent of the population did not have access to safe water supply. Moreover, the supply is not sufficient to cater to the needs of the people.

For example, Jammu is located along the river Tawi in the foothills of the Himalayas, but it is reported that 70 per cent of the tap water supplied by the Public Health Engineering (PHE) department to the consumers in Jammu was unfit for consumption. Tawi river, the main source of drinking water supply, is itself highly polluted. Besides, the task of monitoring the maze of leaking pipes – the source of fecal matter getting into drinking water – is beyond the capacity of the somnolent PHE department.[4] At present, 80 tankers are being utilized for supplying drinking water to water scarcity areas. This is because, against the demand of 63 MGD drinking water in Jammu city, the present availability is 50.80 MGD.

The problem of water supply has been so acute that the PHE department has also started exploitation of ground water in a big way due to the depletion of surface water resources. The department is facing a shortage of rigs for digging of tubewells and handpumps, as only four such rigs are available in the state. Mr. Ali Mohammad Sagar, the Minister for Works, said that the department is now purchasing 28 rigs at a cost of Rs. 90 crore with NABARD assistance for massive exploitation of ground water.[5]

The PHE department has installed 10 tube-wells in Jammu city during the past two years. With the installation of these tube-wells, there has been an increase of around 50 lakh gallons of potable water in the city. These tube-wells have been installed at

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4 Drink Cola, Not Water, *Daily Excelsior.*

5 'Sharing of Ravi Water to be taken up with Punjab: Sagar', J & K Legislative Assembly Proceedings, *Daily Excelsior*, Tuesday, 19 March, 2002

NITCO Lane, Tawi Left, Muthi Left, Gole Gujral, Langeth, Kalu Chak, Dream Land Muthi, Shastri Nagar, Thanger Pattian and Bodhori.The department also plans to install 109 tubewells in Jammu district, 58 in Kathua, 48 in Udhampur, 32 in Rajouri, 15 in Poonch and 11 in Doda. The department has also formulated a Rs 100 crore plan for utilization of Chenab water for drinking purposes in Jammu region.[6]

The Minister said that under the Ground Water Exploration Programme, 173 tubewells have been installed in the state since 1996. Out of these, 81 tubewells have been commissioned in Jammu region while 92 tubewells have been installed in Kashmir Valley. Besides, 1720 handwells and 1332 shallow pumps have also been installed in Jammu region and 1467 hand pumps in Kashmir Valley. He said that during the last six years, 55 lakh gallons of potable water per day have been added to Srinagar and 50 lakh gallons to the Jammu city, as stated before. The Minister also said that a Rs.535 crore project has been formulated for the augmentation of potable water in Greater Jammu. He said a similar project is also being formulated for the augmentation of drinking water in Greater Srinagar.[7]

• *Sewerage and Drainage*

Prior to 1953, the Dal lake's water flushed out through the two major drains, the lock at Dal Gate, leading into canals which cut through downtown Srinagar, and the Nallah Mar. The canals in downtown Srinagar served as the city's communication arteries, with boats transporting goods and passengers. Due to the introduction of bus services in 1953 and the growth of population, the canals degenerated into sewage drains since there was no incentive to keep them clean and desilted. Today the canals are just gutters.[8] Without a municipal waste disposal system and the absence of a sewerage system, residents of Bhagwanpora directly discharged their waste into the lake.

The waste water from the towns of Anantnag, Srinagar, Sopore and Baramulla are discharged into nalahs, drains and canals which ultimately reach the river Jhelum and is the main source of its pollution. With high growth of urban areas and increase in development, the quantum of untreated wastewater and solid waste is rapidly increasing. Various sewerage schemes have been taken up by the state to tackle the problem. Mention may be made of the Sewerage Scheme of Div A Phase II Talab Tilloo, Jammu, Pilot Sewerage scheme Khushal Sar, Pilot Sewerage scheme

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6 The Official Website of Jammu & Kashmir Government, India, *Newsline*, 21 August, 2001.

