Status, Availability and Utilization of Health Services for Women: A Study of Kulgam District of Jammu and Kashmir

DISSERTATION

SUBMITTED TO

BABASAHEB BHIMRAO AMBEDKAR UNIVERSITY

(A CENTRAL UNIVERSITY)

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CERTIFICATE

This is to certify that the dissertation titled **Status, Availability and Utilization of Health services for women: A study of Kulgam district of Jammu and Kashmir** submitted by **Ms. Asma Farooq** is an original research work and has not been previously submitted in part or full for the award of any other degree or diploma to this or any other university.

The dissertation submitted to Babasaheb Bhimrao Ambedkar University, Lucknow satisfies all the requirements as stipulated in the Master of Philosophy (M.Phil). Regulations amended in 2017 incorporating the provision of the University Grants Commission Regulations, 2016 and it is fit for submission and evaluation for the award of the degree of Master of Philosophy of the University.

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DECLARATION

I hereby, declare that the work embodied in the dissertation entitled **Status, Availability and Utilisation of Health Services for Women: A Study of Kulgam District of Jammu and Kashmir** submitted in the partial fulfilment for the award of the degree of Master of Philosophy in Economics is an authentic record of original work carried out by me under the guidance of Dr. Pranav Kumar Anand, Department of Economics, Babasaheb Bhimrao Ambedkar University. I further declare that this is the original work and has not been submitted in any university or institution for the award of any degree. I also want to declare that this dissertation is free from all kind of plagiarism.

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Asma Farooq

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ABBRIVATIONS

ANC	Anti Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Workers
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BEmOC	Basic Emergency Obstetric Care
BP	Blood Pressure
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
DH	District Hospital
DLHS	District Level Household and Facility Survey
FP	Family Planning
FRU	First Referral Unit
FWCW	Fourth World Conference on Women
FWP	Family Welfare Programme
GDP	Gross Domestic Product
GHP	General Health Problem
GOI	Government of India
HDI	Human Development Index
HDR	Human Development Report
ICDS	Integrated Child Development Services
ICPD	International Conference on Population Development
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
JSY	Janani Suraksha Yojana
JSSY	Janani Sishu Shraksha Yojana
LHV	Lady Health Visitor
LMO	Lady Medical Officer
MCH	Mother and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MMU	Medical Mobile Unit

MO	Medical Officer
NFHS	National Family Health Survey
NHP	National Health Policy
NNMR	Neo Natal Mortality Rate
NPEW	National policy for Employment and Women
NPP	National Population Policy
NRHM	National Rural Health Mission
OHP	Other Health Problems
PHC	Primary Health Centre
PNC	Post Natal Care
RCH	Reproductive and Child Health
RH	Reproductive Health
RHP	Reproductive Health Problem
TT	Tetanus Toxoid Vaccine
VHAI	Voluntary Health Association of India
WHO	World Health Organisation

Chapter 1
Introduction

CHAPTER 1

INTRODUCTION

1.1 Introduction:

Health has been recognized as a fundamental human right, regardless of sex, political affiliation, social class or ethnicity, as well as the right to minimum condition of wellbeing, including the provision of medical care and public services for all people (The Universal Declaration of Human Right, *60th Anniversary Special Edition* 1948-2008).

Status is important, be it in family or community. Status of a person is a combination of social, economic, political and health status. This status individually represents different aspects of life. Traditionally, the Indian woman has always been dependent on man throughout her life, on her father in childhood, on her husband in adulthood and on her son in old age. It affects how a woman is treated, how she values and accepts herself, the kinds of activities she is allowed to do, and the kinds of decisions she is allowed to make. In most communities in India, women have status lower than men. Social and cultural practices support this low status. Women's lower status leads to discrimination, being treated poorly or denied something simply because they are women. It may take different forms in different communities, but it always affects women's health.

Good health is a personal and social state of well being in which a woman feels active, creative, wise and worthwhile but the health status of women and the disparities in health between the men and women are often critical indicators of equality in a society. Poverty and discrimination in the family and community not only lead to more health problems for women; they also make the health care system less likely to provide the services that women need. Government policies and the global economy may add to this problem.

In India many people do not have access to health services of any kind. And because of discrimination against women, the little money that does exist will probably not be spent on women's health needs. So a woman may not be able to get good care even if she can afford to pay for it. Some very basic health and reproductive health services

may be provided by the government, but to meet all of her health needs, she will probably have to travel along with someone at her own cost to the hospital or perhaps to the state capital hospital (Poswal, S. M. 2012:1).

Health and well being of human resource plays an important role in the economic as well as social development of the country. Both Health and well being of the people of a country largely depends on well developed, accessible and effective healthcare infrastructure. Healthcare infrastructure is an important indicator for analyzing the healthcare policy and welfare mechanism in the country. To ensure better health of the people an adequate healthcare infrastructure is of primary importance. Inadequate infrastructure generally leads to poor quality of health services which is positively dangerous to health and welfare of the community at large. Also India is second most populous country in the world, and it also has largest rural population in the world. Although India has achieved robust economic growth in the last few decades and has become one of the world's fastest and most dynamic big economies, it has performed poorly in terms of health sector development. Today health sector in India particularly in rural areas is in a debilitating condition with lack of proper physical infrastructure, manpower and necessary drugs. Health makes an important contribution to economic progress, there exists a positive correlation of economic growth with improved health indicators, as healthy populations live longer, are more productive, save more. This has huge human and economic costs: India is losing more than six percent of its GDP annually due to premature deaths and preventable illnesses (World Health Organization. Country Cooperation strategy a glance India. 2013.)

1.2 Identification of the Problem

The 21st century began with new thoughts, new policies and emphasis is on their proper implementation but the fruits of development continue to elude the bulk of rural mass, especially the women. Today there is a dualism which relates to gender (men and women). Although official surveys do not substantially present the poor health status of women, there is increasing evidence that the interplay of various social forces outside the health sector jointly limits women's opportunities for improving their health status. Researcher has felt that the health care system does not recognize women's needs. In the process of economic development, women play an

important role. Researcher thinks if women are not healthy, then how can an economy grow? How can economical status make healthy women? How income and expenditures are related to women's health. To gain answers to these questions researcher reviewed the literature within the next.

1.3 Review of Literature:

Many studies have been conducted on various aspects of women's health but there are few aspects, which are still untouched or few studies have been undertaken on these aspects. Despite various policy measures taken by the government, women are not able to fully utilize them for improvement of their health and work efficiency

Fayaz Ahmad Bhat et al. (2014) in his paper "Gender, Health and Availability of Health Services in Jammu and Kashmir" concluded that inspite of the widespread agreement on the importance of health in general and women's health in particular, many people, most of them women are deprived of this privilege. Gender discrimination is found in many aspects of health such as; declining female population, higher female IMR, low consumption of protein rich diet by women, suffer from malnutrition, anaemia, diabetes, goiter and asthma. In addition to this women are vulnerable to reproductive tract infections and problems related to menstruation. Despite the fact that State government in collaboration with Central government has introduced so many programmes and policies but it has failed to deliver what it promised for providing health care facilities to all, especially women. Though there has been substantial expansion of healthcare infrastructure and facilities by the state government along the private sector, but it has been unable to fulfill the growing demand owing to several factors viz., topography, armed conflict, deficit of healthcare infrastructure in terms of both quality and quantity. The general health problems of women are aggravated further by the ongoing conflict in the state as they become victims of direct or indirect violence. There is therefore need for further expansion of healthcare infrastructure keeping in mind the gender specific health needs not only in terms of quantity but also in quality by government as well as by private sector. He further discussed that involvement of the third sector, i.e., non-governmental organisations is also very important in generating awareness among masses regarding the importance of women's health, highlighting gender specific

health problems and assisting people especially women how to make full use of healthcare facilities so as to achieve the value of 'being healthy' because health is what the Noble Laureate Amartya Sen has called "an important condition of human life and a critically significant constituent of human capabilities that we have reason to value.

Harini Narayanan (2011) on "Women's health, population control and collective action" discusses the health policy in India. According to her, health policy in India like all public policies has always been the product of complex political processes. In the area of women's health, the situation is further complicated by the fact that policy processes have to straddle a treacherous fault line between target driven population control goals on the one hand, and issues of individual reproductive rights and general well-being on the other. Most recent discussions on women's health policy in India argue that over time, such policies and the programmes associated with them are today more inclusive and sensitive to the articulated and apparent needs of the women concerned than they earlier were.

A case study in villages from Orissa, conducted by Sachita Nanda Sa and Dr. G. Sridevi (2009) concludes that logic variable coefficients are positive which show the positive effects. It can also be seen that only total income of household, the educational status of the head of the household and health care facilities are significantly affecting the health status of the people in the study area. The coefficients of the variables show that Health Care Facilities (3.313) and Educational Status (2.278) are more responsive than income (0.0003) in the health status issue.

Neelam Sharma (2009) has analyzed that since the last few decades, women's health has been receiving special attention the world over. Women in India, especially those in rural areas bearing double burden on their shoulders, have never publicly voiced their concern over health needs. Even in urban areas where infrastructure and physical access to public health services is relatively far better, women get a raw deal. Even women's general health needs do not get the necessary attention.

Dr. Nirmala Murthy (2009) carried out a study in rural areas of three states i.e. Chhattisgarh, Karnataka and Rajasthan. It was noted that comprehensive reproductive health is still a distant goal for poor women resulting in significant health inequities

between the poor and the non-poor, between the rural and the urban residents; between the illiterate and the educated. For programme planners and service providers, service quality meant being able to handle medical emergencies. For improving service quality, they suggested controlling quackery, making emergency transport available, increasing medicine supply and reducing workload of staff (or increase staff strength). Women clients also seemed to agree with this view. They rated service quality as good if they received immediate attention, proper examination, deftness in handling complications, and effective treatment. However the various programmes designed to improve service quality could benefit women only to the extent they could access services. The study identified six factors that seemed to determine poor women's access to 'quality' services. These were - awareness of the problem, felt need for the service, acceptability of service provider, family support, and service quality as perceived by women. These factors came out of over 450 case studies of poor and financially well women who had experienced various reproductive health problems.

A study was done by Dr. Alka Barua (2007) to understand the knowledge, attitude and behaviour and the reproductive health needs of married adolescent girls as perceived by them and by their influential members. The data showed that the girls were either unaware that their reproductive problems were treatable or were discouraged by family members from mentioning their condition; while the husbands were either ignorant of or believed that women's illnesses were in women's domain. Those aware helped their wives seek treatment. Mother-in-laws, though better informed, generally endorsed more traditional treatments, many of which were inconsistent with modern medicine. The study suggested that it would be more realistic to build reproductive health services for adolescent married girls within the existing women's health services and make them gender (male) sensitive as the husbands and mother-in-laws influenced women's health seeking behavior.

Anand Sharma, Vibhakar Mansotra and Sourabh Shastri (2015) in paper "An Exploratory Analysis of Public Healthcare Data: A Case Study of Jammu & Kashmir State" conducted an exploratory secondary data analysis of facility level data of Jammu and Kashmir. They analyzed data to identify various patterns by exploring the structure of public healthcare institutions prevalent in Jammu and Kashmir along with

the distribution of patients in different districts. In their study they found that there is a high variation and significant differences among districts in the distribution of healthcare facility. Instead of this significant relationships among public healthcare institutions which are available in each district of Jammu and Kashmir and also they observed that there is significant distribution of healthcare but distribution pattern still is not uniform. Lastly they concluded by recommended suggestions for the improvement of patient services and overall performance of public healthcare institution.

G. Rama Padma's (2005) study found that complications of pregnancy and childbirth in developing countries often result in illness or permanent disability for the mother or child. While the tragedy of maternal mortality affects mainly the poorer sections, it is only very recently that serious attention has been focused on the issue of 'safe motherhood'. This paper analyzed the levels of safe motherhood in rural areas of Andhra Pradesh vis-à-vis other southern states; it also seeks to understand the perceptions and limiting causes that come in the way of safe motherhood. While data suggest that women in rural Andhra Pradesh experience safe motherhood, social and group perspectives reveal that many women are exposed to unsafe motherhood; very often non-biomedical causes influence the determinants of safe motherhood.

Rob Stephenson and Zoe Matthew (2004) have examined the utilisation of maternal health-care services among rural and urban migrant women and non migrant women in Maharashtra. Indian rural-urban migrant women had similar patterns of prenatal care utilisation to urban non-migrant women, yet their choices of places of delivery closely resemble those of rural non-migrant women. The high utilisation of prenatal care services among rural-urban migrant and non migrant women is attributed to the greater availability of maternal health care services in the urban area. The similarity in the choices of place of delivery between rural-urban migrant women and rural non migrant women is attributed to the prevailing norms of home births, which migrants continue after migration to urban areas. The main barriers to services utilisation were the lack of services in rural areas, distances to services, the perception that maternal health care services were for curative purposes, cost and traditional attitudes towards childbirth. Rural-urban migrant's women face the added burden of being new to a city, and unless they have adequate social networks, they are unlikely to use maternal

health care services, highlighting the need to focus these services towards recent migrant in Mumbai.

Shashi Tyagi's (2004), study is related to health status of women in Thar. The study found that the ailments which arise due to lack of knowledge or access of false knowledge, lack of awareness, lack of proper health care facilities in easy reach, lack of sanitation, poverty and a state of isolation of the villages add to the problems of health in Thar. General widespread neglect of women's health results in high pregnancy rate, high miscarriage rate, premature infant death and high risk of mortality and morbidity during labour. The prime cause of this disease is lack of cleanliness during menstrual cycle and usage of dirty sanitary pads. Usage of sand alongwith the sanitary pads was a common practice in this region.

Dr. Almas Ali (2004) stated that the National Population Policy (NPP) is gender sensitive and incorporates a comprehensive holistic approach to health and educational needs of women, adolescents and girl child. It also seeks to address the constraints to accessibility to service due to heavily populated geographical areas and socio-cultural diversity in the population. A primary theme running through the NPP is provision of quality services and supplies and arrangement of a basket of choice. People must be free and enable to access quality health care, make informed choice and adopt measures for fertility regulation best suited to them. It is in this spirit that the NPP advocates small family norms. Population momentum can be curtailed, in part, by investing on adolescents with emphasis on raising the social and economic prospects of girls and enhancing their self-esteem. Measures that would accomplish this include promoting valued roles for women apart from motherhood, increasing young women's access to education, income earning work and financial credit, providing young women and men with information about reproductive and marital rights, health and sexuality and extending their access to appropriate services and fostering equality between young women and men and improving their perception of marital responsibility.

Renu Khanna and Anagha Pradhan (2004) analyzed the 'Women Centered Health Project' which was initiated in 1996 by the Municipal Corporation of Greater Mumbai (MCGM) in collaboration with SAHAJ, an NGO and the women health group from Liverpool School of Tropical Medicine, UK. They have presented the experiences of

these projects. As a result of this project, women's satisfaction with the services provided through the gynaecology clinics at primary health care facilities and number of women availing these increased almost four times.

The Voluntary Health Association of India (2001) has the view that in an age of rapid advancement, despite so many policy proclamations, the poor health status of women in general, particularly in the laggard states, still remains a matter of grave concern. Poverty, unemployment and wide spread gender discrimination have remained core impediments to women's general well being. Recent revelation of the census report on rapidly declining gender ratio further points to the seriousness of the situation. Presently the health care system, both in the government and nongovernment sector is not generally sensitive to specific health needs of women. Apart from providing the usual antenatal and post-natal care, we need to sensitize and train all categories of health profession to respond to women's health needs with greater empathy. A healthy and disciplined dialogue between indigenous systems of medicine and the western system is also necessary to ensure a more holistic approach to women's health.

Ashwini Kumar Nanda (2000) conducted a study of households in the rural area of three north Indian states, aiming to understand women's illness in the context of social, economic and demographic conditions. Results of the study throw insight to the specific problem of women health status in a poor society. In spite of limitations of morbidity data, preponderance of vaccine preventable and hygiene related diseases showing the primacy of economic deprivation leading to ill health among women. The age pattern of morbidity among women reveals that women's disadvantage to health begins to intensify around the age twenty coinciding with marriage and child-birth, and persisting till the onset of old age. The educational attendance of women indicates that the number of years spent in school has the potential to lower the prevalence rates of illness. Women's morbidity is high both in lower and higher income levels, indicating the relative difficulties in establishing the link between poverty and ill health without taking resource to household commodity ownership and use. Logistic regression shows that borrowing presence of household industry, possession of pressure cooker, extended family system, exposure to the newspaper and higher number of children within four years of age lead to improvement in

women's health; whereas, poor accommodation, ownership of sewing machine, larger household size, more membership, lesser share of women in the household increases their vulnerability.

Dr. Ghulam Hassan Khatana and Dr. S.M. Salim Khan (2016) in a paper "A Cross Sectional Study to identify the existing gaps in implementation Indian Public Health Standards in Primary Health Centres of South Kashmir" they analyzed the data of Primary Health Centres of South Kashmir and find the gap which was existing in the Primary Health Centres of south Kashmir through implementation of recommendations of Indian Public Health Standards. A cross sectional study was conducted in randomly selected PHCs of 5 districts of South Kashmir. Checklist from IPHS draft was used to interview in-charge Medical officers of the Primary Health Centres. There was shortage of essential human resources, especially Medical officer (MBBS) and laboratory technicians in PHCs. Wide gap was found in availability of various services especially in terms of availability of diagnostic facilities and services for health promotion and disease prevention and monitoring of sub-centres affiliated with concerned Primary health Centres. In the end the author suggested that, the gap which was identified should be addressed on priority bases and services at PHCs should be enhanced through adequate manpower and infrastructure.

Joyce A. Bredesen, (2013) "Women's Use of Healthcare Services and Their Perspective on Healthcare Utilization during Pregnancy and Childbirth in a Small Village in Northern India", examines women's perspectives and utilization of health care services during pregnancy and childbirth. He examined that Women in rural India have little access to health care resources. His study showed that lack of educational resources, distance, cost and transportation, cultural, religious, and family influences all had an impact on women utilizing healthcare services.

Another study done by Sheraz A.lone and Manzor A. wani in (2017) in the paper namely "Spatial Pattern of Health and Health Care Facilities in District Anantnag of South Kashmir (J&K, India) - A Geo Medical Analysis". The study was carried out across four altitudinal zones (Zone A, Zone B, Zone C and Zone D) among different medical blocks. In his study he uses Kendal's ranking coefficient method and the result found was that there is a greater variation in the distribution of health care amenities and intensity of diseases across different altitudinal zones. The impact of

this regional disparity was reflected in the intensity of diseases which was found corresponding with the availability of health care facilities. Due to these imbalances in the availability of health care facilities and incidence of diseases in different altitudinal zones, therefore there should be a proper coordination between availability of health care facilities and disease intensity in order to formulate a successful plan for improvement in the existing health care delivery system in the study area.

Irm Jalali Bodha (2017) in her paper "Health Care Services of Jammu and Kashmir: A study Hospitals of Jammu and Kashmir", studied that safe and good healthcare service for good health of people is the sign of progress and growth of nation. The Government hospitals make the health care possible with an ease and relatively manageable manner particularly for those who could not afford to pay the bills of private hospitals. Her study shows a good level of satisfaction of services as reflected from the survey of the hospitals. However the Poor condition of Government hospitals, the negligence of doctors there, lack of beds, lack of hygiene makes it worse and the patient's family is nearly afraid of admitting their patients in Government hospitals. The study although reflects the positive and satisfactory level of patients with regard to the basic parameters of health and care, still defines about the improvement in the hygienic and infrastructure level of hospitals. Her suggestion is that Government must take measures to ensure that the hospitals not only provide cost effective treatment but also provide better care and facilities to the ailing patients.

In a research article "Health status of the Indian women- a brief report" given by Raju Kowsalya and Shanmugam Manoharan in 2017 states that the poor nutrition and unawareness on the utilization of health facilities during their childhood and reproductive age are the major factors responsible for the high maternal mortality. Healthy lifestyle and high intake of nutritious food can provide good health throughout life to the humans. A good health is a key criterion, which contributes to human wellbeing and economic growth. Proper nutrition for women would help them to serve as productive members of the society to develop the consequent health generations. The government should take necessary and compulsory policies to improve the literacy rate and quality education as well as to provide adequate employment opportunities for women, which might explore positive impact on the women's health concerns. The author also suggests that the government can improve

the health status of women by strengthening and expanding essential health services as well as by frequent counselling on safe sex, awareness on educational and nutritional needs and gender based violence.

There might have been some research work on women health in the area of Jammu and Kashmir, but beyond the studies covered under my research. The area of Kulgam district has been neglected. As very few studies have been conducted on various aspects of women's health, the scope of review of literature on the related topic becomes very limited. The researcher has tried her best to review the available material on the related topic of study.

1.4 Objectives of the Study:

1. To study government's policies (central and state) and programmes regarding women's Health and the performance of women health programmes in Jammu and Kashmir.
2. To analyze the availability of health facilities for women in Kulgam District of Jammu and Kashmir.
3. To analyze awareness, attitude and utilization of women about Public health services of various levels, towards women's health in Kulgam district of Jammu and Kashmir.

1.5 Hypotheses:

- Government policies do not have a significant impact to elevate women's health status.
- The level of availability regarding women health is not Satisfactory.
- Women do not utilize much and do not have much awareness regarding the public health service.

1.6 Methodology of the Study

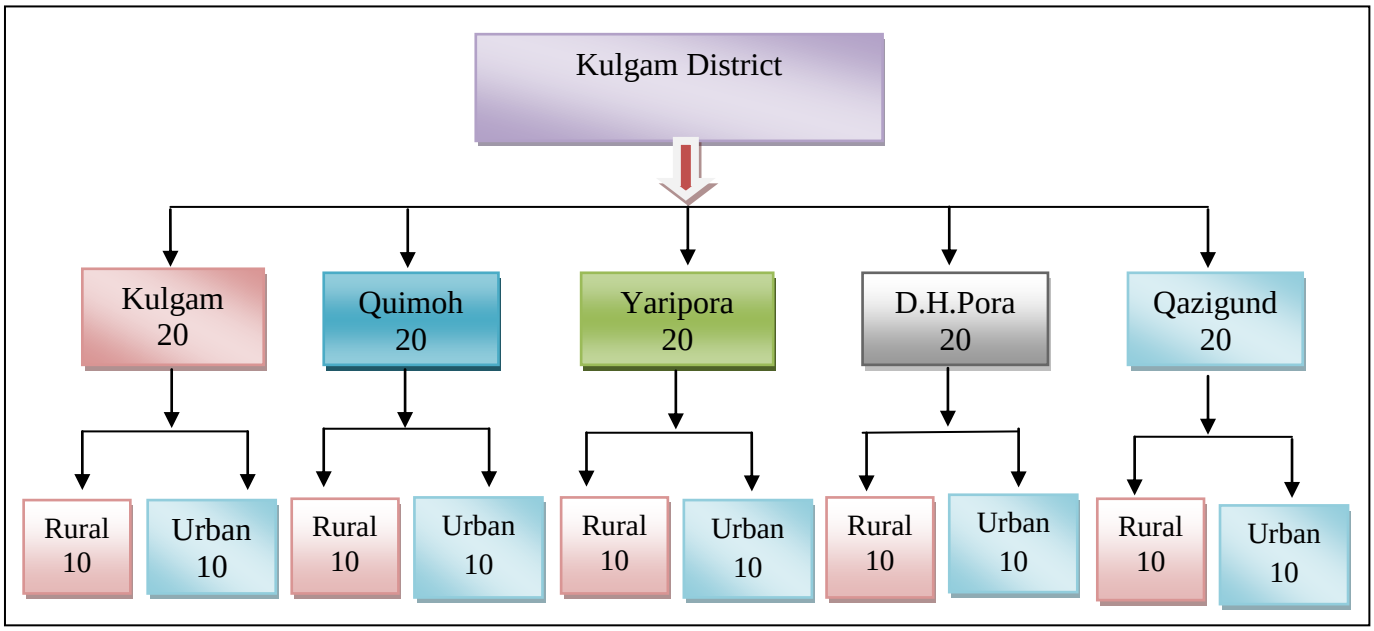
This study is descriptive cum exploratory. The study is based on mixed method. The investigator throw light on some determinants of women's health status such as age, area, education, household size, marital status, education and awareness of women

regarding government availability and utilization of health facilities in Kulgam district of Jammu and Kashmir.