7 'Sharing of Ravi Water to be taken up with Punjab: Sagar', J & K Legislative Assembly Proceedings, *Daily Excelsior*, Tuesday, 19 March, 2002

8 Swami, Praveen, 'To save a Lake', *Frontline*, Vol.15, No.11, 23 May- 05 June, 1998.

Brarinumbal., Sewerage scheme for Greater Srinagar city. The Doodganga drainage project has also been formulated for improving the drainage facilities in Resham Colony and Allochibagh areas of Srinagar.[9]

• *Disposal of Solid Waste*

Safe disposal of Municipal wastes is imperative for maintaining cleanliness and a pollution-free environment in cities and towns. Scientific disposal of solid waste is the only answer. The government is in touch with private and foreign promoters of solid waste management for setting up plants in Jammu and Srinagar to convert solid waste into manure. Giving details about measures taken by the government to improve civic and sanitation facilities, the minister said modern scavenging equipment was being procured to remove the filth in the interiors of congested cities. Manpower was being trained to operate these machines. As many as 16,000 dustbins were being distributed among the people in Jammu city during 2001, while this experiment had already been undertaken in Srinagar city.[10]

On the sanitation front, the Jammu Municipality has launched a night scavenging scheme, door-to-door collection of garbage and house-to-house separate collection of bio-degradable waste and non-biodegradable waste in Jammu city to ensure cleanliness and to initiate scientific solid waste management among the citizens.

• *Power*

Despite large purchases from the central plants and other states, it is unable to meet its peak demand and so has to curtail power supply for long hours in summers as well as in winters. The inadequate supply affects the ultimate consumers both in urban and rural areas. Since the supply of power is usually not metered, consumption is not charged and maintenance becomes costly. Moreover, power theft and pilferage exert additional pressure. Despite having large unexplored potential, the power situation is quite dismal. Inadequate transmission and distribution network, huge transmission and distribution losses, low power tariff, long gestation period of the power projects, paucity of funds for power generation and the law-and-order problems have contributed to a pathetic situation of the power sector. Inadequate and erratic supply of electricity is a major problem faced by the state.

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9 'Acting CM visits various areas of Batamaloo', *Daily Excelsior*, Srinagar, Thursday, 21 June, 2001.
10 Minister: Civic poll within next six months', The Tribune, Jammu, Thursday, 22 March, 2001.

EMPLOYMENT SCENARIO

The roots of the problems in Jammu and Kashmir are of economic nature. Tables III.25 and III.26 indicate the number of unemployed in Jammu and Kashmir.

With the increase in population, the number of young educated applicants in the employment exchanges has increased from 112426 in 1990 to 167238 in 2000 – a growth of 48.75, which is quite high. The absolute increase was in the number of professional and technical workers during the same period

With a view to ameliorating the socio-economic condition of those living below poverty line in urban areas, and creating job opportunities for them under centrally sponsored Swaran Jayanti Shahri Rozgar Yojana (SJSRY), the Urban Development Agency, Kashmir (UDAK) imparted training to 1219 candidates in different crafts during 2000-01. Moreover, under the Urban Wage Employment Programme, aimed at providing wage employment to the beneficiaries within the jurisdiction of the urban local bodies, 81 works have been completed by the Srinagar Municipality and local bodies of Kashmir at a total cost of Rs. 62.93 lakh. Other schemes such as the skill upgradation and Development of Women and Children of Urban Areas (DWCUA) are also under implementation to tackle the unemployment problem. Likewise, under Urban Self-Employment programme (USEP), 995 cases have been sanctioned by various banks during 2000-2001 as against a target of 3262 cases set by the UDAK. The agency has provided a subsidy of Rs. 71 thousand for the sanctioned cases. An amount of Rs. 71.575 lakh has been incurred on the programme up to March 2001 as against a total allocation of 128.665 lakh for the year 2000-01.[11]

The problem of unemployment in J&K has been extremely acute. The position is likely to worsen in view of the fact that the state government, as suggested by the union government, has taken a decision to ensure that the number of employees on the pay roll of the state government and its undertakings get reduced. In order to ensure this, a complete ban on filling up of vacancies through the Service Selection Board/Public Service Commission was imposed during 2000. The major avenue of employment therefore will be in the private sector. In order to achieve this, the self-employment schemes will have to play a major role in providing employment opportunities especially to the educated youth. It has been noted that the targets fixed for providing institutional finance under self-employment schemes are still not being achieved especially by the nationalized banks. This is revealed by the fact that

11 Under SJSRY 81 works completed and 1219 candidates imparted training in different crafts, *Newsline*, Jammu, 31 July, 2001, The official website of J&K Govt.

against the target of 13,974, only 4099 (29.33%) accounts were opened and the institutional loan advanced for self-employment constituted only 27.24% of the target for 2000-01.[12]

POVERTY

The growing urbanization and the relentlessly growing urban population have enhanced the problem of urban poverty. It is considered to be the most demanding urban challenge and most important urban problem because poverty leads to many other problems in the urban areas. Table III.97 shows the urban poverty ratio of the state and nation.

Table III.97
Urban Poverty Ratio in Jammu & Kashmir and India

(in per cent)

	1973-74	1993-94	1999-2000
Jammu & Kashmir	21.32	9.18	1.98
India	49.01	32.36	23.62

Source: Planning Commission quoted in Economic Survey 2001-2002

The poverty ratio is estimated from the state specific poverty lines and the distribution of persons by expenditure groups obtained from the NSS data on consumption expenditure. The poverty ratio of both the state and the country has declined between 1973-74 and 1999-2000. As the figures show, the poverty ratio of the state has always been below the national average. But the figures always do not represent the actual situation. Therefore, socio-economic development intervention is always needed.

This can be justified by the fact that beggars are found in Srinagar right from the hottest tourist spots to the most impoverished places. While their estimated number is still not known, residents feel that there should be at least 2000 beggars moving around the valley. It is interesting to note that the beggars of Srinagar are not solely from among the local people. There are a large number of migrants flowing into the Valley from the states of Rajasthan, Haryana, Uttar Pradesh, and Bihar. Here they mingle with the local population and from there they go on to build their own begging groups.

12 Speech by Dr. Farooq Abdullah, Chief minister, Jammu & Kashmir, in the meeting of the National Development Council, 1st September, 2001, Vigyan Bhawan, New Delhi.

The latest pretext for entry is the Amarnath Yatra. Most migrants come to Srinagar during this part of the season because they get many free provisions here. For Amarnath yatris, the Jammu and Kashmir government has made many attractive arrangements including free tented accommodation, free food at *langars* and special buses to transport them to various places.

Another surprising fact is that most of these migrants secure entry into this region on the tourist list. Since they register with the state transport people, the government conveniently counts them among the visiting tourists. So, where on the one hand the state government gets an easy chance to exaggerate the number of tourists by registering these migrants as the same, the latter also make full use of the opportunity.

Once they enter the region, it is easier for them to operate. In the bargain, the beauty of the Valley suffers. Today, about 70 per cent of the beggars in Srinagar hail from other states. They have also raised small slums in the Batmaloo area which has the largest concentration of migrants. A visit to Batmaloo revealed that while the men in the migrant families worked as daily wagers, the women begged for alms. Most children have also been forced into this business of begging.

The Boulevard Road (which runs along the Dal Lake) alone had about 60 beggars at a time. While about 10 of them were local Kashmiri Muslim, the rest were all migrants from outside states. Large pockets are also found on the Amira Kadal bridge and Hari Singh Estate area. On Fridays they cluster outside the mosques.

Regarding the local Kashmiri Muslims, many of them have taken to beggary in the absence of other means of earning a livelihood. Ahmad Shah, a teacher with a private school said, "Begging is against Islam. On the contrary our religion inspires us to donate money and funds. But now you can find many beggars in Kashmir because they have no other means of livelihood. The entire tourist sector lies ravaged. What will the people do? They have to beg to eat. They can't even get employment because the rate of employment in the Valley is very low."[13]

URBAN DEVELOPMENT AND THE TENTH FIVE-YEAR PLAN (2002-2007)

The housing and urban development sector which received little attention in the First Five-Year Plan came to be an important sector both in terms of providing houses to

13 Wounded Valley, A Tribune Special, ' Beggars throng tourist spots', Aditi Tandon, *The Tribune*, Wednesday, 4 July, 2001.

the people and preservation of environment in the later plans. In the First Five-Year Plan Rs. 0.16 crore was spent on this sector which swelled to a proposed outlay of Rs. 763.87 crore in the Tenth Five-Year Plan. Table III.98 shows the break-up of the proposed outlay for urban development during the Tenth Five-Year Plan.