The present study is based mainly on both primary data and the secondary data. The secondary data is taken from various authenticated sources of government like; Census of India (2011) published by Registrar General (Government of India), Bulletin on Rural Health Statistics (2015, 2016, 2017 and 2018) published by Ministry Of Health and Family Welfare (Government of India), District Level Health Survey (DLHS-3) published by International Institute for Population Science (Ministry Of Health and Family Welfare, Government of India), National Family Health Survey (NFHS-4) Jammu and Kashmir, published by published by International Institute for Population Science (Ministry Of Health and Family Welfare, Government of India), District Chief Medical Officers Office, hospitals official website of Kulgam etc.

However, in collection of primary data, multi-stage-cum-stratified random sampling method has been used .The interview schedule was developed to collect the primary data in which 100 samples were taken. Among 100 samples, 50 samples were taken from women and 50 samples from men respondents within the age group of 15-49 years for women and in men within the age group of 15-54 years were collected, who are the users of the available health facilities. Moreover, Multi Stage Cluster sampling method was used for data collection. The Study area was divided into 5 clusters which were sub divided into 10 sub clusters. The total of 100 samples were taken from 5 medical blocks of Kulgam district namely Kulgam, Quimoh, D.H.Pora, Qazigund and Yaripora. 20 samples were taken from each block. Which were further sub-divided into rural and urban areas and 10 samples were taken from each area. The below figure 1.1 shows clearly the whole areas of district Kulgam in which samples were collected.

Fig. 1.1 Flow Chart of sample collection from Kulgam district



1.7 Primary Data Collection Tool

1.7.1 Questionnaire:

To carry out the research the first step is to develop an interview schedule (Questionnaire) for household survey. The responses were collected from the family members who were able to provide accurate and complete information regarding availability of health facilities for women in Kulgam District of Jammu and Kashmir. To test the validity and reliability of the questionnaire a pilot study was conducted. The total sample size will consist of 100 households.

1.8 Area of the Study:

There are 22 district of Jammu and Kashmir consisting of three divisions namely Jammu, Kashmir and Ladakh. The Jammu and Kashmir State is divided into two administrative divisions namely Jammu and Kashmir. These divisions are further sub-divided into districts and Tehsil's. The total population of district kulgam is 424483 as per the census 2011. The district Kulgam, "Kul" meaning there by the "Whole" and the "Gam" is one of Twenty two districts of Kashmir division situated on its south and southwestern direction.

District Kulgam is a newly created district that came into existence after being carved out from district Anantnag and made functional administratively with effect from 2nd

April, 2007. Kulgam has the distinction of having contributed in the evolution of present day social cultural ethos of Kashmir hinged in sobriety, compassion, non-violence, yearning for learning and receptiveness for new ideas and reformation with no parallel in terms of recorded history in the sub-continent. The geographical area of the districts about 1067 Sq Kms which includes474 Sq. Kms of forest area (44.42%).

Table 1.1 Total number of population

Population	Total	Persons	424483
		Males	217620
		Females	206863
	Urban	Persons	80613
		Males	42046
		Females	38567
	Rural	Persons	343870
		Males	175574
		Females	168296

Sources: Census of india 2011

Table 1.1 shows the total population of the district as per census 2011 is 424483 persons. It consists of 217620 males and 206863 females. The rural sector of the district is inhabited by 343870 males and 168296 females spread over inhabited villages.

Literacy rate of Kulgam District as per census 2011

Table 1.2 Total number of literacy rate in district Kulgam

		State		District	
		Number	Percentage	Number	Percentage
Literates	Persons	7,067,233	67.16	209,085	59.23
	Males	4,264,671	76.75	125,052	69.59
	Females	2,802,562	56.43	84,033	48.49

Sources: Kulgam District Census 2011

In the above table 1.2, the total number of literate persons in J&K is 7067233 which is about 67.16% and in Kulgam district the total number is 209085 which is about 59.23%. The percentage for female and male literacy rate in J&K is 56.43% and 76.75% respectively.

Similarly, in district Kulgam percentage of female and female literacy rate is 48.49% and 69.59% as per the census 2011.

1.9 Details of Health Institutions in Kulgam District:

There are 189 health institutions as on 31-March-2017 in district kulgam: 1 District hospital, 3 Sub-district hospitals, 19 primary health centers, 26 New type P. H. Cs, 117 Health sub centers, 1 Subsidiary health centers and Trauma centers, 22 Ayurvedic/ Unani Dispensaries/ Ayush Unit and the total number of Medical/Paramedical personal are 810 which includes 159 Doctors, 76 Nurses/Sisters. 112 Pharmacists, 14 Dental Assistants, 06 Sanitary Inspectors, 07 Health inspectors, 20 basic health workers, 10 Lady health visitors, 272 Auxiliary Midwives/Dais, 17 X-ray Technicians, 06 Health Educators, 104 Nursing Orderlies, 20 Dawasaaz and 19 Unani Pharmacists/nursing orderlies (Official website district kulgam).

1.10 Definition of Study Unit

Unit for the study includes men and women, both are from reproductive age group (15-49). The term reproductive age group refers to the active reproductive years in women starting with menarche around 12-14 years and ending with menopause around 45-49 years. For demographic purposes, reproductive age group is usually defined as 15-49 years.

Household: To collect information about family income researcher has chose house hold as a unit of the study. The household referred to all individuals who shared a common cooking fire. Information on all individuals who had lived in the household in the year was recorded.

Public Health Facility: Government provided health facilities like Sub Centres, Primary Health Centres, Community Health Centres, District Hospital, Speciality or Super Speciality Hospitals etc.

Private Health Facility: Hospitals which are registered under family welfare or as general hospitals.

Chemist: A place where drugs are sold; a drugstore.

Untrained Practitioner: A person who is not trained nor registered to medical association.

Chapter 2

An Overview of Health

CHAPTER 2

AN OVERVIEW OF HEALTH

The word ***"health"*** derives from Middle English *health*, meaning hale, hearty, sound in wind and limb. Dictionary definitions allude to soundness and efficient functioning and give the same meaning to financial health as to bodily health. Modern medical practice and public health are concerned about the health of individuals and population. However, for most individuals and for many cultures, health is philosophical and subjective concept, associated with contentment and often taken for granted when all is going well. Health in this sense is difficult to describe or define, but its absence is readily recognizable, even when replaced by minor departures from an accustomed level of health.

Health is a fundamental human right and a universal goal of society. It is necessary to fulfilling basic human needs and improving the quality of life. Health is a causative factor affecting the overall economic growth rate of the country. Because development is a result of good health, investing in the health sector should be a priority for even the poorest developing countries. Unfortunately, health has been poorly invested in low-development countries, and the health sector continues to be largely untapped and neglected.

India's rank in the 2018 Human Development Index (130 out of 189 countries) released by the UNDP shows the level of health sector ignorance in a country like India. India is one of the world's fastest growing economies. The very essential components of primary health care which are; promoting food supply, proper nutrition, safe water and basic sanitation, and providing quality health information about prevailing health problems, are largely ignored. Other bottlenecks in the primary health care scenario are access to healthcare services, the availability of essential medicines and the scarcity of doctors. It is very shocking to hear that India is spending only 1.4% GDP on Health, which is less than Nepal and Sri lanka (Source: India Spend, January 2018). Health is an essential indicator for country's development. The availability of the health facility in India is also in a poor condition. While 63% of primary health centres did not have an operation theatre and 29%

lacked a labour room, community health centres were short of 81.5% specialists-surgeon, gynaecologists and paediatricians. (Source: India Spend, January 2018). According to WHO 70 percent of the overall household expenditure on health in the country is on medicines. Furthermore, an estimated 469 million people in India do not have regular access to essential medicines (WHO). In 2014, 58% Indians in rural areas and 68% in urban areas said they use private facilities for inpatient care, according to the 71st round of the National Sample Survey (Source: India Spend, January 2018).

2.1 Concept of Health:

Health is a multi-dimensional concept and is measured in terms of: 1) absence of physical pain, physical disability, or a condition that is likely to cause death, 2) emotional well-being and 3) satisfactory social functioning. Personal or individual health is largely subjective. It is possible to be physically robust, to be "the picture of good health," and yet have serious mental or emotional impairment. Conversely, an individual can be profoundly disabled physically yet have an intact mind and be emotionally well-adjusted. So while many aspects of health can be identified, there is no single standard measurement of health status for individuals or population groups. Individual health status may be measured by an observer (e.g. a physician), who performs an examination and rates the individual along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease and overall health. Individual health status may also be assessed by asking the person to report his/her health perceptions in the domains of interest, such as physical functioning, emotional well-being, pain or discomfort, and overall perception of health. Economists can derive a single number i.e. the net worth or gross domestic product, as a measure of economic status of an individual or a nation. Although it is theoretically attractive to argue that the measurement of health should consist of the combination of both an objective component plus the individual's subjective impression, no such measure has been developed. At best, public health professionals can create community or national profiles using crude health indicators like life expectancy, infant mortality rates, death or sickness rates from specific cause like cancer, heart disease, suicide and homicide or surrogate measurements such as use of drugs (prescribed or over the counter) and spells of hospital care.

When the WHO was established the text of its constitution defined health as **"***a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity***"** (WHO, 1992). WHO about health promotion led to a revised description and definition that condenses to "the extent to which an Individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment; health is a resource for everyday life, not the objective of living, it is a positive concept, emphasizing social and personal resources, as well as physical capabilities". This implies that Individuals, Families, and Communities have some control over many determinants of their health. But this is a broad definition and is not capable for any meaningful economic analysis or for any resources allocation. Necessarily, health has to be defined from a practical point of view and therefore has been defined by economist according to life expectancy, infant mortality, and crude death rate etc. (Reddy, 1987). In fact, "it has been studied as a function of medical care, income, education, age, sex, race, marital status, environmental pollution, and personal behaviour such as cigarette smoking, diet, and exercise. It also has been used as an independent variable to explain labour force participation particularly at older ages. Not only retired persons frequently cite poor health as the reason for retirement, but the workers who are currently working also report a health limitation and are more likely to withdraw from work in subsequent years. Health status has also been used to explain wages, productivity, school performance, fertility and the demand for medical care. The results are often sensitive to the particular measure of health that is used but the direction of effect generally confirms previous conditions" (Fuchs, 1987).

Broad definitions of health stress not merely the absence of disease but the fulfilment of a whole range of personal, physiological, mental, social and even moral goals. In this context, a health service is but one contributor to health. Even on the narrower model of health, where health is said to be the absence of disease, other policies may be more important than 'the health service' when it comes to maintaining or improving health. This is the familiar point that reducing inequalities of income, improving housing, environmental policy (and so forth) has a great effect upon both the health status of individuals and differentials in health status between social classes and geographical areas (Paton, 1997).

Modern medicine is often accused for its preoccupation with the study of disease, and neglect of the study of health. Consequently, our ignorance about health continues to

be profound, as for example, the determinants of health are not yet clear; the current definitions of health is elusive, and there is no single yardstick for measuring health. Health continues to be a neglected entity despite lip service. At the individual level, it cannot be said that health occupies an important place, it is usually subjected to other needs defined as more important e.g. wealth, power, prestige, knowledge, security. Health is often taken for granted and its value is not fully understood until it is lost.

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a worldwide social goal, that it is essential to the satisfaction of basic human needs to an improved quality of life and that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life, for brevity, called "Health for All''.

2.2 Changing Concepts of health:

In a world of continuous change, new concepts are bound to emerge based on new patterns of thought. Health has evolved over the countries as a concept from an individual concern to a worldwide social goal and encompasses the whole quality of life. A brief account of the changing concepts of health is given below:

- **Biomedical Concept:** in biomedical or we can say traditional concept, Health has been viewed as an "absence of disease", and if one was free from disease the person was considered healthy. Health in this narrow view then became the ultimate goal of medicine. This biomedical concept has minimized the role of the environmental, social, psychological and cultural determinants of health.

- **Ecological Concept:** under ecological concept, Health implies the relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function. Health is a dynamic equilibrium between human beings and their environment, and disease as maladjustment of the human organism to environment. This concept raises two issues, i.e., an imperfect human and an imperfect environment. History argues strongly that

improvement in human adaptation to natural environments can lead to longer life expectancies and a better quality of life even in the absence of modern health delivery services.

- **Psychosocial Concept:** psychosocial concept shows Health is both a biological and social phenomenon. Contemporary developments in social sciences reveal that health is not only a biomedical phenomenon, but one which is influenced by social, psychosocial, cultural, economic and political factors of the people concerned. These factors must be taken into consideration in defining and measuring health. Thus health is both a biological and social phenomenon.

- **Holistic Concept:** A sound mind in a sound body, in a sound family, in a sound environment; All sectors of society like agriculture, animal husbandry, food, industry, education, housing, public works, communication & other sectors have an effect on health. Health is a holistic concept. It relates to a person as a whole. Not just the person you see, but also the person you 'feel'. Health is a triune of three parts: it is a synthesis of all the above concepts. It covers the totality of physical, emotional and mental well–being in the context of prior life experiences and the present way of life including diet, exercise, relationships with others, and future aspirations. Persons in good holistic health are supposedly fit and happy, relate well to others in and outside their family, perform work effectively and efficiently, enjoy recreational pursuits, are in control of their lives, and have planned for and are optimistic about the future. The ideal is admirable, but the concept lacks realistic solutions to the occurrence of disease that might best be dealt with by early detection.

- **New Philosophy of Health:** In recent years, we have acquired a new philosophy of health, which may be stated as a fundamental human right, essence of productive life and not the result of ever increasing expenditure on medical care. Health is inter-sectoral, an integral part of development and central to the concept of quality of life. Health involves Individuals, State, National and International responsibility and its maintenance is a major social investment.

2.3 Determinants of Health:

The operational definition of health defines Health "as a condition or quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic or environmental". Thus health means (a) no obvious evidence of disease and that the person is functioning normally (b) several organs of the body are functioning adequately as well as in relation in relation to one another (Equilibrium or Homeostasis).Health is dependent on multiple factors and hence it is multidimensional. The factors influencing health lies within the individual and in the society in which they are living. Thus, health of individuals and the whole community may be considered to be the result of many determinants. Following are the most important determinants or variables of health.

2.3.1 Biological Determinants:

Our genes are one of the biggest factors in deciding the way in which our health gets deranged. A number of diseases are now known to be of genetic origin. It is a well known fact that conditions like obesity, hypertension, peptic ulcers, diabetes, depression etc. often run in families. The state of health therefore depends partly on the genetic constitution of a person, what we commonly call as genetic disorders. But even the emotional instability tendency to worry a lot or the 'tendency to catch a cold frequently' can be attributed to our genetic inheritance. Now-a-days, medical genetics offers hope for prevention and treatment of a wide spectrum of disease; thus the prospect of better medicine and longer, healthier life.

2.3.2 Behavioural and Socio Cultural Conditions:

Our contemporary life style is the second biggest factor for failing health of people. The term "Life style" is rather a diffuse concept often used to denote "the way people live", reflecting a whole range of social values, attitudes and activities. Increasing sedentary habits, long working hours, reduced rest hours; diet containing highly processed food poor in fibre content and with loads of artificial colours and flavours; increased anxiety and tensions related to education, career, job, performance, etc are some of the factors that are responsible for decreasing the health status of our society at large. It is composed of cultural and behavioural patterns and lifelong personal habits (e.g. smoking, alcoholic) that develop through processes of socialization.

Lifestyles are learnt through social interaction with parents, in-laws, peer groups, friends and siblings and through school, mass media, and health workers like ASHA, anganwadi workers.

Health requires the promotion of healthy lifestyle. Many present day health problems e.g. coronary heart disease, obesity, drug addiction, diabetes are associated with lifestyle changes. But in Jammu and Kashmir, risk of illness and death are connected with lack of sanitation, unclean water, nutrition, personal hygiene, elementary human habits, etc.

2.3.3 Environment:

Environment is classified into two concepts, internal concept and external concept. The internal concept of environment for human beings pertains to "each and every component part, every tissue, organ and organ system and their harmonious functioning within the system". Internal environment is the domain of internal medicine. The external or macro-environment consists of those things to which human's are exposed after conception. It is defined as "all that which is external to the individual human host". It can be divided into physical, biological and psychosocial components, any or all of which can affect the health of individuals and their susceptibility to illness. Environment also includes occupational environment, socioeconomic environment and moral environment.

The external environmental factors range from housing, water supply, psychosocial stress and family structure through social and economic support systems, to the organization of health and social welfare services in the community. Increasing pollution of air, water, and soil is a well known factor in the increasing level of many diseases. There is a high level of asthma and other allergic complaints in urban areas. Depleting ozone layer is a known factor in increasing rate of skin cancers. Noise pollution is a recognized factor in increasing anxiety and stress levels in our society. Water and air pollution, toxic chemicals, deforestation and soil erosion have a negative impact on people's health. If the environment is favourable to the individual, one can make full use of one's physical and mental capabilities. Protection and promotion of family and environmental health is one of the major issues of the world today.

2.3.4 Socio-Economic Conditions:

Majority of the world's people's health status is determined primarily by their level of socio-economic development e.g. per capita GNP, education, nutrition, employment, housing, the political system of country etc. The major factors include:

- **Economic Status**: The economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behaviour in the community. It is also an important factor in seeking health care. It is the economic progress that has been the major factor in reducing morbidity, increasing life expectancy and improving the quality of life. Ironically, affluence may also be a contributory cause of illness as exemplified by the high rates of coronary heart disease, diabetes and obesity in the upper socio-economic groups. Besides all these life style diseases, higher income and social status are linked to better health. The greater the gap between the rich and poor, the greater the differences in health.

- **Education:** A major factor influencing health status of a woman is education of women and her husband. Low education levels are linked with poor health, more stress and lower self-confidence. The literacy level of women has an impact upon health seeking behaviour such as reproductive behaviour, use of contraceptives, health and upbringing of children, proper hygienic practices which lead to increased use of health facilities in general, and reproductive health services in particular. An educated husband would also have positive opinion and attitude. The world map of illiteracy closely coincides with the maps of poverty, malnutrition, ill health, high infant and child mortality rates. Studies indicate that education, to some extent, compensates the effects of poverty on health, irrespective of the availability of health facilities. Education determines aspiration, technology, productivity and social mobility. It also changes perception of values of human beings and their contribution to the economy of the household and the nation.

  Illiteracy is the greatest barrier to any improvement in the position of women in employment, health, the exercise of legal and constitutional rights, in attaining equality of status and equal opportunities in education itself. Women literacy and education, along with employment and income, are decisive for improvement in the quality of the family's life and steady reduction in

fertility. A woman's ability to control the size of her family is closely related to her educational status. Women education increases the use of maternal health services independent of the related factors such as rural/ urban residence or socio economic status and across the range of services and stages of maternal care. Studies have found a significant positive relationship between education and the use of antenatal care, delivery care and postnatal care.

- **Social Support Networks:** Greater support from families, especially from husband, friends and communities are linked to better health. Culture- customs and traditions, and the beliefs of the family and community all affect women's health.

- **Occupation:** The working status of women is also an important variable from the point of view of health seeking behaviour or health expenditure of a family. This can be attributed mainly to her self-reliance through economic independence that gives her more decision making power to exercise her reproductive health needs or other needs. Employment is positively correlated with seeking some maternal health services and other health services. Employment is associated with lower maternal mortality and morbidity and higher utilization of maternal services, even after controlling other key factors.

- **Political system:** Health is also related to a country's political system. Often the main obstacles to the implementation of health technologies are not technical, but rather political. Decisions concerning resources allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services, the percentage of GNP spent on health is a quantitative indicator of political commitment. Social, economic and political actions are required to eliminate health hazards in peoples working and living environments.

2.3.5 Health Services:

Access and use of disease prevention and treatment services have an impact on health. The term health and family welfare services covers a wide range of personal and community services including disease treatment disease prevention and health

promotion. The purpose of health services is to improve the population's health status. For example, care for pregnant women and children will help to reduce morbidity and mortality among mothers and children.

2.3.6 Demographic Indicators:

Gender: Men and women at different ages suffer from various types of diseases. Problems with reproductive health are common in women and the main cause of disease.

Age: It is important to have an age factor. Some health problems in a certain age are common. Elderly people and very young people are more likely to be severely affected by their reduced immunity when they are sick. Women, especially during and after pregnancy, have more problems after marriage. The main causes of their illness are gynaecological problems. Women's gender is one of the population's most important factor in demographic research.

2.3.7 Macroeconomic Policies:

Macroeconomic policies have a profound impact on public health, particularly women's health. These include allocations to the budget, programs for structural adjustment, research policies and trade agreements. A systematic evaluation of the effect of macroeconomic policies, budget allocations and governance decisions on public expenditure patterns in households and their further impact on women's health is needed**.**

2.3.8 Other factors:

The development of information and communication technology provides enormous opportunities to provide convenient and immediate access to medical information. It contributes to the worldwide dissemination of information that serves the needs of many doctors, health professionals, biomedical scientists and researchers, the mass media, and the public.

Other contributions to population health come from systems outside the formal health care system, i.e. health-related systems such as food and agriculture, education, industry, social welfare, rural development, and the adoption of economic and social policies that would help raise living standards.

Allopathic drugs not only have their side effects, but their excessive use diminishes the level of immunity in our society as a whole. The culture of pill-popping is an open invitation to chronic pain. In short, medicine is not the only health and well-being contributor.

2.4 Health and Development:

Good health is an economic growth determinant and a component of the population's well-being. Health is a major priority for all. Health is one of the national development indicators. The health-development relationship is complex, multifaceted and multidirectional. What is the relationship between health and development? The first is that health enhancement is an integral part of development; the second is that good health and economic prosperity tend to support one another. (Amartya Sen, 1999).

Good health is central to the nation's development for promoting development, investing in health (and education) is a good economy. It is important to build up the human capital necessary for a nation's physical capital to be formed and used efficiently. A nation's development depends on its physical and human capital. Human well-being must be the end of development Human development is a process of enlarging the choices made by people. The most critical is leading a long and healthy life, getting educated (HDR 1990) and having a decent living standard. Health policies have profound impact on the quality of people's lives, on their ability to exercise and enjoy their rights, safety, security, health and survival.

Theoretical work as well as empirical evidence clearly shows the positive linkages between good health and economic development. Health is increasingly being seen as a development issue rather than just a medical one. Health interventions can lead to economic growth and reduce inequality (WHO, 2001), as also poverty in developing countries in particular. Better health also contributes directly to economic growth as it reduces production losses on account of illness of workers or, also in terms of higher work productivity for healthy workers..

Health is essential for socio-economic development and has become increasingly recognized. In the 1960s, it was commonly thought that socio-economic progress was not essential to improving people's health status in developing countries, and that

substantial and rapid progress could be made by introducing modern public health measures alone. The role of individuals in the development process was grossly underestimated according to this way of thinking.

The period 1973-1977 was the subject of considerable rethinking. The economic theory has been profoundly modified. It became increasingly clear that the major problems of poverty, hunger, malnutrition and disease cannot be solved by economic development alone. Instead, issues of "non-economic" (e.g. education, productive employment, housing, equity, freedom and dignity, human well-being) have emerged as main objectives in development strategies. There has been a clear link between health and development, one being the starting point for the other and vice versa.

As health is an integral part of development, all sections of society are affected by health. In other words, health services are no longer seen merely as a complex of medical measures alone, but as a "subsystem" of an overall socio-economic system. Ultimately, the ultimate goals of development are human health and well-being. Studies have shown that health programs have reinforced developments in other sectors at the same time.

Women are part of the population of a nation and an important part of human resource as well, their health is important for the development of a nation. A woman is any society's axis. Women's poor health in a society is a big concern because it affects the children who are going to be the country's future citizens. It reduces productivity in the informal and formal economic sectors as well as at the household level. Improving the health of women is an integral part of social and economic development. Women's health plays an important role in labour productivity; healthy women lose less time from their household as well as outside work due to good health and are more productive when they are healthy. The effect of health on individual productivity implies a relationship between population health and development.

2.5. Women Health:

It is increasingly recognized that the issue of women's health goes far beyond maternal morbidity and mortality to include food, childbearing, contraception abortion, reproductive health, RTIs and STDs like HIV/AIDS, communicable diseases, violence against women, etc. The social and economic role of women in

society negatively affects their health (Mable Bianco 2008). They are exposed to high health risks by their reproductive role, resulting in needless and largely preventable suffering. If women and men had access to safe, affordable means of contraception, a large number of abortions would be avoided (World Bank 2009). Indian women have high morbidity and mortality rates, particularly during childhood and in their reproductive years (Victoria A. Velkoff and Arjun Adlakha, 1998). With regard to the health of women in district Kulgam, not enough authentic data is available on their morbidity and mortality. Fortunately enough, for the first time the National Family Health Survey NFHS-4, 2015-16, has come up with information on nutrition status of women, including anaemia among women, reproductive health problems, morbidity among women, awareness of AIDS among women and comprehensive section on women's autonomy and domestic violence. The District Level Household Survey (DLHS) has also come to add up in collecting information on fertility, family planning and other selected reproductive health issues. The paucity of information on the reproductive health issues is of the 15 to 49 age group and the non availability of proper databases by itself is a matter of concern. Without accurate and timely data, public health programs suffer.

Women and men have many of the same health problems, but they can affect women differently. Some diseases or conditions are more common in women, such as osteoarthritis, obesity and depression. And some conditions, such as menopause and pregnancy, are unique to women.

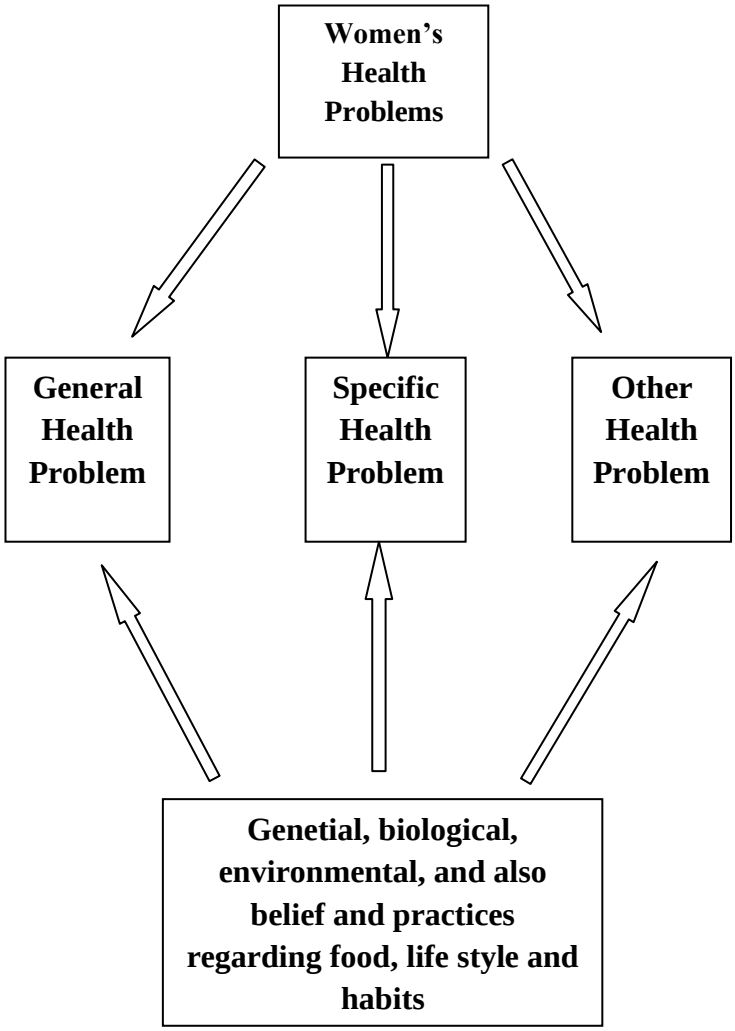
2.5.1 Major Causes of Illness in Women

There are many causes of women's illness. Women's health priorities and consequences change from infancy and childhood to adolescence, reproductive years, and post-reproductive age. But improving the health of 15to 49 age group women offers the biggest return on health care spending for any adult (men or women) demographic group. Women are associated with a broad category of illnesses and health conditions.

In the second half of the 20th century, the rise of the feminist movement gave a boost to assertive approaches, increasingly by physicians and female patients who sought to eliminate the tendency to "medicalize" the normal physiological functions of

menstruation, pregnancy, and menopause. The major causes of women's illness are summarized in the chart below.

Fig. 2.1 Major Health Problems and their Causes



General health problems refer to communicable and non-communicable diseases that affect men and women alike. Anaemia is a physical problem in general. But there is a very close connection with Reproductive Health in women's anaemia. Reproductive health refers to reproductive system diseases that may or may not necessarily be a reproductive consequence. There are three sub-categories of reproductive morbidity:

2.5.1.1 Gynaecological morbidity: Gynaecological morbidity includes any reproductive system disorder, disease or dysfunction that is not related to pregnancy, abortion or childbirth but may be related to sexual behaviour (Fortney, 1995).It is not easily possible to systematically estimate gynaecological morbidity.

2.5.1.2 Obstetric (Maternal) Morbidity: Maternal or obstetric morbidity refers to morbidity due to any cause associated with or aggravated by pregnancy or its management, but not due to accidental or incidental causes (WHO, 2000). Maternal morbidity can be broadly classified as (1) Direct obstetric morbidity resulting from obstetric complications of pregnancy, labour and puerperium; (2) Indirect obstetric morbidity resulting from diseases such as anaemia, malaria, hepatitis and tuberculosis aggravated by the physiological effects of pregnancy; and (3) Psychological obstetric morbidity including postpartum psychoses or depression and other mental health problems related to pregnancy and Childbirth.

2.5.1.3 Contraceptive Morbidity: Contraceptive morbidity (Fortney,1995) refers to morbidity due to specific contraceptives being used. Obviously, contraceptive morbidity does not include the protective effects of contraceptives on a variety of adverse conditions, but the concept of "contraceptive health" includes the absence of these diseases, including ovarian and endometrial cancer, anaemia, and STDs. The study shows that a large proportion of women with disease relate their problems to contraceptive use (Ram and Rangaiyan 1997). A comparatively higher proportion of women who were sterilized repeatedly had contraceptive related illness. Headache, body ache or backache, abdominal pain, weakness or exhaustion, white discharge, and fever are the most common problems experienced by sterilized women. The results indicate an ongoing need to strengthen postoperative care and therapy for acceptors of sterilization.

Sexual and reproductive ill health accounts for one third of the global disease burden among women of reproductive age and nearly 20 percent of the overall disease burden, according to the WHO. High MMR, teenage pregnancies, high fertility and high levels of unmet contraception needs, unplanned pregnancy, unsafe abortions, unsafe delivery, STD and AIDS, nutritional and micronutrient deficiency, complications of pregnancy, substance abuse, malnutrition (anaemic during pregnancy and lactation), infertility, etc.

Instead of all these health problems, some health problems usually affect more during the life cycle and have a disproportionate impact on women due to beliefs and practices in diet, lifestyle habits and cultural norms of differences in exposure or access to treatment. Simple interventions such as access to treatment for common

problems resulting from pregnancy, childbirth, unsafe abortion and sexually transmitted infections can expand and save millions of lives for existing and trusted family planning services.

2.6 Health measurement through various indicators:

Health measurement is far from simple as it cannot be accurately measured. No existing definition (including the WHO definition) contains health measurement requirements as we have problems not only with health definition, we also have health measurement problems and the question is largely unresolved. Health is multidimensional, and many variables, some known and many unknown, affect that aspect. So even for professionals the topic of health measurement is a complicated one**.** Therefore, our understanding of health cannot be in terms of a single indicator, it must be concerned with a profile, using many indicators that can be listed as follows:

Indicators

- Mortality: MMR, IMR, NNMR, Disease-specific Mortality, life expectancy.
- Morbidity: specific disease morbidity rate, in-patient and out-patient attendance rates.
- Nutritional status.
- Delivery of health care.
- Usage or Utilisation rate: use of a pregnant woman's health facility, use of different family planning methods
- Environment Indicator.
- Socio-economic indicators: living standards, age at marriage, ratio of dependence, availability of food.
- Indicators of health policy: political commitment to health for all.

2.6.1 Mortality Indicators

2.6.1.1 Maternal Mortality Ratio (MMR): Maternal mortality ratio refers to deaths per 100,000 live births that occur during pregnancy or within 42 days of delivery (or termination). In other words, the number of maternal deaths per 100,000 live births. A maternal death is the death of women while pregnant or within 42 days of termination

of pregnancy, irrespective of the duration and the site of the pregnancy, and can stem from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (International Classification of Disease or ICD-10, WHO, 1992)

Pregnancy can means a lot of women having serious problems. It can damage the health of the mother or even put her life at risk. The health facilities are poor and people are too poor to pay for a private hospital expenses and also these facilities are at distant places, the roads are poor and even people are too poorer to pay a taxi to get to the health post. Maternal deaths are due to one of the three delays in household-level decision-making or lack of transportation or facilities lag or a cumulative of all these factors. The causes of these delays are rooted in a household's social, cultural and economic status in Kulgam District.

In Kulgam District MMR is 4.0 per 100,000 live births (CMHO 2018-19). Mortality is much higher in rural areas. It is connected to many factors and one of the biggest factors is accessibility of health services.

2.6.1.2 Infant Mortality Rate: IMR is the ratio of deaths in a given year below 1 year of age to the total number of live births in the same year; usually expressed as a rate per 1000 live births. It is one of the most universally accepted health status indicators not only for infants but also for the entire population and the socio-economic conditions under which they live. Furthermore, infant mortality is a sensitive indicator of health care availability, use and effectiveness, particularly prenatal care.

According to Chief Medical Officers Office 2018-19, the IMR in district Kulgam is (49) per thousand live births, in which majority are from rural areas as we know that more than 70% of the population of Kulgam lives in rural areas. It is also found that IMR is greater in females (29) as compared to male (20).

2.6.1.3 Life expectancy: Life expectancy is generally a good indicator of socio-economic development. It can be viewed as a positive indicator of long-term survival. It was adopted as an indicator of global health. The total number of years of life expectancy at birth will be lived by newborns if they pass through the current age-

specific mortality rates. It is estimated to be different for both genders. The increase in life expectancy is known as an improvement in health status inferentially.

2.6.1.4 Disease-specific Mortality: It is easy to calculate mortality rates for specific diseases.

When countries begin to extricate themselves from the burden of communicable diseases, a number of other measures have emerged; such as cancer, cardiovascular diseases, accidents diabetes etc have emerged as measures of specific disease problems.

2.6.1.5 Neo-Natal Mortality Rate: The number of children died, divided by the number of live births that year, within 28 days of age. Neonatal health care is concerned with the birth to 4 weeks of age status of the newborn Neonatal survival is a very sensitive indicator of socio-economic development and population growth. Neonatal deaths are a serious concern for national health. It is directly related to the health of the mother.

NNMR in district Kulgam is 22 per 1000 live births, according to Chief Medical Officers Office 2018-19.

2.6.2 Morbidity indicators

2.6.2.1 Specific disease morbidity rate: Indicators of morbidity are used to supplement mortality rates and define the population's health status. Since mortality indicator does not expose community's burden of ill health. It was found that the morbidity among women was higher than men. The percentage of women patients was almost 75% of total, the disease specific morbidity was of the reproduction problem. The government has to consider the matter for broader policy concerns.

2.6.2.2 In-patient and Out-patient attendance rates: Data on attendance at Kulgam District's Public Health Facilities show that more men than women were treated as outpatients, while more women were treated as inpatients**.** The total population in Kulgam district at present is 531335 (according to CMHO) and the total number in-patients and out-patients in different years of Kulgam district are shown in the table:

Table2.1 Total number of in-patients and out-patients in district Kulgam

Year	District Kulgam	
	Out-patients	**In-patients**
2014	**355584**	**23918**
2015	**775818**	**48896**
2016	**879840**	**47312**
2017	**984936**	**51843**
2018	**1020224**	**56148**

Source: CMHO office, district Kulgam

It is evident from the above table that in 2014 the total number of out-patients was 355584 which increases up to 1020224 respectively. On the other hand the total in-patients increase from 23918 to 56148. As per CMHO office Kulgam, the total number of in-patents was more from female as compared to male. Thus it can be concluded that increase in the number of women in-patients is more than the out-patients. Current study reveals that this increase is due to the government policy of free delivery at institutions and also because women generally ignore their health related problems and are hospitalized at the last moment.

2.6.3 Nutritional status indicator:

A positive indicator of health is the nutritional status. Nutrition may be the most important factor affecting a person's health. An individual's nutritional status is often the result of many factors that are interrelated. It is influenced both by the quality and quantity of food intake and by the individual's physical health. Due to less nutritional content in food, malnutrition occurs. Under nutrition, this reflects a long-term failure to receive adequate nutrition.

2.6.4 Delivery of health care Indicator:

The frequently used healthcare delivery indicators are (a) doctor-to-population ratio, (b) doctor-nurse ratio (c) population-to-bed ratio (d) population per health/sub-centre (e) population per traditional birth attendant. These indicators are mostly used to show the equality of the distribution of health resources to different parts of the country and health care quality**.**

2.6.5 Utilization rate:

The use of services or actual coverage is expressed in the proportion of people in need of a service that receives it in a given period, usually one year. There is a relationship between the use of health care services and the needs and status of health care. The use of health care is also affected by factors such as the availability and accessibility of health services and an individual's attitude towards his or her own health and health care system.

Table 2.2 Utilization of Health facilities by Pregnant women in District Kulgam

S.no	Particulars (in percentage)	Kulgam		J&K	
		Total	Rural	Total	Rural
1.	Mothers who had Antenatal Check-up in the first trimester	87.2	90.2	76.7	74.1
2.	Mothers who had at least 4 antenatal care visits	95.1	94.0	81.3	78.7
3.	Mothers who had at least one TT Injection	91.0	90.3	87.4	86.1
4.	Delivery at Institution	89.5	87.7	85.6	81.9
5.	Delivery at home assisted by doctor/Nurse/LHV/ ANM	2.1	2.1	2.7	2.2
6.	Mothers who received post natal care within 48 hours of delivery	77.8	75.5	74.8	70.9

Source: NFHS-4 (2015-16)

The above table shows that district Kulgam is showing best results in terms of above indicators on an average. Only in case of delivery at home assisted by specialist is showing worst performance in both J&K and district Kulgam. From NFHS-4 report, it is clear that in district Kulgam the proportion of pregnant women who receive ANC in first trimester is 87%, which is more in rural area as compared to urban area. 2% deliveries at home are supervised by a trained birth attendant, which is very less in both J&K and district Kulgam. It is widely accepted that the number of antenatal visits by a pregnant woman determines where the woman delivers her child. In Kulgam district, 95.1% of women made at least 4 visits for antenatal care. The more antenatal visits, the higher the chance of the birth occurring in a health facility or in the presence of a skilled personnel. In accordance to NFHS-4, 89.5% of women in Kulgam district and 85.6% in J&K, delivered in an institutional facility.

Table 2.3 Percentage of population using various methods of Family Planning

S.no	Particulars (in percentage)	Kulgam		J&K	
		Total	Rural	Total	Rural
1.	Contraceptive use (any method)	60.4	59.1	57.3	54.1
2.	Total Unmet Need for Family Planning* (currently married women age 15-49 years).	9.3	10.2	12.3	13.7
3.	For Spacing *	2.9	3.4	5.8	6.4

Source: NFHS-4 (2015-16)

Note : *Unmet need for spacing includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child, are also included.

Table 2.3 shows the utilization of various methods of family planning. In district Kulgam 60% and 57.3% residents in J&K utilize contraceptives. Total unmet need for family planning is 9.2% of which 2.9% for spacing in Kulgam district and 5.8% in whole J&K.

2.6.6 Environment Indicator:

Environmental indicators are a reflection of the quality of the physical and biological environment in which diseases occur and people live. Improved sanitation of the environment brings enormous benefits to the residents the most useful indicators are those that measure the proportion of people who have access to safe water and sanitation.

Table 2.4 Infrastructure in Kulgam District which affects Women's Health

S.no	Particulars (in percentage)	Kulgam		J&K	
		Total	Rural	Total	Rural
1.	Household with Electricity	97.0	96.3	97.4	96.3
2.	Have Access to Toilet Facility	50.9	48.9	52.5	45.9
3.	Use Piped drinking water	89.2	85.0	98.1	98.0

Source: NFHS-4 2015-16

The above table shows the infrastructure in J&K as well in Kulgam. Nearly 97% in Kulgam district and 97.4% in J&K have access to electricity, 50% in Kulgam district and 52.5% in J&K have access to toilet facilities and 89.2% in Kulgam district and 98.1% in J&K have access to piped drinking water. Government policies and processes affect the socio-economic and other conditions of women. Investment on public infrastructure has direct positive effect on the lives and day to day working conditions and routine of women. Providing safe drinking water, better sanitation in the form of access to toilet

facility and electricity not only directly improve the lives and health of women but also reduce their workload by reducing the discomfort in their day- to-day lives.

2.6.7 Socio-Economic Indicators:

These indicators do not assess health directly. Nevertheless, in determining health status, they are of great importance. These include population growth rate, decadal population growth rate, per capita GNP / GDP, distribution of income.

The literacy rate of women in district Kulgam is 61.8% and 69%, the more educated women means more awareness about health and gives good indication towards the improvement of health. Health service providers in the district of Kulgam repeatedly emphasize the role of education, the need for women and girls to understand and practice their health needs, and the use of government or private sector facilities available.

The age of marriage in Kulgam district is low. The percentage of girls who marry before the age of 18 is 3.5% in district Kulgam and 8.7% in J&K. This can have a positive impact on women's health outcomes.

2.6.8 Health Policy Indicators:

The single most important political commitment indicator is "allocation of adequate resources". The proportion of GNP spent on women's health services and related government activities is important for this purpose the focus of this report is on the availability of health facilities as well as on utilization of health facility. That is why information on women's health services and health-related activities were not available for the proportion of GNP. Here is discussed the political commitment to health for all.

Table 2.5 National Goals and MDG Compared with Actual Situation

Health indicators	10th Plan	11th Plan	NPP By 2010	MDG By 2015	India	J&K	Kulgam
IMR (Per 1000)	45	32	>30	Reduce by 2/3	33	23	49
Institutional delivery (%)	80	100	80	100	83.4	85.6	89.5
TFR	2.3	2.1	2.1	-	2.2	2.01	NA
MMR (Per 1000)	2	1.48	> 1	Reduce by ¾	6.15	5.7	4.0

Source: SRS 2017, NFHS-4 2015-16, CMHO 2018-19
Note: IMR and MMR at per 1000 live births

In the table above, different health indicators have been presented for India, J&K and Kulgam district under various programs and policies. It is also evident from the above data that the averages of J&K and also Kulgam district have not been able to achieve the goals of MDG by 2015 and NPP by 2010. IMR is very high in District Kulgam and also in J&K per 1000 live births. According to SRS bulletin, IMR is 23 per 10000 while its national average is 33 per 1000 live births. If we compare this data with the average of Kulgam district, it is 49 per thousand, which is higher than the average of J&K and India. TFR is the average number of children expected to be born per women during her reproductive years and this is also an important health indicator. According to SRS 2017, India's TFR is 2.2 as against 2.01 in 2017. If we compare the recent data with the targets set in the XI plan, the NPP and the MDG goals in India have been achieved. Different findings show significant improvement in most of the health indicators of the state as well as Kulgam district but still are far from MDG goals. After completion of 5 years by NRHM, J&K has been the best achiever. Increase in institutional delivery by 85.6% gives hope to improve IMR and MMR. Due to sufficient decrease in IMR, now the government concentrates on Neo Natal Mortality rate because it is directly related to the mother's health. It is clear that macroeconomic policies have important and differential effects on the condition of women. Under the NRHM: 2005-2012, India proposes a bold approach to meet the MDG challenges for health.

social and economic factors like the low socio-economic and health status of women in communities, the poor understanding of women on when to seek care, lack of transport, poor roads, the cost of seeking care, multiple referrals to different health facilities and a delay in life-saving measures in rural areas need to be addressed. But the success of any program will be dependent on the impact on root causes and changes in social attitudes and beliefs.

2.7 Conclusion:

Gender affects health outcomes as differences in roles of men and women, affects their health differently due to biologically determined physiological and genetic differences that manifest in differences in needs and vulnerabilities; whereas the type of health care needed may vary by gender, age, area, financial condition, culture, weather, etc. Maternal health services play a crucial role in improving reproductive health for women.

Chapter 3

Indian Health Policies: A Snap Shot of Centre State Health Programmes in Jammu and Kashmir

CHAPTER 3

INDIAN HEALTH POLICIES: A SNAP SHOT OF CENTRE STATE HEALTH PROGRAMMES IN JAMMU AND KASHMIR

3. Introduction:

A health policy is defined as the "decision, plans and actions that are undertaken to achieve specific health care goals within a society". According to World Health Organization, the health policy of a nation refers to decisions, plans and actions that are undertaken to reach explicit health care goals within a society. A specific health policy can help to achieve several things; it gives a definition of a vision for the future, which in turn helps to set up targets and points of reference for the short and medium term. It also brings out priorities and the expected roles of different groups, as well as it builds consensus and informs people. In other words, health policies define the future goals and priorities by planning with the existing resources. According to WHO, an explicit health policy can achieve several things; it defines a vision for the future, outlines priorities and the expected roles of different groups and also builds consensus and informs people.

National health policies, strategies, and plans play a very important role in describing a country's priorities, vision, budgetary decisions and course of actions taken for improving and maintaining the health of the nation. Most countries have been using the development of national health policies, strategies, and plans for decades to give direction and coherence to their efforts and decisions to improve health. Public Health Policy has a great impact on the health status of a nation.

According to Doss (2008) good health is considered to be a prior condition for economic development and social welfare of the country. Good health not only promotes enthusiasm and labour productivity but also produces a positive environment of economic growth. It is believed that not only good health is an important factor for the provision of regular supply of labour, it prevents the disruption caused by sickness and the resulting absenteeism. A healthy society is in fact an important as well as necessary factor in the building of a strong and successful

nation. An unhealthy population can have serious economic related implications on future growth and development of a society. The health of a society plays a significant role in formulating the public policy, as it requires deployment of huge public funds. Health is influenced by a number of factors such as adequate food, housing, sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases. It is generally believed that the two principal benefits of investment in health care are: longevity and improvement in the physical and mental development of the people and provision of health care facilities.

India recognizes that socio-economic development requires a good health. The government has given high priority to enhancing the health status since independence. Policymakers have regarded spending on health and education as social investment (Mabel Binaco 2008). Its degree of interaction is bidirectional in which health affects economic development and the development process is affected in effect (Sachita Nanda Sa and Dr. G. Sridevi 2009). Investing in education and improving health metrics is therefore essential to a country's development of human resources and economic growth (WHO, 1979). Gender disparities in health services are significant and the policy makers deserve special attention. India never had a specific women's health policy, but a number of policy decisions and actions directly influenced women's health (N. B. Sarojini & others, 2007). A gender-based public health approach begins with recognizing the differences between men and women. Indian development planning has always aimed to remove inequalities in the development process, recognizing that women are lagging behind due to multiple socio-economic-cultural-political obstacles. The policy makers realize that real development cannot take roots if it bypasses women; but, due to limited resources the programme has its limitations.

The 1990 was a decade of change and promise On the one hand, far-reaching economic changes were implemented within the country while there were some international conferences in the social sector that promised to change women's subordinate situation. The International Conference on Population and Development (Cairo 1994) and the Fourth World Women's Conference (Beijing 1995) were two significant conferences in this regard. The 9th Five-Year Plan (1997-2002) adopted a strategy to empower women as agents of socio-economic growth and development.

Significant policy interventions have been taken in this context; significant policy initiatives have been taken. The new approach, which started on 1 April 1996, focusing on improving facilities for Reproductive and Child Health services and discarding the earlier 62 target-oriented approach, has given the Family Planning initiatives a new lease of life. Women are the main objectives of the programs of family planning.

3.1 Influence of International Commitments:

3.1.1 The International Conference on Population Development (ICPD, 1994):

The ICPD held a conference in Budapest in 1974, stressing that development is best contraceptive, and the need for safe motherhood was highlighted by a conference in Mexico City in 1984. The ICPD at Cairo on 14 September 1994 was seen as a watershed in the implementation of population and health programs. Earlier world population conferences, mainly through family planning (FP), focused on controlling population growth in developing countries.