Table III.98
Tenth Five-Year Plan – Proposed Outlay

(Rs. in lakh)

Urban Development	**Rs.76387.03**
a) Urban Development	Rs.25979.40
b) Dal Development	Rs.48181.00
c) Urban Poverty Alleviation	Rs.2019.33
d) Fire Services	Rs.257.30
Housing, Water Supply and Sanitation	**Rs.2050.00**
a) PHE-Jammu	Rs.42277.87
b) PHE-Kashmir	Rs.39585.22
c) Sewerage	Rs.10204.00
d) Drainage	Rs.12796.72

Source: Planning and Development Department, Government of J & K, Tenth Five-Year Plan (2002-2007)

Under the urban development sector, the schemes, in the Ninth Plan, will continue in the Tenth Plan also, to provide basic facilities to the urban population. The main schemes which were taken up during the Ninth Five-Year Plan include Capital City Development Programme (CCDP), Civic Amenities in Town (CAT), Integrated Development of Small and Medium Towns (IDSMT), Financial Assistance to Local Bodies (FALB), Comprehensive Urban Transportation Project, Low-cost Sanitation (LCS), Development of Patnitop, Dal Conservation and Development of Model Town Charar-I-Sharif, Integrated Development of Medium Towns (IDMT), and National Slum Development Programme (NSDP).

During the Ninth Plan (1997-2002), the target for the construction of new houses was 24454, while the achievement was 29719. The target for the Tenth Plan is 31704 houses. The housing schemes of the Ninth Five-Year Plan will continue in the Tenth Five-Year Plan as well. The proposed land for acquisition will be used for the development of various EWS/LIG/MIG colonies in the state. These colonies are Sidhra township, Zakura, Channi Rama, Ompora etc. During the 9th Five-Year Plan Sidhra near Jammu and Zakura near Srinagar was taken up for development of satellite townships. Valmiki Ambedkar Awas Yojana (VAMBAY) scheme has recently been launched by Government of India for providing shelter/upgradation to

the urban slum dwellers with 50 per cent subsidy component which will be provided by HUDCO.

The PHE Department Jammu along with the augmentation and improvement of water supply in Greater Jammu, have also identified 30 towns for the same. Among 30 towns, work in 6 towns namely, Vijaypur, Hiranagar, Sunderbani, Chanani, Ramnagar and Reasi is already complete. During the Tenth Plan, it is proposed to complete all the remaining 24 towns.

Similarly, the PHE Department Kashmir undertook to implement the water supply scheme in 14 towns during the Ninth Five-Year Plan. Three towns have been completed since 1997 and two towns namely, Harrensheerpathri and Budgam have been targeted for completion during the current financial year, the rest of nine towns for completion during the 10th Five-Year Plan. It is proposed that along with these nine towns eight more towns, namely, Kangan, Kupwara, Hajin, Kokernag, Pampore, Tral, Kulgam and Qazigund shall be taken up as new schemes for providing safe drinking water.

Under urban development, the development of model town of Charar-I-Sharif which is estimated to cost Rs. 24 crore, is planned to be completed during the Tenth Plan. The main feature of the scheme is to develop a satellite colony for the people living around the shrine complex, besides providing other civic amenities for the town. The project has been exposed to HUDCO for the provision of loan and HUDCO has accepted the same in principle for an amount of Rs.19 crore. The state contribution is to provide Rs. 5 crore and since the state has already incurred an expenditure of Rs.5.32 crore on the project, it will be treated as state contribution.