The conference in Cairo narrowed the scope of policy discussions. Family planning programs globally from a modern point of view under the umbrella of reproductive health support a new approach that stresses the multiple linkages between population and growth and focuses on meeting the needs of individual men and women rather than on achieving demographic goals. This new perspective shifted population policies emphasis away from slowing population growth to improving people's lives, particularly women.

It also explained that advancing gender equality and empowering women, removing all kinds of violence against women, and ensuring the right of women to regulate their own fertility, are the cornerstones of programs related to population and development. Governments have now accepted that population policies should address social development beyond FP, particularly women's advancement, and that Family Planning should be implemented as part of a wider Reproductive Health (RH) care package.

Underlying this new emphasis was a belief that improving the health and rights of individuals would ultimately reduce fertility and reduce population growth. Most countries have redefined policy and program goals and implemented strategies aimed at meeting individual needs rather than national demographic goals. In most nations, the language on sexuality and reproductive health that was considered a modern and ground break for 1994 is now part of the health lexicon. India reoriented its national family planning programs to meet Reproductive Health needs in the second half of the 1990s.

The right of men and women to be informed and to have access to safe, effective, affordable and acceptable FP methods of their choice, as well as other methods of their choice for regulating fertility that are not contrary to the law, and the right of access to health care services that will allow women to pass through pregnancy and childbirth safely. RH care also includes sexual health with the purpose of improving life and personal relationships. ICPD recommends actions to increase accessibility availability acceptability and affordability of healthcare services and facilities, and to increase safe lifespan with improved quality of life for all people, as well as to minimize inequalities in life expectancy between and to reduce the disparities in life expectancy between and within countries. Women were recognized as the poorest of the poor, but also as key players in the process of development. In addition to regular sexual and reproductive health and rights programs the ICPD Program of Action (PoA) encourages governments to increase the scope of population and development programs to include needs of women, adolescent's elderly people. It also urges governments to increase the allocation of resources for their systems to strengthen RH services. The goal is to improve existing methods and to develop new methods Fertility control that meets the needs of users and is acceptable, easy to use, safe, effective and free of side effects. It has been working with government, NGOs, media, and other stakeholders to help translate the Reproductive Health agenda into policies and programs.

3.1.2 The Fourth World Conference on Women (FWCW, 1995)

On September 1995, FWCW was held in Beijing. It focused on issues that matter most to women and their families lives, such as access to education, health care, jobs,

credit, the chance to enjoy basic legal and human rights, and to participate fully in their country's political life.

FWCW Platform for Action (PFA) has established five strategic objectives for women's health. Women's health is characterized to include their emotional social and physical well-being and is determined by their life's social, political, and economic context, as well as biology. Inequality is a major barrier facing women in reaching the highest attainable health level.

The PFA advises governments to promote an active and noticeable policy of mainstreaming a gender perspective in all policies and programs in addressing gender inequalities in terms of health status and unequal access and inadequate health care services. The assessment of the consequences on women and men should also be made before decisions are taken. Specifically, the PFA advises that women's access to reliable, affordable and quality health care, information and related services must be improved throughout the life cycle, becoming a major challenge for developing countries such as India. It is important to improve preventive services that support women's health. Gender-sensitive initiatives need to be undertaken to address issues of sexually transmitted diseases, HIV/AIDS and sexual reproductive health. Research and dissemination of women's health information must be promoted. They need to increase the allocation of resources for women's health. There is common concern about the rising incidence of violence against women, and governments are encouraged to address this issue as Part of their services for population and health programs, This conference's great challenge is to give voice to women wherever their stories go unnoticed, whose voices go unheard.

3.1.3 The Convention on Elimination of all forms of Discrimination against Women (CEDAW, 1979)

Adopted in 1979 by the General Assembly of the United Nations, it is often described as an International Bill of Rights for Women and ratified in 1993 by India. Governments agree to take all appropriate measures, including legislation and temporary special measures, as part of their commitment to this convention, so that women can enjoy all their human rights and fundamental freedoms. India is

committed to reducing and eliminating all forms of discrimination against women by policies, programs and legislative measures as a country that has ratified this convention.

Policy adequacy can be measured by its impact on health of the population. Indian development planning has always sought to remove inequalities in the development process, recognizing that women are lagging behind due to multiple socio-economic-cultural-political obstacles. Recognition of the root cause allows us to assess how different health risks, behaviours and outcomes are different for women and men, boys and girls and to act accordingly.

3.2 National and State initiative:

Since India became free, the Five Year Plans have implicitly provided policy measures for women's health as well as a number of special committees. Additionally, the WHO and other international agencies have influenced policy making in India as well as provides financial and technical assistance. Various women's healthcare, medical education, and research institutions and organizations are continuously being strengthened for better women's health. The chronology below highlights the active change in the Indian programme.

Chronological order

1) 1952 - Family Planning Programme was launched
2) 1963 - The program for family planning was recognized
3) 1975 - ICDS program launched
4) 1977 -Family planning was made concurrent subject
5) 1978 - Family planning program renamed as FWP
6) 1979- Oral pill distribution was introduced in FWP
7) 1987-88- FP Incentive program for Panchyati Raj bodies started
8) 1996-97- Target approach in FWP finished.
9) 1997-TFA has been renamed CNAA
10) 1999- CNAA was adopted in RCH programme
11) 1999- Medicare Relief Society Scheme has started encouraging FP

12) 2001- Amendment to the Act on entry into government service and encouraging FP for government officials.
13) 2001-The amount of compensation in FP operation was increased from Rs. 50,000 to Rs. 2 Lakh if a woman died within 30 days of operation.
14) 2004- Introduction of the compensation scheme in FP. Women will earn Rs. 5000/-in cash in case of failure of an FP operation. Free MTP facility.
15) 2004- Cash payment incentive scheme for FP operations
16) 2004 - Mother and child health day scheme started
17) 2005 - NRHM was launched

The Indian Family Planning Program started with a clinic-based approach back in 1951. Extension Education Program was introduced in the 3rd Five-Year Plan to teach the values of a small family. The intra-uterine approach to contraception was later initiated. Not all of these approaches have been able to show encouraging results.

In the past, women's health work focused on their reproductive role and generally their motherhood, and on limiting birth but much less on the viability of that birth and the mother as an individual. A gender-based approach has broadened our understanding of women's health problems, as well as helping to identify ways for women to address them. While India has never had a clear policy on women's health, a number of policy decisions have influenced women's health directly or indirectly, some of which are as follows:

3.2.1 National Population Policy (NPP) 2000

India was the world's first country with a population policy. Growth of the population was seen as an urgent problem related to resource-limited economic development. The policy aims to view the population as a liability. Population policy must be 'gender-sensitive' and family planning must be adjudicated as a pragmatic and essential step towards improving mother and child health. With the introduction of the 1952 family planning programmer population policy centred on the control of women's fertility and neglected other women's health needs (VHAI/WHO 2000). Family planning was treated as part of the health program and in 1966 a separate department coined as the Ministry of Health's Department of Family Planning was

carved out. Contraception responsibility continues to fall on women; men's role in family planning is overlooked.

Family Planning changed to Family Welfare program in 1977 and has been maintained to date. The policy is undoubtedly broader than in the past. But there is need for stronger emphasis on gender equality in programmes, strengthening the quality of FP and health services, and stronger institutional mechanisms to ensure inter-sectoral participation to evolve workable procedures and operational guidelines. Rapid increase in institutional deliveries has been felt to be neither feasible nor desirable unless their quality and access can be dramatically improved.

Stabilizing the population is a requirement for the promotion of sustainable development. The policy was of the main goal of lowering the fertility rate to replacement level by 2010 and achieving a stable population by 2045. The main thrust in achieving these goals remains to delay the first child spacing the second and stopping the third. NPP 2000 calls for decentralization in planning and implementation, service delivery convergence empowerment of women for health and nutrition, meeting unmet needs by improving service delivery. Fourteen national socio-demographic goals were also set for 2010. Such goals relate to several important aspects and areas of maternal and child health as well as socially critical issues such as promoting delayed girl's marriage, universal marriage registration with institutional improvements such as inter-sectoral coordination and social sector convergence.

3.2.2 National Health policy (NHP) 2002

The 1983 NHP was revised in India in 2002. The policy ensured equitable and increased access to decentralized public health services and increased investment in public health in order to achieve an acceptable standard of good health among the Indian population. In the health sector, the contribution of NGOs and the private sector will be increased. This brings in disparities and large gaps in health facilities, shortage of required health facilities and public health medical personnel.

NHP calls for the identification of specific women's health programs .The policy commits the central government's highest priority to funding identified women's

health programs and recognizes the need to review the public health administration's staffing standards in order to meet women's specific requirements. The 2002 NHP drafts agree women are in need. This says that political, cultural and economic factors tend to prevent women from obtaining sufficient access to existing facilities for public health. This disability does not only affect women as individuals; it also adversely affects the health, overall well-being and development of the whole family, particularly children. This policy recognizes empowered women's catalytic role in improving the community's overall health standards. However the NHP did not give separate identity to women related health issues and formulate strategies and approaches to resolve them. Women's health reference has become an incidental issue.

3.2.3 National Health Policy (NHP) 2017

The 2017 National Health Policy (NHP, 2017) seeks to reach everyone in an integrated and comprehensive way to move towards wellness. It seeks to achieve universal health coverage and deliver quality health care services at an affordable price for everyone. As its goal the policy envisages achieving the highest possible level of health and well-being for all ages, through preventive and promoting health care orientation in all development policies, and universal access to good quality health care services without anybody having to face financial hardship as a consequence. This would be achieved by increasing access, improving quality and reducing healthcare delivery costs.

The objective of National Health Policy 2017 is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

Some Specific Quantitative Goals and Objectives under NHP 2017 for women health status are:

- Reduction of TFR to 2.1 at national and sub-national level by 2025.
- Reduce under five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.

- Reduce infant mortality rate to 28 by 2019.
- Reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025.
- Ante-natal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.
- More than 90% of the newborn are fully immunized by one year of age by 2025.
- Meet need of family planning above 90% at national and sub national levels by 2025.

Since survival of the mother and child is a mirror that reflects entire spectrum of social development. National Health Policy-2017 aims at promoting all sectors developmental action in support of maternal and child survival. In order to ensure continuity of care and emergency services for maternal health, the policy strongly recommends strengthening general health systems to prevent and manage maternal complications. The National Health Policy-2017 seeks to address the social determinants by developmental action in all sectors in order to address comprehensively factors affecting maternal survival. The State has adopted various strategies framed by the Ministry of Health and Family Welfare, Govt, to achieve the goal of Maternal Mortality Ratio (MMR) less than 100 by 2020 as envisaged in the National Health Policy-2017. In India and the state's maternal health indicators have been substantially improved.

3.2.4 National policy for Empowerment of Women (NPEW) 2001

The NPEW 2001 includes among its objectives.

- Women's enjoyment of all human rights and fundamental freedoms on an equal basis with men in all areas-political, economic, social, cultural and civil.
- Equal access to women's participation and decision-making in the nation's social, political and economic life.
- Equal access to health care for women, quality education at all levels, career and professional guidance, employment, equal remuneration, occupational health and safety, social security and public office.

- Changing societal attitudes and community practices by men and women's active participation and involvement of both men and women.
- Elimination of all forms of discrimination against women and girls.
- Mainstreaming in the development process a gender perspective

Among its policy prescriptions, it suggests adopting a holistic approach to women's health, which includes both nutrition and health services, and paying special attention to women's and girl's needs at all stages of the life cycle. A priority concern is the reduction of IMR and MMR, which are sensitive indicators of human development; women should have access to comprehensive affordable and quality health care. Measures to take into account women's reproductive rights to enable them to exercise informed choices, their vulnerability to sexual and health problems together with endemic, infectious and communicable diseases will be adopted. From a gender perspective, the social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases will be tackled. The policy also requires the availability of good and accurate micro-level data on deaths, births and marriages and the strict implementation of the registration of births and deaths would be ensured and the registration of marriages would be made compulsory in order to effectively address the problems of early marriage and infant and maternal mortality.

All three policies reflect a common concern about the need to stabilize the population at a level consistent with the national economy's requirement. The NHP (2002) argued that "attainment of improved health indices would be significantly dependent on population stabilization", and unless the population stabilization goals are achieved, no amount of effort in the other components of the public health sector can bring about significantly better national health standards". The NPEW 2001 takes into account the commitment contained in the NPP 2000 to population stabilization. The NPP 2000 discusses the decentralized planning and implementation of the RCH system in detail. In all three policy statements, the panchayat's participation in health and family welfare activities is recommended. The NPP 2000 links decentralization to the convergence of the national family welfare program with ICDS, without which decentralization would be meaningless it argues. The NPEW 2001 recommends that all women institutions establish themselves from the grassroots level upwards to achieve synergistic implementation of economic and social programs by drawing

resources from sources of state and NGOs. For instance, at the level of Anganwadi, self-help groups (SHG's) will form and federate at the level of Panchayat and Municipal.

All three policies are in favour of integrating and using indigenous medicine systems to increase health services outreach. The NPEW 2001 explicitly recommends its enhancement in the context of women's health. In the provision of RCH services, especially in tribal areas, the NPP 2000 recommends these systems. It also advocates the use of barefoot in reaching women as part of the mainstreaming of indigenous systems, as well as providing for their training and orientation.

3.3 Analysis of Women Related Issues in the Policy Documents:

3.3.1 Lack of priority in improvement of women's overall health status Improving the overall health status of women is not expressed in the policies in question, presumably because it is presumed that meeting the unmet needs of women for basic reproductive and health services sums up the agenda of women Women's burden of morbidity and disease find no place in the description of the current health scenario presented in the first part of the NHP 2002 draft. However, there is no consideration of the differential impact of different health issues on women, some of which have very serious consequences, especially in some stages of women's lives.

3.3.2 Women Health-From NHP 2002: There was a lack of strong steps in NHP 2002 to ensure the sustainability of various programs, failing to bring on the platform Anganwadi workers and other grass root level workers. It is silent about the village health worker, the primary health care system's first contact.

3.3.3 Women and Mental Health: Policies do not make any separate or specific mention of those mental health problems of women that are more pronounced in some age groups as in women bearing children and those without children; nor do they outline any strategies to help and encourage these women to seek professional help. The NPEW 2001 and NPP 2000 make no mention of or psychosocial impact of women's mental health problems. In addition, none of the three documents relate either to the status of implementation or to the misuse of mental health in regard to women.

3.3.4 Women and Nutrition: The NPEW 2001 indicates the high risk of malnutrition and diseases faced by women during infancy, childhood, adolescence and years of childbirth. It speaks of making special efforts to tackle the problem of deficiencies in macro and micro nutrients, especially among pregnant and lactating women, and their connection with various other diseases and disabilities. The NPP 2000 recommends the convergence of family health and nutrition and ICDS convergence with Health and Family Welfare Department services. The NHP 2002 draft makes no specific mention of malnutrition, nor does it suggest any policy strategy or intervention in nutrition programs other than to term it a social sector 'complementary initiative'. The NPEW 2001 highlights the issue of intra-household nutritional discrimination toward girls and the need to address it through educational strategies.

3.3.5 Effects of Contraception on Women Health: National and state policies and contraceptive technologies are mostly targeted at women, male dominance and cultural norms at the micro-household level are most important (Sabiha Hussain 2009). The current approach to population control in family planning programs is to provide a 'cafeteria choice' to provide all the methods from which a person can choose according to their needs wishes, and to promote FP as a way of life. But no one is there to protect these contraceptive's further effects. After liberalization, multinational drug companies have often persuaded the Indian government to introduce contraceptive drugs that have often been poorly tested, tested, or insufficiently controlled in the subsidized government distribution program for disturbing side effects (Harini Narayanan 2011). It is important to have a side effect on women's health. The complications are like bleeding (abnormal bleeding-greater volume of blood loss during menstruation, longer menstrual periods or mid cycle bleeding), pain, pelvic infection, uterine perforation, expulsion, fertility after removal of IUD, cardiovascular effects, carcinogenesis, metabolic effects, liver disorders subsequent fertility, fetal birth defects, breast tenderness, weight gain, etc. Women's policies have been taken into account but nobody knows how uncomfortable they are for women. Women's groups have conducted campaigns protesting long-acting contraceptives on the grounds that they have been inadequately tested, have negative side effects, and the country lacks the infrastructure to provide adequate follow-up.

3.3.6 Lack of Attention to Differentials Across Groups and Categories: Improvements in the country's health indicators (described in NHP 2002) and its demographic achievements (described in NPP 2000) over the past five decades (i.e., birth rate reduction, IMR, MMR, death rate, TFR or CPR increase, life expectancy, etc.) are expressed in national or state averages. Such completion does not capture the differentials in the population across the different socio-economic or social categories and subgroups. The NPP 2000 does not break down the national averages, although it categorizes some spatially defined groups (urban, slums, tribal communities, hill population displaced and migrant populations) as well as adolescents in terms of access to information and services as 'underserved population groups'. The NPP has neglected to discuss whether it advocates support for all adolescents or only for married adolescents. But it does not provide any clear comparisons and does not classify the population by any socio-economic criterion.

3.3.7 Concern for Adverse Sex Ratio is Not Uniform: The NPEW 2001 speaks as an example of gender disparity of the declining female-male sex ratio. It points to the lower status of 'marginalized, poor and socially excluded' women. The policy attempts to go beyond aggregate numbers of women and insists that good and accurate micro-level data on births, deaths and marriages be available. Although this is a major demographic change, the nearly consistent decline in the female-male sex ratio over the last century was not addressed either in the NPP 2000 or in the NHP 2002.

3.3.8 Discrimination and Violence: The NPEW 2001 refers to all forms of discrimination against the girl child as a violation of her rights and specifically refers to the selection of parental sex and the practices of female foeticide, female infanticide, child abuse and child prostitution. In order to support the girl child, it makes major commitments to make substantial public investments in health and nutrition. The NPP 2000 speaks of the girl child in terms of 'too early, too regular and too many' high fertility rate, and points to the high percentage of girls (over 50 percent) who marry under the age of 18. The NPP stresses the implementation of the 1976 child marriage law to reduce the incidence of teenage pregnancy. There is no reference in the NHP 2002 to girl children or their health needs. In the goals listed in

NHP 2002 to be achieved by 2015, only two indicators of overall child health (IMR and low birth weight) are included.

The NPEW 2001 committed itself to eliminating 'violence against women, both physical and mental whether at home or in society', including those arising from customs, traditions or accepted practices, by establishing institutions and mechanisms for prevention, rehabilitation and punishment. Neither the NPP 2000 nor the NHP 2002 addresses violence against women and children of girls. Neither the NPP 2000 nor the NHP 2002 addresses violence against women and children of girls. There is no discussion in either of the two documents on the links between women's health, women's reproductive health and violence nor is there recognition of the decreasing female-male sex ratio and violence factor inherent in the increasing incidence of foeticide. The NHP document provides no space for the medical community to discuss medical ethics and profit making arising from the misuse of the PNDT Act 1994. However, there is no mention of this act in either the NPP 2000 or the 2002 NHP.

3.3.9 Concern for Elderly Women: While the NPEW 2001 refers to 'elderly women' in difficult circumstances as a sub group of women, it does not make any commitment or reference to their health needs. The NPP 2000 refers to the problems of the ageing population and the National Older Persons Policy (Ministry of Social Justice and Empowerment), but does not address the gender aspects of aging or the health and reproductive health needs of older women.

3.3.10 Private sector and Women's Health: The policy highlights the increasing role of the private health sector in secondary and tertiary care and speaks of the need for statutory licensing, regulation and monitoring to ensure minimum yet silent standards of diagnostic centres and proper regulation of them if such institutes provide inaccurate treatment. Accessibility and affordability are issues that are merely mentioned but not discussed in the NPP, and confidentiality issues are not discussed or mentioned. Confidentiality and friendly care for women are needed.

3.3.11 Inter-Sectoral Linkages: In the NPP there is no mention of the macro issues of income, employment, food, basic health and livelihood. It is more important for

women's health to acknowledge the links between complementary initiatives and non-health determinants. Policies emphasize delayed marriage, but are silent about vocational training and job empowerment opportunities, reflecting that their goals are still very limited to reducing fertility.

While the policy is completely silent and ambiguous about the need for essential drugs, price control and standardized treatment regime, regulation of private medical colleges/ institutions, and medical research, on the one hand.

Even after all these policies except during pregnancy or for contraception, women's health care remains a neglected region. Women in Kulgam district hardly have access to the health care system because there is limited family funding for clinical visits and medicines. It is evident that, according to the least priority, women themselves tend to neglect their health. While crucial, the problem will not be solved by policy alone. Fulfilling fundamental gaps and building health systems that can provide professional-skilled health care staff, emergency care, postpartum care, clean and accessible reproductive health services, and family planning for every woman everywhere is urgently needed. Because real solutions need to focus not only on supply, but also on demand, and both sides are affected by these measures.

3.4 Programmes for Women's Health:

It is the responsibility of state governments to implement health programs, as health is a state subject. Women's health in J&K has shown definite improvement after a long planning period. A number of programs that have been critical to women's health over the years have evolved in the planning process, the MCH, nutrition and immunization programs have been brought into the Family Welfare Program (FWP) program and finally converted into a strategy for RCH. Although the RCH, along with ICDS, provides a range of services to women, the impact of effective general health services for women is not recognized by official policy.

Despite concerted efforts by both the state and central government, women's health status in J&K continues to be appalling. While some positive developments indicate progress over the past couple of years, there is a growing need to ensure that benefits are more widely distributed.

India is the world's first country to officially declare an 11 April National Safe Motherhood Day, which is Kasturba Gandhi's birth anniversary. Special programs are selected as priority programs for special attention in terms of support and resources by national, state and district level. NRHM has included some of the previously functioning national programs in one and has also defined some indicators to be achieved by 2012/2015. Over the past half-century, considerable progress has been made in improving the health status of the population. Despite this impressive progress, there are still many challenges. The main objectives of these programs/schemes are population stabilization, improving quality of life, reducing indicators of mortality, morbidity and fertility, and strengthening primary, secondary and tertiary health care delivery. The following analysis will try to examine the impact of health programs on the present situation of women of reproductive age in the J&K. The main health programs and schemes for women in J&K are as under:

3.4.1Family Welfare Programme: In 1951, India introduced FWP with the objective of reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the national economy's requirements. During the five-year plans I and II, the approach under the program was mainly 'clinical' through which facilities for service provision were created. On the basis of data from the 1961 census, however, clinical approach was replaced by 'Extension and Education Approach' which envisaged the expansion of service facilities along with the spread of small family standard message.

The FP program has always focused solely on women, excluded their ill health, and addressed their reproductive capacity; therefore, women are denied the chance to use a really safe and user-controlled contraceptive because research funds are diverted to find safer, but not safer, contraceptives that make women dependent. This techno-centricity of a women's population-centered policy actually damages women's health rather than improving it.

3.4.2 Integrated Child Development Scheme (ICDS): On October 2, 1975, this scheme was launched. Today ICDS is one of the largest early childhood development programs in the world. Since then, the program has been slowly expanding. Since 1999, with the assistance of the World Bank, ICDS-3 has been operating in J&K.

Additional nutrition, immunization, health check-ups, referral services, nutrition and health education are given through ICDS to promote women and children's health and nutritional status. Emphasis is placed on strengthening the ongoing scheme as well as providing additional services inputs. Anganwadi workers are the functionaries of grass roots to implement the ICDS system. It is also proposed that additional Anganwadies should be opened to maintain parity with the growth rate of the decade. Women's service programs in ICDS do not cover the general health needs of women that are critical to the health of women.

Under ICDS, supplementary nutrition is given to 0-6-year-old children and pregnant/lactating mothers with the primary objective of fighting malnutrition. Presently, there are 141 projects under J&K ICDS covering 29,599 Anganwadi Centers. As of June 2019, the State has covered almost 7,80,000 beneficiaries under the Supplementary Nutrition Program (Ministry of Women and Child Development, 2015)

3.4.3 National rural Health Mission (NRHM): National efforts to ensure effective healthcare, especially for the poor and vulnerable sections of society, was launched on April 12, 2005 for a seven-year duration (2005-2012) throughout the country, with a particular focus on 18 states, including J&K. Recognizing the importance of health in the economic and social development process and improving the quality of life of our people, the Government of India (GOI) has launched the NRHM to introduce the required architectural correction in the basic health care delivery system. The National Rural Health Mission (NRHM) was launched at the National Level in April 2005 and at the J&K State in December 2005. It was renamed the National Health Mission (NHM) in 2012 and its two submissions were the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM).

The program aims to strengthen state health systems with a special focus on services and disease control programs for Reproductive, Maternal, Newborn, Child & Adolescent Health (RMNCH+A). NHM has a clear set of measurable goals, such as MMR, IMR, and TFR reduction, and National Disease Control Program targets. The mission emphasizes on empowering people through effective Rogi Kalyan Samitis process, decentralized planning and implementation, improving physical infrastructure and ensuring fully functional facilities at people's door steps that do not withstand topography and situational constraints.

The Mission takes a synergistic approach by relating health to good health determinants. Nutrition, hygiene, and safe drinking water segments. It also aims to integrate Indian medicine systems to facilitate health care. The NRHM is seeking a complete paradigm shift in the delivery system of health care. This seeks to restructure the health delivery mechanism and provide universal access to equitable affordable and quality healthcare that is accountable and responsive to the needs of people; to reduce infant and maternal deaths and to stabilize population growth; and to ensure gender and demographic balance. The mission is an articulation of the government's commitment to rise public spending on health from 1.4% to 2.3% of the GDP of India.

It identified "Health for All" principles such as equitable distribution, community participation, inter-sectoral coordination and communication, flexible funding, innovations in human resource management monitoring complying with IPHS standards, and capacity building at all levels as the principal approaches to quality service delivery, efficient use of scarce resources, and most of all, it ensures service guarantees to the local people. The NRHM's success will depend on the capacity of state and local institutions, including strong partnerships with civil society organizations and actors in the private sector. Increased resources and decentralization alone will not be enough.

Public health facilities are witnessing an increase in institutional deliveries with the launch of NHM, i.e. the overall improvement in the state's health care delivery system. The state achieved a substantial increase in the percentage of pregnant mothers who had antenatal check-up in the first trimester, from 54.8% as per NFHS 3 (2005-2006) to 76.8% as per NFHS 4 (2015-16) report, as well as an increase in the percentage of mothers who had at least 4 antenatal care visits from 60.4% in NFHS-3 to 81.4% in NFHS-4, respectively. The number of institutional deliveries in the state has seen a quantum jump, increasing from 50% in 2005-06 (NFHS-3) to 85.7% in 2015-16 (NFHS-4). This is achieved through the National Health Mission's multipronged strategy. The prevalence of anaemia among women in the country decreased marginally by about 2% between 2005-06 and 2015-16, from 55% to 53%, but after Sikkim and Mizoram, J&K State recorded 11.5% decrease in the prevalence

of anaemia at the same time and ranked third in terms of decrease in the percentage age of anaemia. (Source: NFHS data)

The improvement in Maternal Health indicators in the State is evident from following graphs:

Fig.3.1 Percentage of mothers with antenatal checkups and care visits

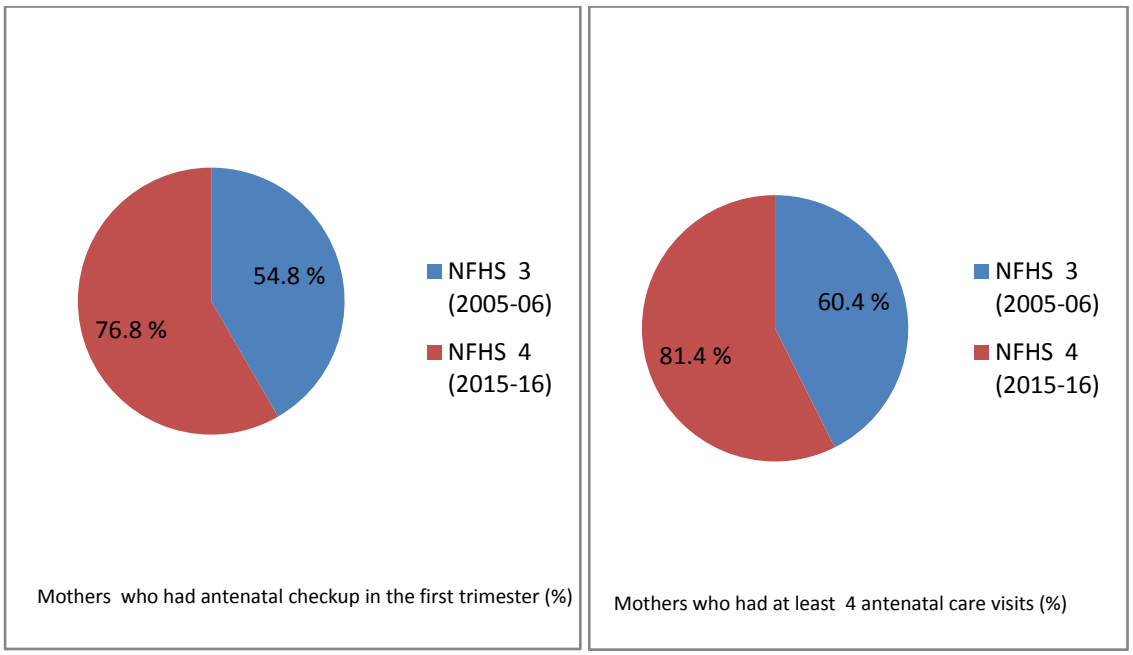
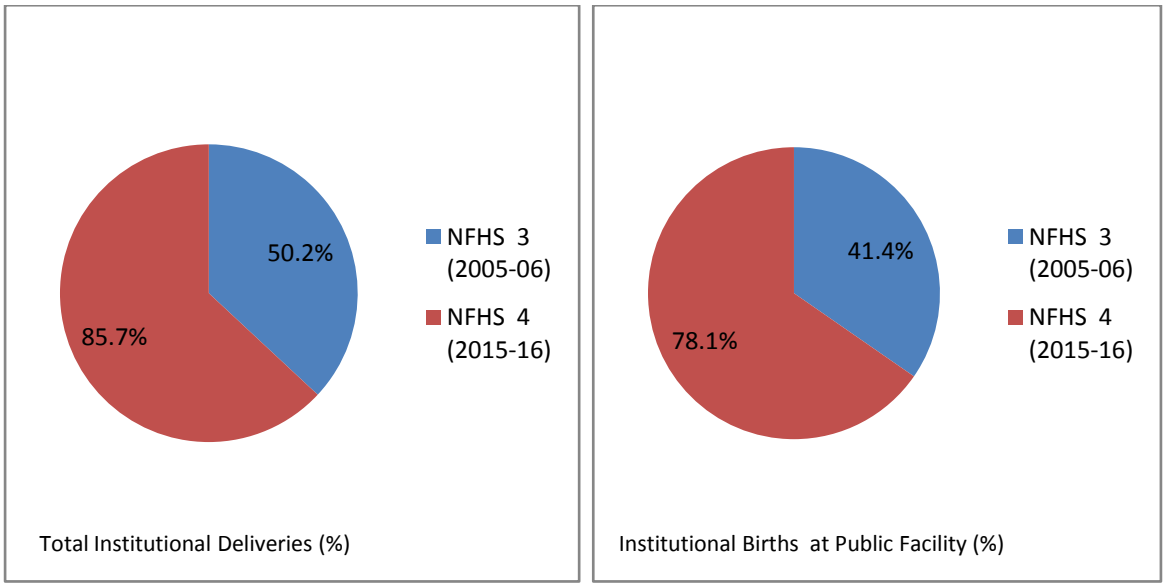


Fig. 3.2 Percentage of institutional deliveries and births in public facility



Source: NHM J&K 2018-19

Maternal health remains an important indicator of a country or state's well-being. In order to ensure their good health, the necessary health care facilities provided to mothers are central to qualitative development, and a high number of maternal deaths indicate lack of access to proper medical facilities and a wide gap between rich and poor.

Under NHM, J&K state is striving to bring about an improvement in people's health status, especially women and children living in rural and remote state areas. The program envisaged the provision of quality antenatal care (early registration, at least four antenatal check-ups, two injections of tetanus toxoid and IFA tablets). It is also aimed at promoting safe institutional delivery by qualified birth attendants.

3.4.4 Accredited Social Health Activists (ASHA): ASHA is a trained female community health activist who raises awareness about health and its social determinants and mobilizes the community for local health planning. There are approx 12,000 ASHAs engaged in the State. No fixed monthly remuneration is paid to ASHAs, but performance-based incentives are paid. Under JSY, Rs. 600/-for facilitating the institutional delivery of pregnant women in rural areas and Rs.400/- under NUHM is paid to ASHA. Each ASHA is also entitled to an assured incentive of Rs.1000/- per month for carrying out eight different activities on monthly basis.

The NRHM covers all villages through village-based ASHA Sahyogini, a joint worker of the Department of Women and Child Development and Medical and Health Services, selected by the community through Gram Sabhas and responsible to the Community. She is co-terminus with Anganwadi and acts as a connection between villagers and health centres. To people living in rural areas, ASHA would be a service or information kiosk. The ASHA would be trained to advise villagers on complications of pregnancy and safe delivery, sanitation, hygiene, contraception and immunization to provide primary medical care for diarrhea, minor injuries, and fever and to escort patients to medical centres. ASHA will act as a link between village-level beneficiaries, Anganwadi Worker and ANM.

ASHAs are trained in awareness generating. If rural women want advice on important issues such as birth preparedness, safe delivery, breastfeeding and complementary

feeding, immunization, contraception and prevention of common infections, including RTIs/STIs and child care, then they are contacted, the ASHA concerned provides them with all relevant information, guidance and assistance. For actual data collection, linking ASHA to the health system is important because they are the residents of that particular area and cover a small population. ASHAs are expected to make monthly estimates of the expected number of deliveries and the number of deliveries at institutions. They are effective in increasing awareness through comprehensive complaint that emphasizes the importance of institutional delivery and other malpractices that hamper women's health.

The success of the study revealed ASHA program in Kulgam districts depends on ASHA's functional efficiency and effectiveness as the grass root health activist. Because ASHAs are the residents of the same village, they understand the socio-cultural norms and also the beliefs of the misconceptions that are spread and practiced in that particular region. The program can be successful by generating this service provider's appropriate, realistic and scientific approach. The government should provide them with opportunities for higher education during their service as ASHAs, as they are educated to only 8th standard. ASHA's success depends on their health services and practices training But ASHAs training is not completed in time, it should be quick to complete the different training steps. The improved quality of services and counselling they provide can only be determined through full training, so the government must complete their training as soon as possible.

3.4.5 Janani Suraksha Yojana (JSY): The scheme is a safe motherhood intervention and seeks to reduce maternal and neo-natal mortality by promoting institutional deliveries and providing cash incentives for mothers delivering in a public health facility. Cash benefits are given to the mother beneficiaries at Rs 1400/-in rural areas and Rs 1000/-in urban areas in order to promote institutional deliveries**.** JSY is a centrally sponsored scheme to benefit pregnant women and poor families through certification by amending the existing National Maternity Benefit Scheme (NMBS) under NRHM, JSY is being proposed and is fully funded by GOI. A new integrated cash assistance scheme JSY introduced in J&K in 2005 aims to provide comprehensive medical treatment during pregnancy, childbirth and postnatal care, and

to reduce maternal and neo-natal mortality by promoting women's institutional delivery.

In the case of home deliveries, a financial assistance of Rs. 500 will be paid to BPL. A financial incentive of Rs. 1400 in rural areas and Rs. 1000 in urban areas is paid to the beneficiary for government hospital and accredited private hospital institution deliveries (after 2006). Payment is made to pregnant women and ASHA by bearer cheque at the institution prior to discharge after 24 hours of delivery. Now JSY scheme is more economic for users as free transportation is available of 108 services provided by government in both rural and urban areas. The government tries to overcome the effect of three delays through these services Kulgam district is also one of the best performers in institutional delivery after JSY has been delivered, but there is an urgent need to upgrade multiple levels of health facilities to meet the increased need. Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution in Kulgam district was 69.4% and 54% in J&K (NFHS 4 2015-16).

The number of institutional deliveries has increased significantly with the launch of the Janani Suraksha Yojana (JSY). However there are around 15 to 20% of pregnant women who still hesitate to use facilities for public health. Those who have opted for institutional delivery are unwilling to stay for 48 hours, hampering the provision of essential services to both mothers and neonates, critical for identifying and managing complications within the first 48 hours after delivery.

3.4.6 Janani Shishu Suraksha Karyakaram (JSSK): The Janani Shishu Suraksha Karyakaram (JSSK) was launched by the Government of India on 1 June 2011. The scheme is to benefit pregnant women for their delivery who have access to government health facilities. It will also motivate those who still choose to deliver for institutional deliveries at their homes. The scheme was initiated by all States and UTs. Given the difficulties faced by pregnant women and parents of sick new-born with high out-of-pocket expenses incurred by them in the delivery and treatment of sick new-born sick, the Ministry of Health and Family Welfare (MoHFW) has taken a major initiative to evolve a consensus on the part of all States to provide fully free and cashless services to pregnant women, including normal deliveries and C-section

operations and sick new born (up to 0 days after birth) in Government health institutions in both rural and urban areas. Janani Sishu Suraksh Karyakram (JSSK) has been implemented in the State to enable women to stay at the facility for 48 hours after delivery and to make zero spending or with a view to encouraging all pregnant women to deliver in public health facilities and fully fulfilling the commitment to achieve 100% institutional deliveries. JSSK aims to mitigate the burden of out-of-pocket expenses incurred by pregnant women and infants and acts as a major factor in enhancing access to institutions of public health and helping to reduce maternal and infant mortality.

During the financial year 2013-14, the scheme was extended to cover the infants & complications during antenatal, postnatal period, the entitlements under the programme for infants (0-1 year) are:

1) Free and zero expense treatment.
2) Free Drugs and consumables.
3) Free diagnostics.
4) Free Provision of blood.
5) Free transport from home to health institution, between health institutions in case of referrals and drop back home.
6) Exemption from all kinds of user charges.

3.4.7 Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA): With the goal of providing quality ANC to every pregnant woman, the Government of India has launched "Pradhan Mantri Surakshit Matritva Abhiyan" (PMSMA), a fixed-day ANC service to be given across the country on the 9th of each month. This will be given at the health facility in addition to the routine ANC.

This new initiative was launched in all districts of the state in Jammu & Kashmir on June 9, 2016. As part of this campaign on the 9th of each month, Specialists & Medical Officers provide a minimum package of antenatal care services to beneficiaries at identified health facilities (134) so that each pregnant woman receives at least one check-up during the 2nd and 3rd trimesters of pregnancy and ensures that

no high-risk pregnancy is undetected. It is also ensured that all essential investigations are also conducted during the ANC period.

In addition to the existing screening protocol, PMSMA would ensure that all pregnant women are screened for following conditions:

a) Gestational diabetes mellitus
b) Hypothyroidism in high-risk cases
c) Syphilis

In addition, health workers training will be planned to ensure that IFA is supplemented with calcium as per the revised guidelines. It would also include building capacity during pregnancy on Deworming.

Because beneficiaries have to wait for a long time at the hospital to make use of this service. Pregnant women should have a timely diet and on PMSMA Day women traveling from distant places had to remain empty stomach. To address this issue, under its mandate to provide additional nutrition to all pregnant women for extra calories and proteins in the form of cooked food or to take home rations, the ICDS Department was asked to provide cooked meals and J&K issued directions to the District Program Officers, ICDS arrange and provide hot cooked food as per local customs to all pregnant women coming for ANC check-up at designated health facilities in their district on the 9th of each month i.e. Day of the PMSMA. This initiative began on February 9, 2017 in a few districts of the state and on the day of PMSMA, hot cooked food is being provided to the beneficiaries at the hospital premises. In J&K 130 health facilities have been identified & designated as PMSMA clinics in the State. And in Kulgam district DH Kulgam, CHC Yaripora, CHC DH Pora, PHC Qazigund and PHC Qaimoh are identified as PMSMA clinics.

3.4.8 Village Health and Nutrition Days:

The VHND was implemented in the State in order to provide an effective platform for the provision of primary health care for first contact. The village's Health & Nutrition days are held at the village's prefixed AWW Centres each month (thursdays). The following services will be provided during VHNDs:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them

Counselling for pregnant women also conducted during pregnancy with regard to signs of danger, importance of delivery institutional and where to go and importance to seek post-natal care.

3.5 Ayushman Bharat:

As recommended by the National Health Policy 2017, Ayushman Bharat, a flagship scheme of the Government of India, was launched to achieve the Universal Health Coverage (UHC) vision. This initiative was designed to meet the SDG and its underlining commitment, "leaving no one behind".

Ayushman Bharat is an attempt to move from a sectoral and segmented approach to providing healthcare to a comprehensive need-based health care service. Ayushman Bharat aims to undertake path-breaking interventions at the primary, secondary and tertiary levels to address health holistically (including prevention, promotion and ambulatory care). Ayushman Bharat adopts a continuum of care comprising of two interrelated components which are:

- Health and Wellness Centres (HWCs)
- Pradhan Mantri Jan Arogya Yojana (PM-JAY)

1. Health and Wellness Centres (HWCs):

The Government of India announced the creation of 1,50,000 Health and Wellness Centres (HWCs) in February 2018 by transforming existing sub-centres and primary health centres. These centres would provide comprehensive primary health care (CPHC) that would bring health care closer to the homes of both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

Health and Wellness Centres are designed to provide an expanded range of services to address the primary health care needs of the entire population in their area expanding access, universality and community-friendly equity. Health promotion and prevention focuses on keeping people healthy by engaging and empowering individuals and communities to choose healthy behaviors and make changes that reduce the risk of developing chronic diseases and morbidity.

2. Pradhan Mantri Jan Arogya Yojana (PM-JAY):

The second component under Ayushman Bharat is PM-JAY, which aims to provide health insurance coverage of Rs. 5 lakhs per family per year for hospitalization in secondary and tertiary care to over 10,74 poor and vulnerable families (about 50 crore recipients). Under the scheme there is no limit on the family size. Before being renamed as PM-JAY, this scheme was earlier known as the National Health Protection Scheme (NHPS). This scheme was launched by Honrable Prime Minister Shri Narendra Modi in Ranchi, Jharkhand, on September 23, 2018.

For the lowest 40 percent of the poor and vulnerable population, PM-JAY was rolled out. The households included are based on the Socio-Economic Caste Census 2011 (SECC 2011) deprivation and occupational criteria for both rural and urban areas. The scheme then subsumed Rashtriya Swasthya Bima Yojana (RSBY), which was launched in 2008. The coverage mentioned under PM-JAY therefore also includes families that were covered by RSBY but were not present in the database of SECC 2011. PM-JAY is fully government-funded, and implementation costs are shared between central and state governments.

Benefit Cover under PM-JAY

Benefit coverage under different government-funded health insurance schemes in India has always been based on an upper ceiling and has varied from an annual coverage of INR 30,000 to INR 3,00,000 per family across different states, creating a fragmented system. PM-JAY provides up to INR 5,00,000 cashless coverage for each eligible family per year for the listed conditions of secondary and tertiary care. The scheme cover includes all costs incurred for the following treatment components.

- Medical examination, treatment, and consultation
- Pre-hospitalization
- Medicine and medical consumables
- Non-intensive and intensive care services
- Diagnostic and laboratory investigations
- Medical implant services (where necessary)
- Accommodation benefits
- Food services
- Complications arising during treatment
- Post-hospitalization follow-up care up to 15 days

Ayushman Bharat PM-JAY was rolled out in the state of J&K in 12th January 2019. The total number of hospitals empanelled under this scheme in J&K is 126 public and 29 private hospitals in which 6,13,697 are total eligible families for PM-JAY (7oct 2019). In district Kulgam the scheme is also playing its role in DH Kulgam, CHC Yaripora, CHC Qazigund and CHC DH Pora with total of 44215 eligible families.

3.6 Reproductive and Child Health Programme (RCH):

The RCH program funded by the World Bank was launched on October 15, 1997. Under the National Rural Health Mission (NRHM), the Reproductive and Child Health Program (RCH) integrates comprehensively interventions that improve child health and address factors that contribute to infant and under-five mortality. Reduction of infant and child mortality was an important concept of the Government of India's health policy and attempted to address the issue right from the early stages of planned development. The National Population Policy (NPP) 2000, the National Health Policy 2002 and the Eleventh Five Year Plan (2007-12) and the National Rural Health Mission (NRHM-2005-2012) laid the child health goals. In addition, the Twelfth Five Year Plan (2012-2017) and the National Health Mission (NHM) set the goal of reducing infant mortality rates (IMR) by 2017 to 25 per 1,000 live births.

The main objective of the program was to bring about a change in mainly three critical health indicators, i.e. to reduce IMR 77 from 68.1 to 56.8 per 1000 live births by 2011, to reduce TFR to 2.1 by 2011, to conduct maternal death audits of 50% of maternal deaths and to improve full ANC coverage from 16.6% to 90%, to improve full immunization coverage from 37% to 100%, Improving the safety of delivery from

33.4% to 80%. It is aimed at achieving the outcomes envisaged in India's MDG, NPP 2002, and Vision 2020.

RCH fulfills the needs of pregnant women, nursing mothers, eligible couples, adolescents and provides safe pregnancy services, ANCs and early recognition of dangerous signals, anaemia prevention and treatment, and tetanus immunization. The most important for them are PNC for nursing mothers, infection prevention, breast care, adequate diet, prophylaxis and anaemia treatment, spacing births, and limited family size.

There will be 24x 7 delivery services at PHCs & CHCs, MTP, and IEC services under the RCH program camps. However, due to the erratic supply of equipment, the RCH program was unable to achieve its goals in Kulgam district; lack of specialist availability, unavailability of blood storage facilities; and poor understanding of program managers at different levels. Currently, the Model Sub Centres in Kulgam district are not functioning due to lack of proper building, labour room, and ANM and male health worker shortages with lack of proper training. Scheme is good, but not implemented from its entirety. A comprehensive strategy is needed to avoid all three delays from household to institutional level (delay in seeking medical care, delay in reaching a treatment facility, delay in receiving adequate treatment at the facility).

3.7 Conclusion:

The main objectives of these programs were to reduce maternal mortality rates, infant mortality rates, neo-natal mortality rates, infant mortality rates under 5, expanded use of maternal services such as janani suraksha yojana, anti-natal care post-natal care, medical pregnancy termination, etc. Improvement in planning to strengthen public sector institutions to match increased demand for services is needed before implementing the changes discussed. Finally, a good start is the National Rural Health Mission.

It is well known that the reproductive health needs of women have not been recognized as a policy concern, nor have they been set within an overall integrated health approach. Full of resounding policy and study silences, misdirected and partial

approaches and insufficient attention to critical issues have been given to women's health. It is clear that there are gaps in implemented policies, their promises of welcoming women are only on documents. Until these gaps are met, programs under these policies will not be able to meet the health needs of the Kulgam district's reproductive-aged women.

Increasing the supply of health care with all different types of inputs is essential to improve women's health status, as a program provides sufficient returns on investment when limited resources are efficiently allocated and used otherwise all resources are wasted.

There are weaknesses in the implementation of health programs in Kulgam district. When services are not properly implemented and managed effectively, the benefits for reproductive-aged women do not increase.

Chapter 4
Availability of Health Facilities in Kulgam District

CHAPTER 4

AVAILABILITY OF HEALTH FACILITIES IN KULGAM DISTRICT

4.1 Introduction:

Health is a key driver of development, so in a welfare country like India, Government needs to play a major role to provide the basic health services to the public in general and poor and needy in particular. Health care includes availability of health facilities, availability of needed drugs, equipment, manpower, and health services at various levels. Health services should be easily accessible and available especially to the under privileged sections of society. Once the basic health care services reaches to all the strata of the society, public health services has to shift its focus from disease prevention to health promotion. To achieve all these goals Government needs to develop adequate health infrastructure. Health infrastructure is an important indicator to understand the healthcare delivery provisions and mechanisms in a country. It also signifies the investments and priority accorded to creating the infrastructure in public and private sectors.