Two new programmes regarding development of the road network in Bemina Colony, Srinagar and the development of extended areas in Srinagar city are being taken up with an outlay of Rs. 6 crore and Rs. 12 crore respectively as part of Capital City Development Project. A project for development of Lakhanpur, the gateway to the state of J&K, has also been prepared at an estimated cost of Rs. 15.74 crore.

Under the Jhelum Action Plan, an estimated cost of Rs. 284 crore has been prepared and is expected to be fully financed by the Government of India (GOI). Already the National River Conservation Directorate, Ministry of Environment and Forests, GOI is coordinating the overall implementation of the schemes under the Jhelum River Conservation Plan (JRCP) through the state government identified nodal agency, J&K Lakes and Waterways Development Authority (LWWDA), Srinagar.

RECOMMENDATIONS FOR URBAN DEVELOPMENT

1. Urbanisation, being a state subject, the state government should prepare urbanization strategies. Comprehensive integrated urban area development plans including zonal, district and sector plans and layouts are recommended after site evaluation and environmental impact analysis. Integration of smaller urban units within broader economic networks is essential.

   Overall area planning also includes circulation networks and public utilities. Therefore, before planning, evaluation studies should be taken up to assess the impact at the local level of macro-economic policies and of the globalisation of markets and technology, and the new forms of economic integration and urbanisation they generate. According to the feasibility of growth, urban form of the towns should be recommended. Therefore the strategy and overall design of urbanization projects should reflect a multi-level approach.

2. As far as an urban area is concerned, the municipalities and corporations should also be brought within the framework of the proposed decentralized set up. The functions and powers of the municipalities and corporations should be incorporated in the constitution of the state, according to the provisions of the 74th Amendment to the Indian Constitution on the subject.

3. There should be reservation and not nomination for the SC, ST and OBC in proportion to their population in the area; minimum, not maximum reservation of 33 per cent for women as recommended in the case of panchayati raj institutions (PRIs). The reserved seats may be allocated by rotation to different constituencies in municipalities or corporations.

4. As the urban agenda involves a host of broad sub sectors development like sustainable provision or expansion of urban infrastructure facilities, an increasing involvement of the private sector in the provision of urban services becomes imperative not only in terms of increased resource flows but also in terms of efficiency gains in provision of services. The private sector participation helps in:

   - bringing technical and managerial expertise to the sector;
   - improving operational efficiency;

- reducing the need for subsidies; and
- increasing responsiveness to consumer needs and preferences.

Private sector participation can be encouraged in urban infrastructure in several ways including extending of resources, providing state-of-the-art technology at the project management and maintenance levels. Besides, public-private partnership can be developed on models like build-operate-transfer (BOT), build-operate-own-transfer (BOOT), build-operate-lease-transfer (BOLT) and design-build-finance- operate-transfer (DBFOT) models.

5. The private sector is yet not confident of putting money in urban infrastructure sector even though the financing options are rapidly changing due to financial, technological and organisational innovations. There are other issues like levy of user-pay charges. People should be made aware that if they pay for water, sewerage and electricity, they will get better services. The concepts of user-pay, abuser-pay and polluter-pay should be implemented while determining the service charges to assess the practical aspect of pricing.

6. Provision should be made to regulate the discharge of urban waste water into bodies of water by establishing control measures in the context of overall water management policy, taking into account both qualitative and quantitative requirements.

7. Micro-level planning needs to be carried out for solid waste management in different wards of the cities. The innovative sanitation schemes introduced by the Jammu municipality (discussed earlier) could be implemented in other urban areas as well. For this Public-Private-Peoples Partnerships (PPPP) is recommended from the present 100 per cent focus on Public as it allows for synergy/convergence /integration.

8. A critical component of any urban development plan is the provision of adequate water supply. The drinking water arrangements both in Srinagar and Jammu need to be strengthened and improved. What is required is an assessment of drinking water requirements in the next twenty years and drawing up of plans that can be implemented within a short time frame. There

has been talk of supplementing drinking water requirements of Jammu city by laying a pipeline from Chenab river near Akhnoor. The cost involved no doubt is a deterrent but no other viable alternative is in sight.