"Availability", as defined by W.H.O, is the ratio between the population of an administrative unit and the health facilities and personnel assigned to it. This, however, is an imperfect measure of the provision of health services and needs to be supplemented by other indicators such as types of communities and types of health agencies. The term "basic health services" is defined by UNICEF and WHO (1965) as a network of co-ordinated, peripheral and intermediate health units capable of performing effectively, a selected group of functions essential to the health of an area and assuring the availability of competent professional personnel to perform these functions. Since time immemorial, extensive health systems have been developed and implemented to handle the needs of population. Different patterns of population settlement call for different patterns of health care. The basic organization of health services should aim at providing primary health care to all inhabitants of a place (Montoya 1985).

A health care system constitutes various components such as infrastructure, human resources, data system and financial system. Adequate infrastructure which includes

building, equipment, supplies and communication equipment forms a crucial part for the health services. (Kieczkowski et al, 1984). Availability of drugs, pharmaceuticals are important service related determinants for the utilization of health services Sauerborn et al. (1989) and Vogel and Stephens (1989).

Generally poor quality of services is due to poor quality of infrastructure, which in turn not only wastes resources but is positively dangerous to the health of the patient and welfare of the community at large. If the government services are not functional or are of poor quality, the poor suffer more as they do not have any other choice. Inadequate priorities for health infrastructure by the health managers and politicians, as well as insufficient funds from the government, are the main causes for the poor state of health infrastructure in many developing countries. Deteriorated health buildings are not only unattractive to the staff and patients but also could become positively dangerous; critical areas such as operation theatres (OTs) and labour rooms could cause life threatening infections if not maintained properly. WHO estimates that less than half of all medical equipment in developing countries is usable (WHO, 1986).If medical equipments in government facilities are not working, poor patients are forced to go to higher levels which are far off or seek medical help from the private sector by paying very high user fee, which contradicts the very purpose of setting up government health facilities. Inadequate and poorly maintained health infrastructure is a major barrier for use of health services in rural areas which primarily focus on maternal and child health services for the poor. Poor infrastructure will therefore be a major obstacle in achieving the millennium development goals.

In the era of globalization, healthcare becomes very important for a nation to make women compatible. Different policies and programmes have been implemented to improve the overall status of women. Women's health issues have attained higher international visibility. After the renewed political commitment in the recent decades, health programmes like NRHM (National Rural Health Mission) at the national, JSY (Janani Suraksha Yojana) and JSSK (Janani Shishu Suraksha Karyakaram) at state level have been undertaken by the governments to improve the health of the people.

Researches on women's health status, show that women have high mortality and morbidity rates (Ichiro Kawachi, Sarah Wamala 2007), particularly during their reproductive years (Sadik& Dr. Nafis. UNFPA,1997). For this purpose availability of

health facility has great importance. The present chapter discusses the availability of health facilities with special reference to reproductive aged women in Kulgam district, including infrastructure, human resource and services.

Health care means looking after women's health in health centres. Health facilities are places that provide health care viz. hospitals, clinics, outpatient care centres and specialized care centres, such as maternity centre etc. The health centre is an institution for promoting the health and welfare services in an area under the direction of health personnel under one roof (Paswan, 1994). Women health interventions require more complex clinical and surgical interventions which depend upon a well functioning health system that provides adequate clinical back-up for outreach interventions.

This chapter has been divided in to Two Sections

Section 1. Status of Health Facilities in India

Section 2. Status of Health Facilities in District Kulgam.

4.2 Section 1. Status of Health Facilities in India:

4.2.1 Indian Health Care System

Health care in India is delivered through a three tier structure of health services comprising the primary, secondary and tertiary health care facilities with the objective of bringing health care services within the reach of the people of both the rural and urban areas. Primary healthcare is the vital strategy that remains the backbone of health service delivery. It was understood as universal health care that is acceptable and affordable to all, comprising the preventive, promotive, curative, and rehabilitative aspects of health and an integrated and comprehensive approach to development of health services. There is widespread and growing demand for primary health care in developing countries, especially in India. India was one of the first countries to recognize the merits of primary health care approach. Primary health care was conceptualized in 1946, three decades before the Alma-Ata declaration. This demand in turn displays a growing eagerness among policymakers and program managers for knowledge related to how health systems can become more equitable,

inclusive, and fair (Alma-Ata 1978). The Declaration of Alma-Ata on Primary Health Care in 1978 guided and directed path for establishing effective primary health care in member countries, especially in India. Alma-Ata Declaration viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that states needed to pursue to achieve the goals of development. The declaration recommended that primary health care should include at least: Education concerning prevailing health problems and methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and promotion of mental health and provision of essential drugs (Alma-Ata 1978). Further, the Bhore Committee (1946) strongly proposed the primary health care approach for effective and equitable health care services despite enormous progress in health service delivery in terms of infrastructure, human resources, and service provision, our collective failures to deliver in line with primary health care values deserve greatest attention. In rural areas, mothers suffer complications of labour without access to qualified support and children missing out on essential vaccinations required serious efforts to rectify the problems associated with these health outcomes. In moving forward, it is important to learn from the past and, on looking back, it is clear that we can do better in the future. Recognizing the importance of health in the process of economic and social development of India, the Government of India has launched the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic health care delivery system in India. The plan of action of NRHM included apart from many other sector reforms, upgrading health centres as per the Indian Public Health Standards (IPHS) (Prahlad Rai Sodani 2012). Ministry of Health and Family Welfare, Government of India, formulated the IPHS and streamlined the requirements of physical infrastructure based on population and human resource requirements for health facilities ranging from the grassroots level sub centres (SCs), primary health centres (PHCs), community health centres (CHCs), as well as hospitals with bed strengths of 31–50, 51–100, 101–200, 201–300, and 301–500 beds, respectively.

The primary tier has been developed to provide health and family welfare related services to the vast majority of rural people. It would have three types of health care institutions, namely, a Sub-Centre (with 3 health workers and 1 voluntary worker for 5000 population in plain area or 3000 population in hilly and tribal area), a Primary Health Centre (for 30000 population in plain area and 20000 population in hilly and tribal area with 4-6 beds, 1 doctor, and 14 other paramedical and supporting staff), and a Community Health Centre (for 120000 population in plain area or 80000 population in hilly and tribal area with 30 beds, 4 medical specialists, and 21 other paramedical and supporting staff). The secondary tier, which is primary to the urban mass, includes medical care provided by the specialists at the district and sub-divisional hospitals. The tertiary health care is to be provided by health care institutions in urban areas which are well equipped with sophisticated diagnostic or super-specialists and investigative facilities at medical colleges and specialised hospitals (GOI, 1997).

However, in spite of a vast network of health care institutions in India, there exists a wide gap between the rural and urban areas in terms of availability and accessibility of health care infrastructure, as the urban areas are found better equipped with these facilities. Moreover, health being a state subject, there are imbalances and variations in availability and accessibility of these services in the rural areas across the states.

Table 4.1 Primary Health Structure and their Population Norms in India, 2018.

Centres	**Population Norms**	
	Plain Area	**Hilly/Tribal/Difficult Areas**
Sub-Centre	**5000**	**3000**
Primary Health Centre	**30,000**	**20,000**
Community Health Centres	**1,20000**	**80,000**

Source: Rural Health Statistics, Ministry of Health and Family Welfare, 2018

Table 4.1 shows the number of persons covered under the services of a particular facility (SC, PHC and CHC). The district level on an average there is a 150 bedded Civil General Hospital in the main district town and a few smaller hospitals and dispensaries spread over the other towns in the district and sometimes in large villages. In the rural areas of the district there are rural hospitals, Community health

centres, primary health centres and sub-centres that provide various health services and outreach services.

The sub-centre is the most peripheral institution and the first contact point between the primary healthcare system and the community. Each sub-centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM)/female health worker and one male Multi-purpose Worker (MPW). A Lady Health Visitor (LHV) is in charge of six sub-centres each of which are provided with basic drugs for minor ailments and are expected to provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control, and control of communicable diseases. Sub-centres are also expected to use various mediums of interpersonal communication in order to bring about behavioural change in reproductive and hygiene practices. The sub-centres are needed for taking care of basic health needs of men, women and children. The Ministry of Health & Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country since April, 2002 in the form of salaries of ANMs and LHVs and rent of the buildings.

Table 4.2 Number of Sub Centres during Plan Periods

Plans	Number of Sub Centres (SCs) in India	Number of SCs in J&K
Seventh Plan (1985-90)	**130165**	**1460**
Eighth Plan (1992-97)	**136258**	**1700**
Ninth Plan (1997-2002)	**137311**	**1700**
Tenth Plan (2002-2007)	**145272**	**1888**
Eleventh Plan (2007-2012)	**148366**	**1907**
Twelth Plan (2012-2017)	**156231**	**2967**
(31st March 2018)	**158417**	**2967**

Source: Rural Health Statistics (MoHFW)

Fig.4.1Number of sub centres in India

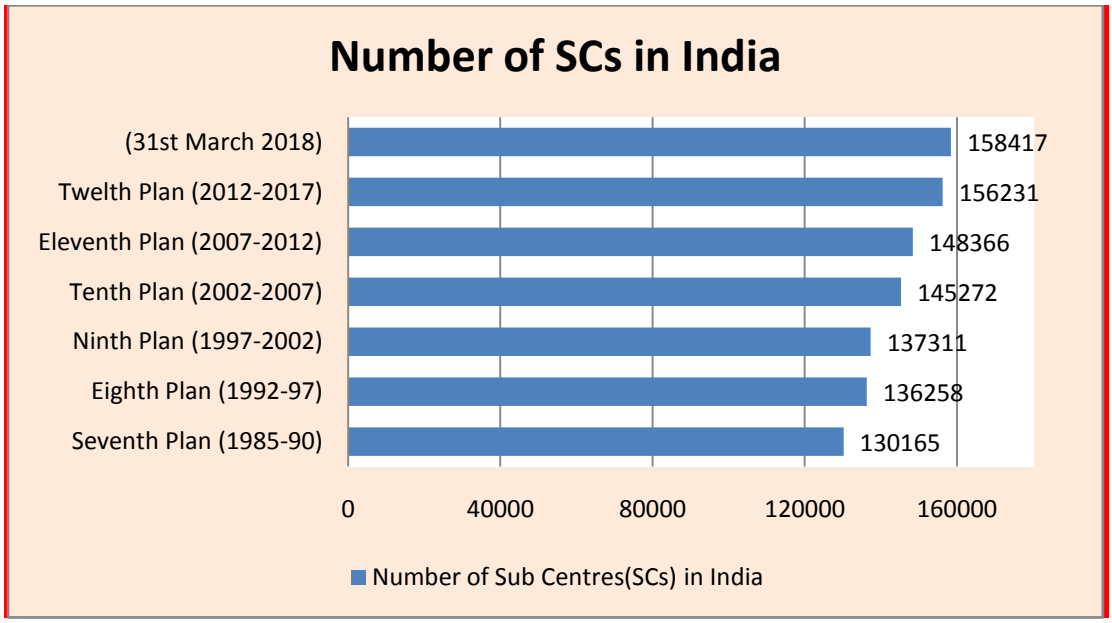


Fig.4.1.1Number of Sub Centres in J&K

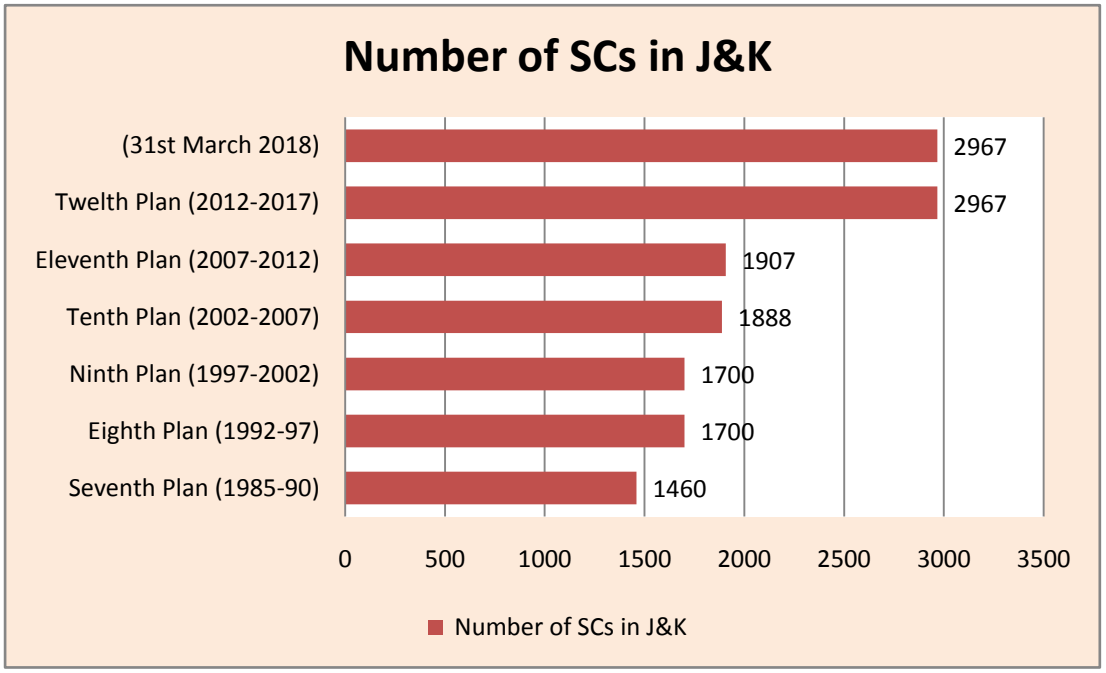


Table 4.2 shows number of SC sub centres in India and Jammu and Kashmir during plan periods. A look at the number of Sub Centres functioning over the years revealed that at the end of the Seventh Plan (1985-90), there were 1,30,165 Sub Centres in India and 1460 Sub Centres in Jammu and Kashmir, which increased to 1,56,231 and 2967 respectively at the end of Twelfth Plan (2012-2017).There are 1,58,417 number of functioning SCs in the country and 2967 in J&K as on 31st March, 2018.There is significant increase in the number of Sub Centres in many states of India which are

Rajasthan (3893), Madhya Pradesh (2318), Gujarat (1878), Chhattisgarh (1382), Karnataka (1300), Jammu & Kashmir (1088), Odessa (761), Tripura (481), Kerala (286) Uttarakhand (271). Although a decrease in number of SCs in few States have also been observed.

Primary Health Centre is the first contact point between village community and the Medical Officer. It comprises the second tier in rural healthcare structure envisaged to provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects. (Promotive activities include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries.) PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS) and are being strengthened under NRHM to provide a package of essential public health services, and support for outreach services including for regular supplies of essential drugs and equipment's, upgrading single doctor PHC to 2 doctors PHC by posting AYUSH practitioners at PHC level, provision of 3 Staff Nurses in a phased manner based on patient load and delivery load. The States/UTs have to incorporate their proposals and requirement of funds in their Programme Implementation Plans under NRHM. As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4-6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Table 4.3 Number of Primary Health Centres during Plan Periods

Plans	Number of Primary Health Centres(PHCs) in India	Number of PHCs in J&K
Seventh Plan (1985-90)	**18671**	**266**
Eighth Plan (1992-97)	**22149**	**335**
Ninth Plan (1997-2002)	**22875**	**337**
Tenth Plan (2002-2007)	**22370**	**374**
Eleventh Plan (2007-2012)	**24049**	**396**
Twelth Plan (2012-2017)	**25650**	**637**
(31st March 2018)	**25743**	**637**

Source: Rural Health Statistics (MoHFW)

Fig. 4.2 Number of Primary Health Centres in India

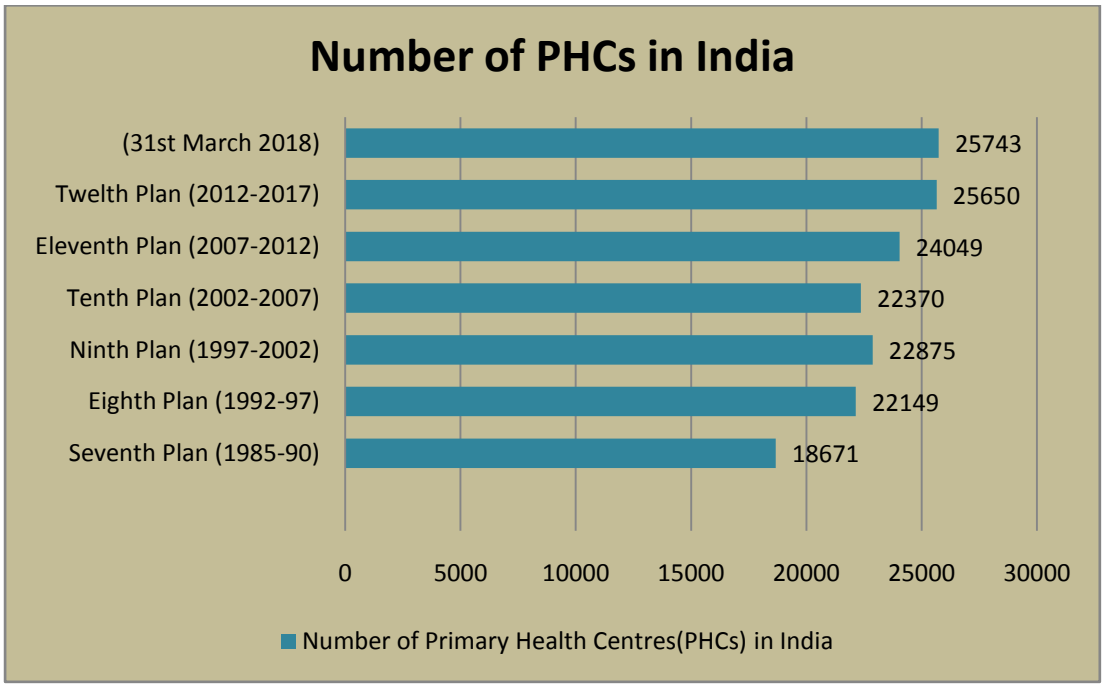
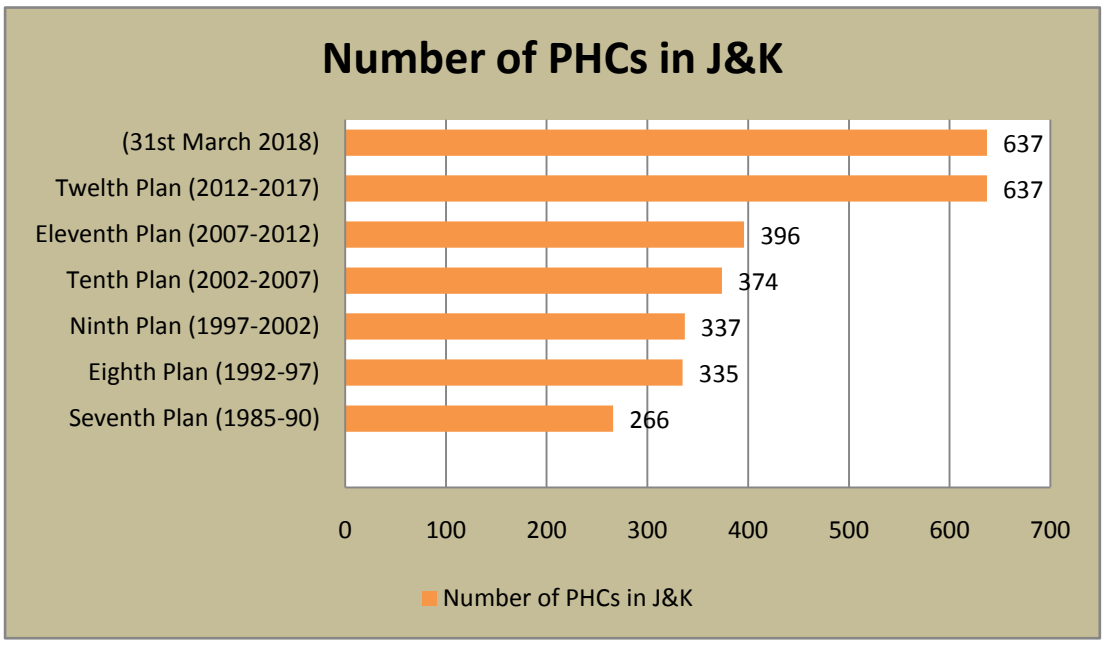


Fig. 4.2.1 Number of Primary Health Centres in J&K



In table 4.3 there is a progress seen in the number of PHCs both in India as well as in Jammu and Kashmir. The number of PHCs was 18671 in India and 266 in J&K at the end of Seventh Plan (1985-90) and almost doubled to 637 in J&K and 25650 at the end of twelfth Plan (2015-17).As on 31st March, 2018, there are 25,743 PHCs functioning in all over India and 637 in J&K. Significant increase is observed in the number of PHCs in the States of Karnataka (678), Gujarat (404), Assam (336),

Rajasthan (365), Jammu & Kashmir (303) and Chhattisgarh (276) and Bihar (251). The marginal decrease is also observed in the State of Assam (68) and Telangana (46).

Community Health Centres (CHC) forming the uppermost tier are established and maintained by the State Government under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). CHC is supposed to be manned by four Medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It normally has 30 indoor beds with one OT, X-ray, and Labour room and Laboratory facilities and serves as a referral centre for 4 PHCs. It provides facilities for emergency obstetrics are and specialist consultations. Indian Public Health standards lays down that this CHC should be manned by 6 Medical Specialists including an Anaesthetics and Gynaecologist supported by 24 paramedical and other staff with inclusion of two nurse midwives in the present system of seven nurse midwives. A CHC is a referral centre for four PHCs within its jurisdiction, providing facilities for obstetric care and specialist expertise. Over the years, the number of PHCs has been upgraded to the level of CHCs in many States.

Table 4.4 Number of Community Health Centres during Plan Period

Plans	Number of Community Health Centres(CHCs) in India	Number of CHCs in J&K
Seventh Plan (1985-90)	**1910**	**33**
Eighth Plan (1992-97)	**2633**	**45**
Ninth Plan (1997-2002)	**3054**	**53**
Tenth Plan (2002-2007)	**4045**	**80**
Eleventh Plan (2007-2012)	**4833**	**84**
Twelth Plan (2012-2017)	**5624**	**84**
(31st March 2018)	**5624**	**84**

Source: Rural Health Statistics (MoHFW)

Fig. 4.3Number of community Health centres in India

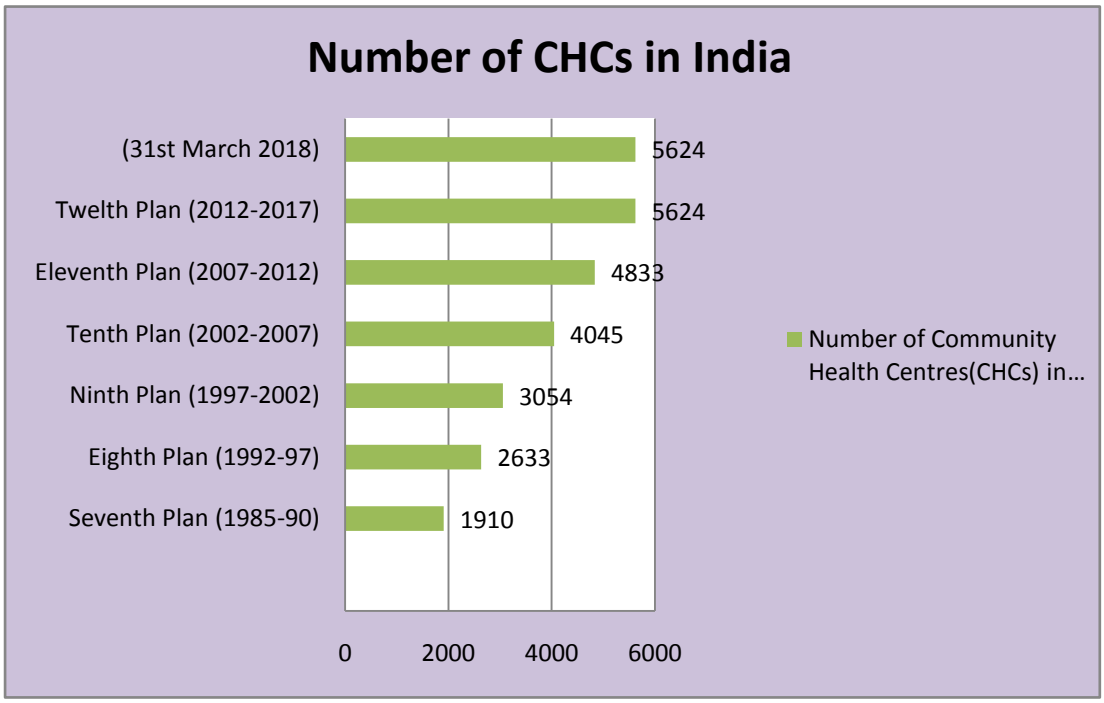
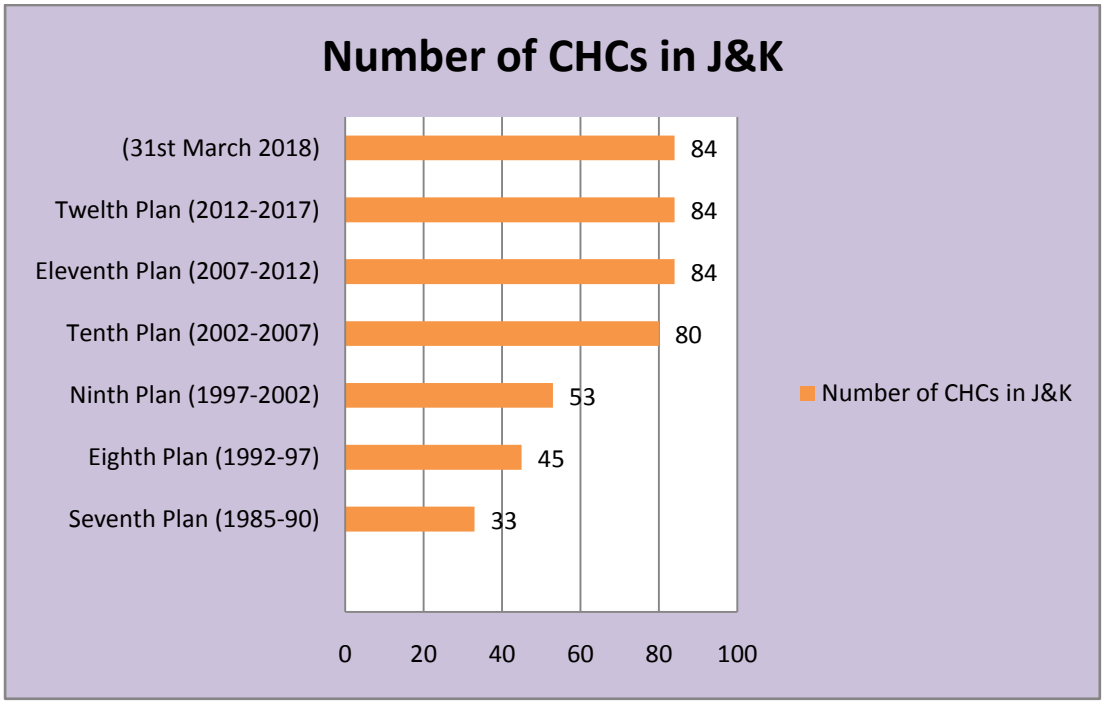


Fig 4.3.1Number of community Health centres in J&K



In accordance with the progress in the number of SCs and PHCs, the number of CHCs has also increased which is clearly shown in table4.4, from 1910 in India and 33 in J&K at the end of seventh Plan (1985-90) to 4833 and 84 respectively at the end of Eleventh Plan (2007-2012). At the end of Twelfth Plan (2012-2017) there were 5,624 CHCs in India and 84 in J&K. As on 31st March, 2018 total number of CHCs

functioning at the country are 5624 and 84 in J&K. Significant increase is observed in the number of CHCs in the States of Uttar Pradesh (436), Tamil Nadu (350), West Bengal (253), Rajasthan (253), Odessa (146), Jharkhand (124), Kerala (121), Gujarat (91) and Madhya Pradesh (80). The marginal decrease is also observed in the State of Telangana (46) and Jharkhand (17).

4.2.2 Year wise (from 2005 to 2018) increase in number of Health facilities (SCs, PHCs & CHCs) catering to the Rural areas in the India.

Table 4.5 Number of Sub Centres in India, J&K and Kulgam during years (2005 to 2018)

Year	Number of Sub centres (SCs) in India	Number of Sub Centres in J&K	Number of Sub Centres in Kulgam
2005	**146026**	**1897**	**NA**
2006	**144988**	**1897**	**NA**
2007	**145272**	**1888***	**NA**
2008	**146036**	**1907**	**NA**
2009	**145894**	**1907**	**NA**
2010	**147069**	**1907**	**81**
2011	**148124**	**1907**	**81**
2012	**148366**	**1907**	**81**
2013	**151684**	**2265**	**81**
2014	**152326**	**2265**	**91**
2015	**153655**	**2265**	**91**
2016	**155069**	**2805**	**123**
2017	**156231**	**2967**	**133**
2018	**158417**	**2967**	**133**

Source: Rural Health Statistics (MOHFW))
*number of SCs upgraded to the level of PHCs

Table 4.5 shows the total number of Sub centres in India, J&K and Kulgam. The total number of Sub Centres in India in the year 2005 was 146026 and then increased to 153655 in 2015 and in the year of 2018 the total number of Sub Centres in all over India is 158417. In State J&K the number of Sub Centres increases from 1897 in 2005 to 2265 in 2015 and in 2018 the total number of Sub Centres in J&K was 2967. From the table above table in case of district Kulgam the data is not available till the year

2009 the reason for not availability of data is that district Kulgam is a district which was created in 2007 carved out from district Anantnag one of the 22 districts of J&K. The reason for not availability of data for district Kulgam is its existence. From 2010 the total number of Sub Centres in Kulgam was 81 and the numbers did not increased upto 2014. In 2014 the number was increased to 91 and in 2018 the number of Sub Centres in total is 133.

Fig. 4.4 Increase in Number of Sub Centres in India during 2005 to 2018

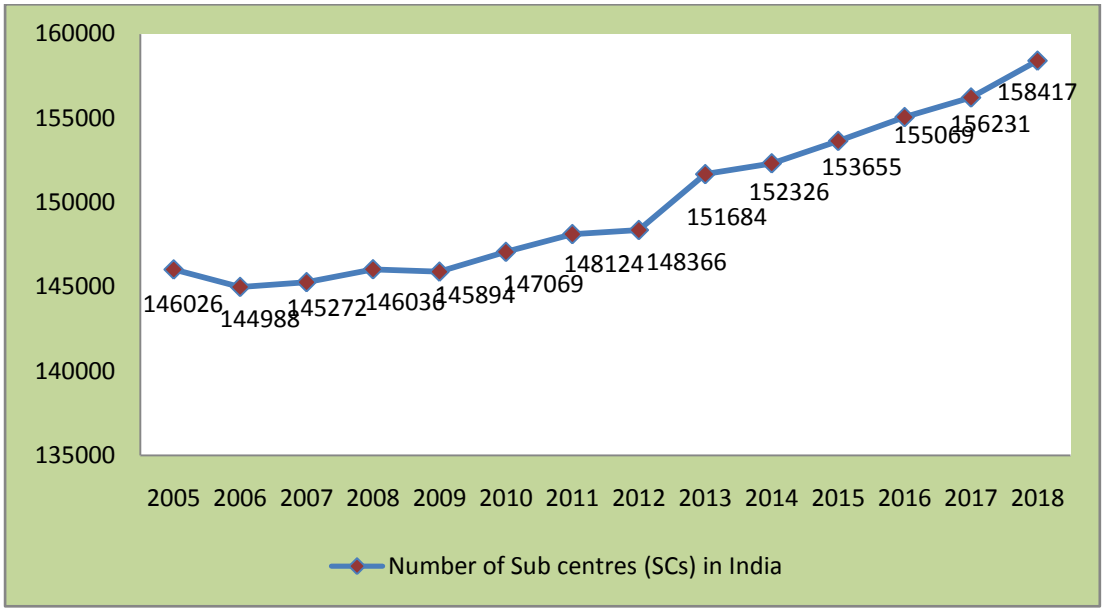


Fig.4.4.1 Increase in number of Sub Centres in Jammu and Kashmirduring 2005 to 2018

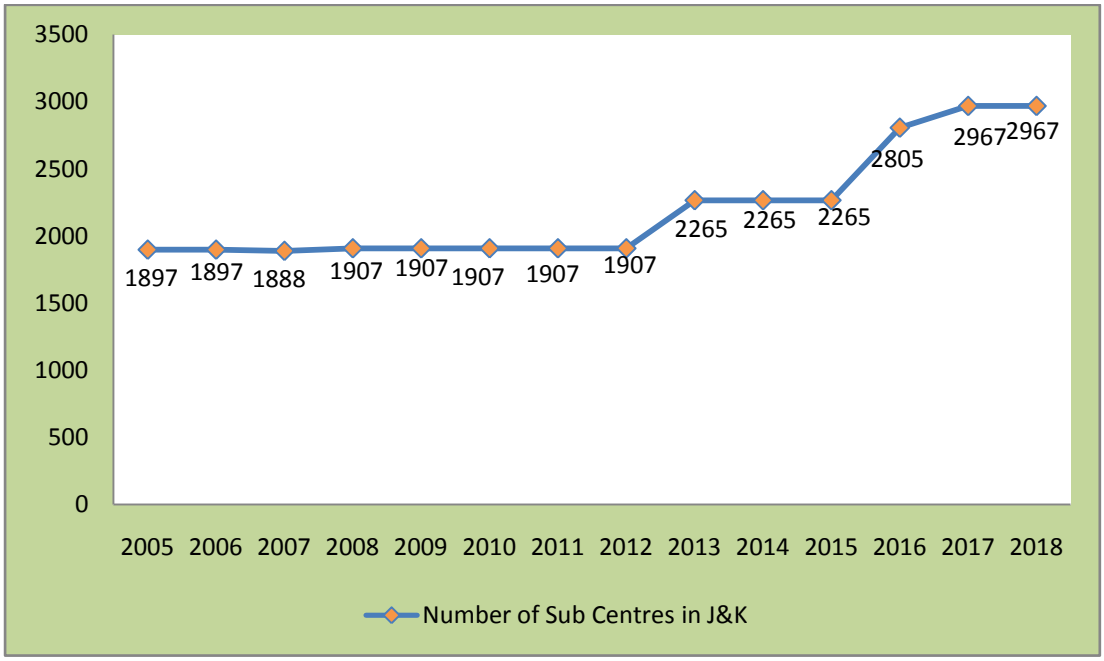


Fig. 4.4.2 increase in number of Sub Centres in District Kulgam during 2005 to 2018

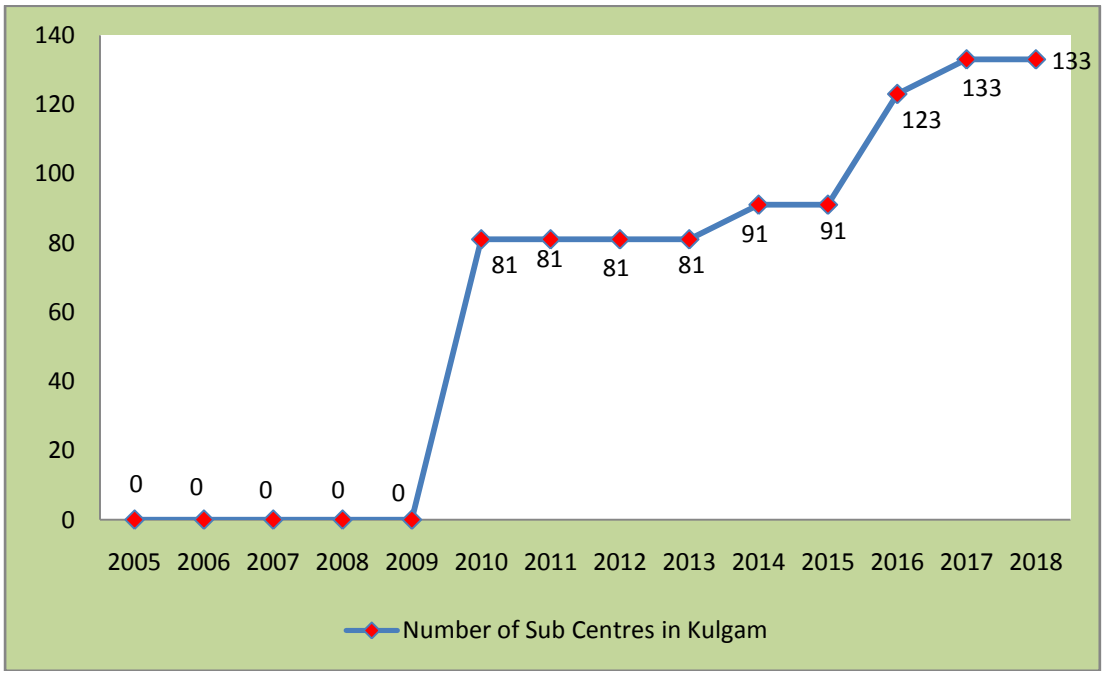


Table 4.6 Number of PHCs in India, J&K and Kulgam during years (2005 to 2018)

Year	Number of Primary Health Centres (PHCs) in India	Number of PHCs in J&K	Number of PHCs in Kulgam
2005	23236	334	NA
2006	22669	334	NA
2007	22370	334	NA
2008	23458	375	NA
2009	23391	375	NA
2010	23673	375	15
2011	23887	397	19
2012	24049	396	19
2013	24448	637	19
2014	25020	637	28
2015	25308	637	28
2016	25354	637	28
2017	25650	637	28
2018	25743	637	28

Source: Rural health statistics (MOHFW)

From the above table 4.6, it is clearly seen that the PHCs in India during the year 2005 was 23236 which increase to 25650 in 2015. In the year 2018 the total number of PHCs in India was 25743. Similarly in J&K the number of PHCs increased from 334 in 2005 to 637 in 2018.In Kulgam district the number of PHCs was19 in the year of 2010 and then increased to 28 in the year 2018.

Fig. 4.5 Increase in number of PHCs in India during 2005 to 2018

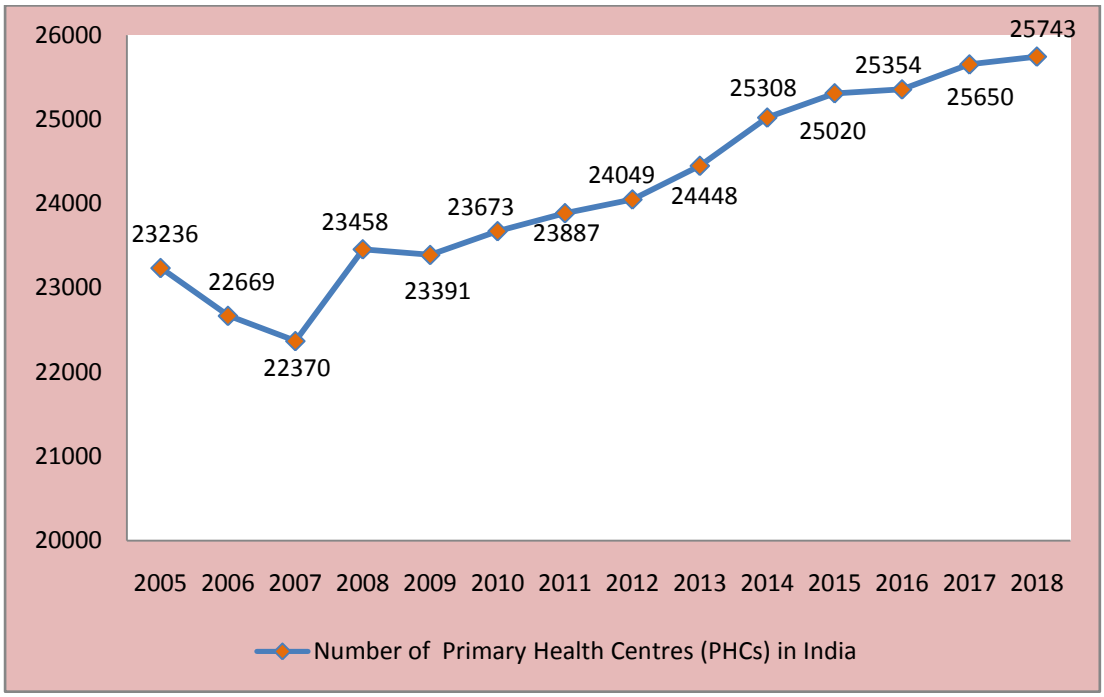


Fig.4.5.1 Increase in number of PHCs in J&K during 2005 to 2018

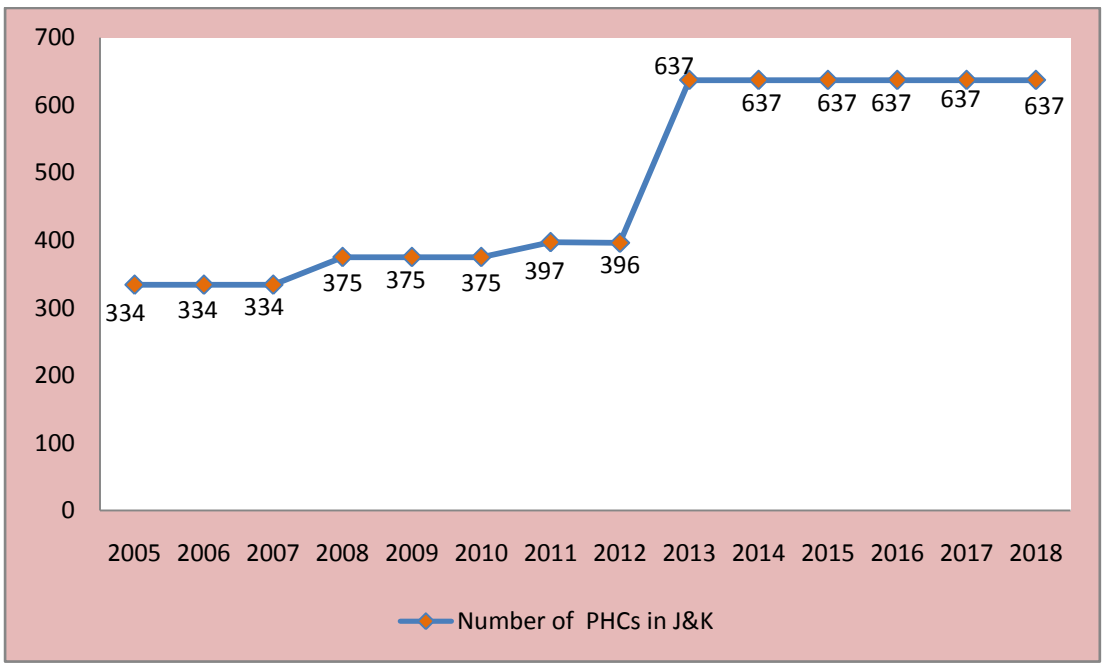


Fig. 4.5.2 increase in number of PHCs in Kulgam during 2005 to 2018

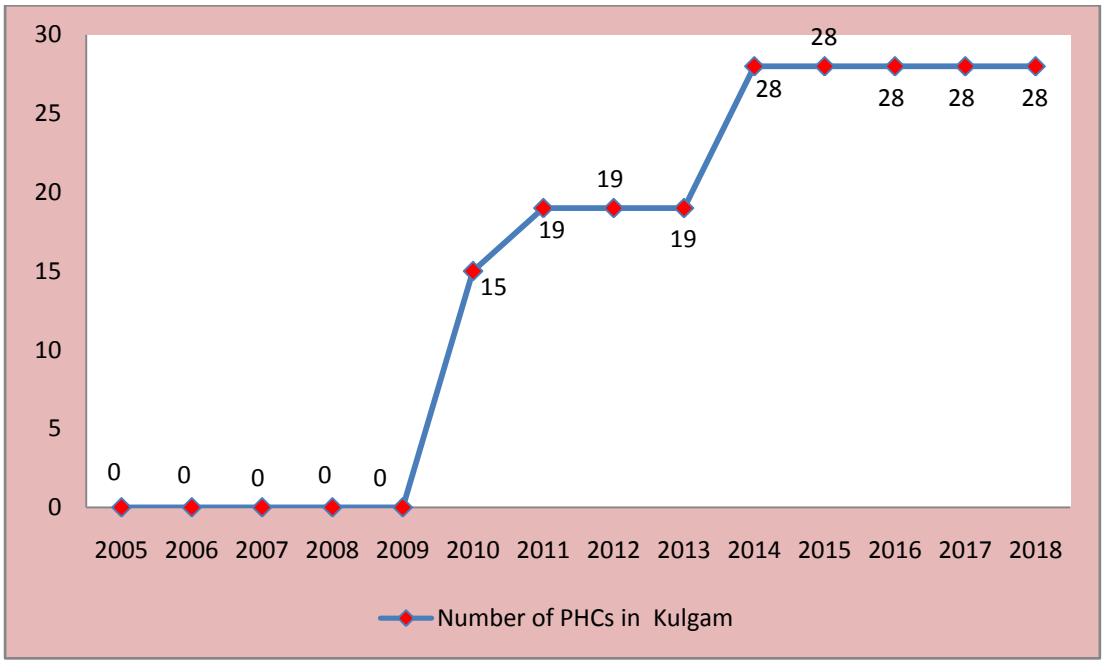


Table 4.7 Number of CHCs in India, J&K and Kulgam during years (2005 to 2018)

Year	Number of Community Health Centres(CHCs) in India	Number of CHCs in J&K	Number of CHCs in Kulgam
2005	3346	70	NA
2006	3910	70	NA
2007	4045	80	NA
2008	4276	85	NA
2009	4510	85	NA
2010	4535	77*	3
2011	4809	83	3
2012	4833	84	3
2013	5187	84	3
2014	5363	84	3
2015	5396	84	3
2016	5510	84	3
2017	5624	84	3
2018	5624	84	3

Source: Rural Health Statistics (MOHFW)
Note:*8CHCs upgraded to the level of District Hospital

Table 4.7 shows the total number of CHC in India, J&K and district Kulgam. It is clearly seen from the table that the total number of CHCs in India was 3346 in 2005 which increases upto the number 5624 in the year 2018. Same is the case of J&K; the total number of CHCs was 70 in 2005 which increase to 84 in 2018. In Kulgam there were 3 CHCs from 2010 and in present still there are 3 CHCs working.