9. There are a number of urban water supply and sewerage projects which the Ministry of Urban Affairs and Employment has taken up for external assistance through the Department of Economic Affairs of the Ministry of Finance. The projects are funded by the Overseas Economic Cooperation Fund (OECF), Japan, and the World Bank. As urban water supply and sanitation are state subjects, the selection of sites for the projects rests entirely with the state governments. The criteria for selection normally depend on the need for augmentation and improvement of the services and the technical, financial and institutional capacity of the urban local bodies to implement the projects with foreign assistance. The state government can also take up some externally funded projects to augment water supply and sanitation

10. The role of cooperatives in mitigating the housing condition in India is appreciable. Increasing emphasis can be laid on the formation of housing cooperatives to meet the growing demands of housing facilities in urban areas. These cooperative societies can be made responsible for the maintenance of essential services and other common assets to reduce the pressure on the ULBs.

11. To increase the availability of affordable housing to economically weaker sections and low-income groups**,** the state government should provide policy framework and legislative, fiscal and financial system that would put into effect the enabling role of the government in the housing delivery system. The government should also introduce a separate housing scheme for persons living below poverty line in urban areas along with HIG/MIG and LIG schemes for all towns with more than 50,000 population. To cope with the problem of slums, if the government could grant legal occupancy leases to the existing tenants and also thereafter permit the new occupancy leases to be bought, sold or rented out to different occupants, there would be a free market which would facilitate greater mobility and the exchange of property as well as encourage private improvement of slums.

The Government of Kerala has initiated an innovative scheme for down marketing housing credit for the urban poor as cash loan to the individual

beneficiary for construction of houses with the beneficiary family's participation, as a special programme during the 50th anniversary of India's independence. This novel scheme is a self-help programme by the beneficiary households organized as Community Development Societies (CDS) in all the municipalities and corporations of Kerala with a special arrangement for savings of the order of 15 per cent of the house cost in HUDCO's Public Deposit Scheme. The J&K state government could also try such innovative schemes to solve the housing problem of the urban poor.

12. Urban Transport should be given due attention as the primary tool for the development of urban forms in India. The state government should prepare a transport policy that is affordable, and provide accessibility and reasonable mobility to all sections of the society, reduce and control pollution, optimize fuel consumption, improve safety and be socially, environmentally and financially sustainable. The policy should be dynamic and should take into account the increasing population, ongoing urbanization and economic growth. Efforts should be made to provide compulsory cycle tracks and separation of road traffic according to mode of transport in medium and large towns. Computerized traffic signals should be made mandatory.

13. Another crucial issue is the development of a strong Urban Information base. The developing and nurturing of partnerships has been identified as the new tool for achieving the progress without hampering resources for future generations. Education and capacity building has to provide an important input in this agenda if it has to be successfully implemented. Capacity-building efforts along with the policies have to be developed to allow for greater awareness and attitude towards formation of Public-Private People's Partnerships (PPPP).

14. A reliable database needs to be created on a continuous updating basis. This can be generated through compulsory assessment by landlord/occupant to be reconciled by the municipal officials followed by a comprehensive study on the restructuring of the municipal finances that will include Management Information System and training programme to make the ULBs more service oriented. The gaps and shortcomings in the delivery of municipal services should be identified. Since urban poverty is a growing/ persistent phenomenon there will be a continuous need to gather information on the levels of poverty, relative income inequalities, etc., and to study the composition of its

manifestations. The state has one of the unique problems of encroachment on water more rather than land. There is a definite case for preparation of well-documented case studies of success failures, reasons thereof spelling out clear cut steps, initiatives, etc.

15. Training should be given targeting the building up of capacity of the local government to: i) identify, develop and manage commercially viable environmental and infrastructure projects; ii) enter into agreements with private providers of basic urban services, rationally price the delivery of services and recover costs; iii) improve the planning of basic urban services; and to operate, maintain and recover costs for basic urban services in order to develop sound financial management systems which will support access to the capital market, and iv) to improve the ability to form partnerships with private land developers.