Fig. 4.6 Increase in number of CHCs in India during 2005 to 2018

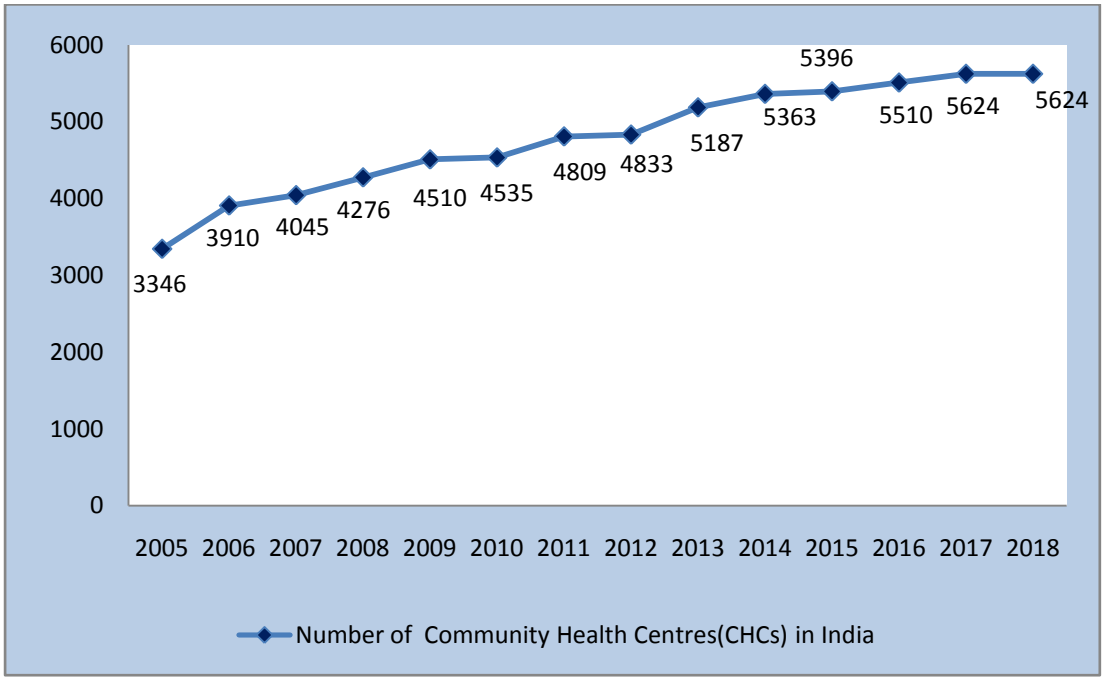


Fig. 4.6.1 Increase in number of CHCs in J&K during 2005 2018

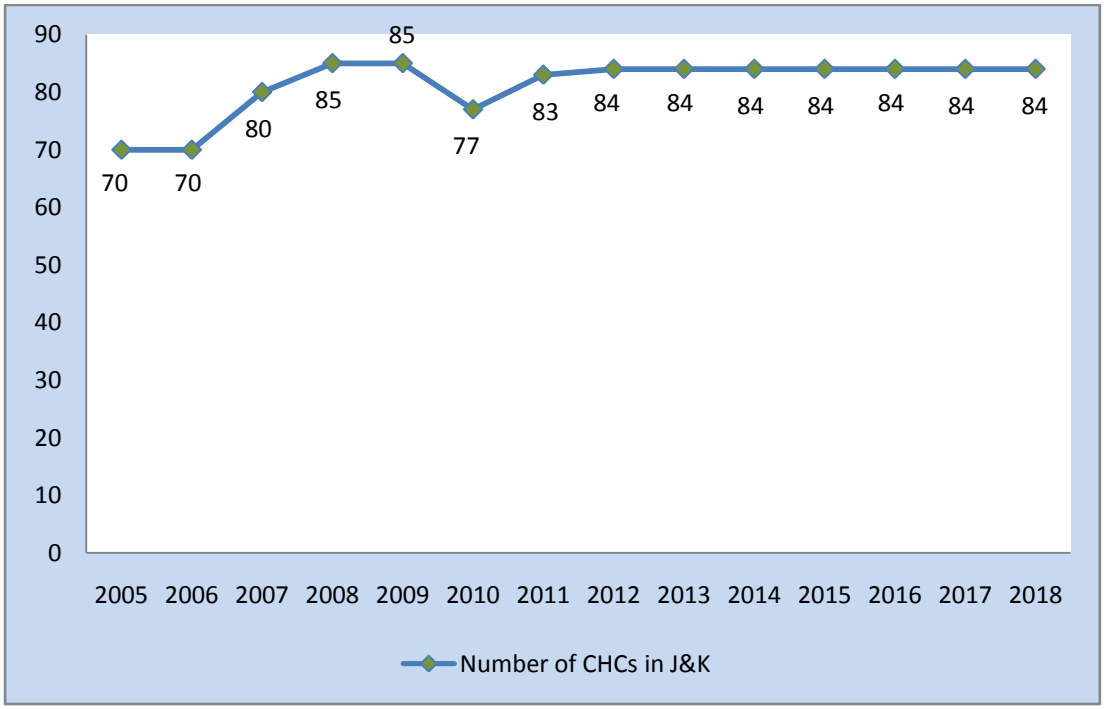
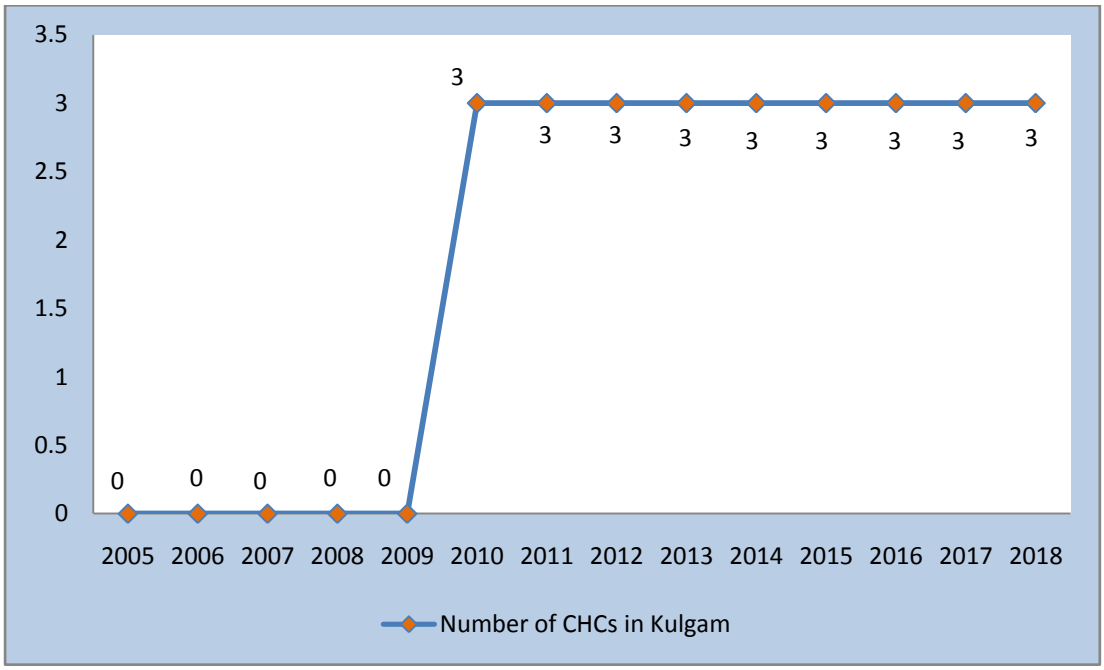


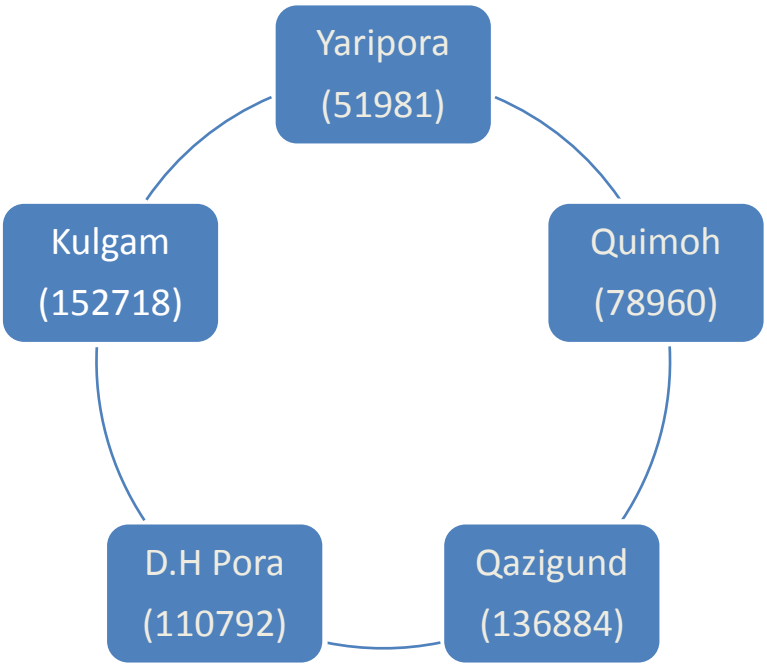
Fig. 4.6.2 increase in number of CHCs in Kulgam during 2005 to 2018



4.3 Section 2. Status of Health Facilities in District Kulgam:

4.3.1 Analysis of Health Facilities in District Kulgam Below flow chart shows sample population of district Kulgam which has been collected from five medical blocks which are: Kulgam, Yaripora, Qazigund, Quimoh , and DH-Pora

Fig 4.7 Flow chart of sample Population from District Kulgam



4.3.1.1 Distribution of Health Centres in district Kulgam

Table 4.8 total number of population covered by Health Centres

Health Centres	Total population (A)	Number of Health centres (B)	Population covered (A:B)
DH	**531335**	**1**	**5,31,335**
CHCs	**531335**	**3**	**1,77,112**
PHCs	**531335**	**19**	**27,965**
NTPHCs	**531335**	**9**	**59,037**
SCs	**531335**	**117**	**4,541**

Source: data from CMHO office Kulgam
Note: Calculation Done by Author

The above table shows the distribution of health facilities with total population. It is clearly seen that there are only three CHC's in district Kulgam. And the ratio of population per CHC is 177112. Similarly, ratio of population per PHC is 27965. And for SC's it is 4541. All the ratios clearly show that dependency on available health facility is very high. There is need for more establishments of Health facilities in district Kulgam.

Estimation has been calculated from the below:

District Hospital $= \frac{\text{Total Population}}{\text{Total number of DH's}} = \frac{531335}{1} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (1)$

Community Health Centre $= \frac{\text{Total Population}}{\text{Total number of CHC's}} = \frac{531335}{3} \ldots\ldots\ldots\ldots\ldots\ldots (2)$

Primary Health Centre $= \frac{\text{Total Population}}{\text{Total number of PHC's}} = \frac{531335}{19} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (3)$

New Type Primary Health Centre $= \frac{\text{Total Population}}{\text{Total number of NTPHC's}} = \frac{531335}{9} \ldots\ldots\ldots (4)$

Sub Centre $= \frac{\text{Total Population}}{\text{Total number of SC's}} = \frac{531335}{117} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (5)$

Where,

Total Population: refers to total population of the district Kulgam

Total number of DH's: total number of District Hospitals in district Kulgam =1

Total number of CHC's: total number of Community Health Centres = 3

Total number of PHC's: total number of Primary Health Centres = 19

Total number of NTPHC's: total number of New Type Primary Health Centres = 9

Total number of SC's: total number of Sub Centres =117

The above table 4.8 shows the distribution of health facilities with total population. It is clearly seen that there are only three CHC's in district Kulgam. And the ratio of population per CHC is 177112. Similarly, ratio of population per PHC is 27965. And for SC's it is 4541. All the ratios clearly show that dependency on available health facility is very high. There is need for more establishments of Health facilities in district Kulgam.

4.3.2 Availability of Health Infrastructure in Kulgam district

Health care is broadly divided into two sectors: the public and private sectors. Public health services generally consist of the following 'step-up referral' network of Sub Centres, Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs). Public health facilities are allocated on the basis of population-based norms and/or basis of specific geographic area. Rural areas mostly have health centres like PHCs and Sub Centres which provide care largely through paramedics. Special feature of public health services is mass healthcare programmes, largely of a preventive and promotive nature like Selected Disease Control Programmes, FP and RCH Programmes. Private sector includes private owned hospitals, private clinics, medical laboratories; services from physicians, support staff, nurses, therapists, psychologists, dentists, ophthalmologist, paramedics, pharmacists, or even a practitioner who is not qualified.

Table 4.9 Details of health institutions in Kulgam district in total

S.No.	Description	Magnitude (No.)
1.	**District Hospital**	**1**
2.	**Sub District Hospital/CHCs**	**03**
3.	**Primary Health Centres**	**19**
4.	**New Type P.H.Cs**	**9**
5.	**Health Sub Centres**	**117**
6.	**Subsidiary Health Centre & Trauma Centre**	**01**
7.	**Ayurvedic /Unani Dispensaries / Ayush Unit**	**22**
	Total	**189**

Source: CMHO office Kulgam 2019

Table 4.10 Number of Medical/Paramedical Personnel

S.No.	Description	Magnitude (No.)
1.	Doctors	159
2.	Nurses/Sisters	76
3.	Pharmacists	112
4.	Dental Assistants	14
5.	Sanitary Inspectors	06
6.	Health Inspectors	07
7.	Basic Health Workers	20
8.	Lady Health Visitors	10
9.	Auxiliary Nurse Midwives/Dais	272
10.	X-Ray Technicians	17
11.	Health Educators	06
12.	Nursing Orderlies	104
13.	Dawasaaz	20
14	Unani Pharmacists/Nursing Orderlies	19
	Total	810

Source: CMHO office Kulgam

4.3.3 Health care infrastructure of Kulgam district in Public Sector

One of the 21 targets of WHO state that, "by the year 2010, people in the given region of a community should have much better access to family and community oriented primary health, supported by a flexible and responsive hospital system". The performance of a health system affects people's lives and livelihood (WHO 2000). For better performance, the NRHM started operating from May 2005 to increase public spending on health sector. To achieve the goals of MDG and associated national and state goals of NPP 2000 and NHP, there is a need to bring these centres to Indian Public Health Standards (IPHS) in phased manner as the existing institutions have different levels of functional status. The public health care infrastructure of Kulgam district has been developed as a three-tier system. In Kulgam district, projected population in 2018-19 is 5,31,335. According to IPHS norms the Kulgam district should have 6 CHCs, 26 PHCs and 177 Sub Centres. But the real situation is as below in table:

Table 4.11 Availability and shortfall of Public Health Facilities in Kulgam district

S. No.	Particulars	IPHS norms (Required)	Availability (In position)	Shortfall
1.	Sub Centre	177	117	60
2.	PHC	26	19	7
3.	CHC	6	3	3
4.	ANM at CHC	21	9	12
5.	ANM at Sub Centre	231	231	0
6.	Gynaecologist at CHCs	3*	1	1
7.	Doctor at PHCs	38	56	0
8.	Total Specialists	18	16	2
9.	ASHA	531	650	0

Source: CMHO office Kulgam, 2019*According to available CHCs
Note: Calculation Done by Author

Shortfall estimation has been calculated from the below

$$\text{Sub Centre} = \frac{\text{Total Population}}{3000} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (6)$$

$$\text{Primary Health Centre} = \frac{\text{Total Population}}{20000} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (7)$$

$$\text{Community Health Centre} = \frac{\text{Total Population}}{80000} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (8)$$

Where,

Population total: refers to total population of the district Kulgam

3000, 20,000 and 80,000: refers to population norms as per IPHS for sub centres, PHC and CHC.

Sub centre: At the grass-root level, sub centre provides all the primary health care services in which some particular importance are the packages of services, specifically immunization, antenatal, natal and postnatal care, prevention of malnutrition and common childhood diseases, FP services and counselling etc. They also provide elementary drugs for minor ailments such as ARI, diarrhea, fever, worm

infestation etc. Besides the above, the government implements several National Health and Family Welfare Programmes which again are delivered through these frontline workers of Sub Centre.

As on August 2019, a total of 117 Sub Centres are functional in the Kulgam district. The success of any health programme largely depends on the well-functioning of Sub Centres. But the existing services provided by Sub Centres are below the expectation and not up to the standards of IPHS. The district has shortfall of 66Sub Centres. In Kulgam district, the building, manpower, instruments and equipment's, drugs and other facilities of the Sub Centres are not sufficient to provide quality health care and are not sensitive to the specific needs of women. Due to absence of male health workers at Sub Centres, most of the Sub Centres are running with just one ANM.

Kulgam district has 231 ANMs in the Sub Centres, there is not any shortfall found in case of ANM at sub centres. The centres are usually open for half of the day, just for two or three days in a week, which is sufficient for the treatment of all the health problems suffered by women. An ANM spends her maximum time in field visits followed by record keeping, attending meetings, immunization and clinic work. Much of the ANMs time is spent in travelling; in this situation availability of health service provider at Sub Centre is more difficult. No deliveries take place at these centres. They are not trained enough to measure even basic things like blood pressure or even haemoglobin estimation for anaemia.

In Kulgam district, according to NFHS-4, more than 70% population residing in rural areas, for women's health, ANM is considered as the first person who fulfils the demand of health services. At the contact point between the primary health care system and the women, ANM faces so many challenges from both demand and supply side; initially there have been no key person specially to provide care counsellor for women suffering from Reproductive Health Problems. Because they have no techno-medical knowledge regarding their health needs; even the ANMs and LHVs are not able to well deliver the services to women. ANMs are untrained to treat women's special needs, and most Sub Centres are not equipped for deliveries.

Primary Health Centre: The concept of PHC is given by Bhore committee in 1946 and is not new in India. The concept of PHC is to provide a basic health care unit as close to the people as possible, an integrated curative and preventive health care to the

rural population with emphasis on preventive and promotive aspect of health care. The PHC cover a population of 20,000 to 30,000. Applying current norms of IPHS for a PHC to the population projected for the year 2018-19 of Kulgam district, it is estimated that the district has a shortfall of 7 PHCs. The numbers of PHCs functioning in Kulgam district are 19.PHCs are keystone of rural health services- a first port of call to a qualified doctor of the public health facilities in rural area for the sick (female) and those who directly report or referred from Sub Centres.

In district Kulgam, PHCs are not spared from issues such as the inability to perform up to the expectation due to (i) non-availability of doctors at PHCs (ii) even if posted, doctors do not stay at the PHC HQ (iii) inadequate physical infrastructure and facilities (iv) insufficient quantities of drugs (v) lack of accountability to the public and lack of community participation (vi) lack of set standards for monitoring quality care etc.

Community health centre: The Community Health Centre (CHC), the third tier of the network of rural health care institutions, was required to act primarily as a referral centre (for the neighbouring PHCs, usually 4 in numbers) for the patients requiring specialised health care services. The objective of having a referral centre for the primary health care institutions was two-fold; to make modern health care services accessible to the rural people and to ease the overcrowding in the district hospitals. The CHCs were accordingly designed to be equipped with: four specialists in the areas of medicine, surgery, paediatrics and gynaecology; 30 beds for indoor patients; operation theatre, labour room, X-ray machine, pathological laboratory, standby generator, etc., along with the complementary medical and para medical staff.

A CHC is responsible for 1,20,000 population in plain areas and 80,000 population in hilly/tribal/difficult areas. The establishment as well as the maintenance of CHCs are under the hands of state Government under Minimum Needs Programme/Basic Minimum Service Programme. There are only 3 CHCs which are currently operational in district Kulgam but the number of requirements of CHCs in Kulgam is 6 according to guidelines given by IPHS (Indian Public Health Standards). These 3 CHCs are located in three medical blocks of District Kulgam which are Yaripora, Qazigund and D.H Pora. According to IPHS norms Kulgam district with 3 operational CHCs requires 3 surgeons and there are 3 surgeons present, but the condition of CHC

D.H Pora is appalling with no surgeon and no gynaecologist. In the case of Physician only one is posted in CHC Yaripora hence there is a shortfall of 2 Physicians in CHCs of Kulgam district. Similarly, in case of paediatricians on 2 are posted and CHC D H Pora is again in shortfall. Women should increase the utilization of health facilities in order to get overall improvement of women health. Utilization of Public Health facilities depends on the availability of Obstetricians and gynaecologist. There are only 2 gynaecologists in CHC Yaripora and CHC Qazigund. There are FRU, but no institution is functioning as FRU and there is no facility of blood transformation service.

First Referral Units (FRUs): The facility which is existing (District Hospital, Primary Health Centre, Community Health Centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU: i) Emergency Obstetric Care including surgical interventions like caesarean sections; ii) new-born care; and iii) blood storage facility on a 24-hour basis**.**

There is a benchmark set by Ministry of Health and Family Welfare (GOI), for the Health Facilities which are functioning as FRUs. In the year of 2017-18 the functionality of First Referral Units (FRUs) as in hilly states are that for District Hospital an average of 6 C-sections per month and for CHC in an average 3 C-section per month should be done. But the situation is different in district Kulgam here out of 3 CHCs, which are CHC Qazigund, CHC Yaripora and CHC DH Pora only CHC Qazigund performs this function. The following table given below shows the total number performances of FRUs in Kulgam district:

Table 4.12 total number of performances of FRUs in Kulgam district

Name of designated FRU	Total Deliveries 2017-18	Total C-Section 2017-18	Average C-Sec. per month	FRU Functional as per benchmark
DH Kulgam	**2570**	**1009**	**84**	**Yes**
CHC DH Pora	**459**	**0**	**0**	**No**
CHC Yaripora	**83**	**0**	**0**	**No**
CHC Qazigund	**207**	**70**	**6**	**Yes**
Total	**3319**	**1079**	**90**	**..**

Source: JKNHM Programme Management Unit (Maternal Health) 2018-19

It is evident from the above table that in district Kulgam on one CHC out of 3 CHCs perform function of FRU. As per the benchmark set up by the MoHFW, GOI only CHC Qazigund and DH Kulgam perform the function. According to the data of 2017-18 the total number of deliveries was 3319 in which highest number was of DH Kulgam which was 2570 followed by CHC DH Pora 459 and the CHC Qazigund with 207 and then CHC Yaripora with 83 total number of deliveries were done. The C-sections in total was 1079 in which 1009 were done in DH Kulgam and 70 were taken in CHC Qazigund. The above data shows the condition of Health facility which performs as FRU in Kulgam district.

District Hospital: A District Hospital functioning as a secondary level referral centre for the Public Health Facilities below the district level, such as CHCs, PHCs and SCs. In recent past, States have recognized their service structure in order to bring all health care programmes in a district under unified control. It receives information from the state level and transmits the same to the periphery by suitable modifications to meet the local needs. District health system is the fundamental basis for implementing various health policies and programmes or delivery of health care.

District Hospital is an essential component of the district health system which provides curative, preventive and promotive healthcare services to the people in the district. Every district is expected to have a District Hospital linked with the public hospitals. Various specialists like surgeons, physicians, obstetricians and gynaecologists, paediatricians, orthopaedic surgeons, ophthalmologist, anaesthetists, ENT specialists and dentists have been placed in the district headquarter hospital.

The functioning of the district hospital Kulgam in the public sector is not up to the expectation especially in relation to availability, accessibility and quality, bed strength, drug supply, equipment supply, the staff strength and service availability. The bed strength of DH Kulgam is 72 beds. District hospital has one separate operation theatre especially for gynaecological purpose, laboratories, X-ray and ultrasound are available, one aseptic labour room, linkage with District Blood Bank. Only District Hospital has Blood bank facility in the district.

District Hospital Kulgam has 2 Gynaecologists, 2 Anaesthetist, 2 Surgeons, 2 Physicians, 1 Pediatrician, 1 ENT specialist, 2 Dentists and there is not any Pathologist in DH Kulgam. OPD services, Emergency services and referral services are also available. MCH, normal and assisted delivery services and Emergency Obstetric Care including C-section are available. MTP facility and facility under JSY are also available.

From the above data it is clear that in Kulgam district, there is a huge challenge to meet the shortfall for rural health infrastructure, specially the manpower. To rectify the mismatch between the number of specialists needed, and the availability in different disciplines, in order to meet the requirements of the Public Health Facilities, certain policy initiatives are immediately needed. Additional Sub Centres, PHCs and CHCs required to meet population norms. Inadequacies in the existing health infrastructure have led to an unmet need of health services, and obvious gaps in coverage and outreach.

Available health care centres are overburdened and are struggling to provide services with limited personnel and equipment. The health service providers lack motivation to work in rural areas. This is also a kind of insensitivity to the client's needs on the part of the government. A more flexible approach, which is client centric, need based and which extends basic reproductive health services through mobile clinics with lady medical officer and counselling services is to be promoted.

4.3.4 State and District Kulgam scenario in reference to Infrastructure, staff and services, accessibility and Programmes in Health Centres.

Table 4.13 percentage of infrastructure, accessibility and programmes in J&K and Kulgam

S.no	Particulars	J&K*	Kulgam**
1.	PHCs functioning on 24x7 bases (%)	32.4	78.9
2.	CHCs having 24x7 delivery services (%)	84.9	100
3.	PHCs having referral services for pregnancies (BEmOC) (%)	51.4	0
4.	CHCs having functional operation theatre (%)	58.9	33.3
5.	CHCs having obstetrician/gynaecologist (%)	45.2	33.3
6.	PHCs having lady medical officer (%)	39.2	57.9
7.	PHCs having new born care services (%)	66.7	0
8.	CHCs designated as FRUs (%)	71.2	100
9.	CHCs designated as FRU offering caesarean section (%)	20.4	0
10.	FRUs having Blood storage facility (%)	15.4	0
11.	Number of villages having ASHA (%)	78.6	100
12.	Villages having beneficiary under JSY (%)	28.5	97.8

Source: * DLHS-3 and **data collected from CMHO office of district Kulgam

From the above table 4.12, it is clear that Kulgam district shows better situation from the average of Jammu and Kashmir in respect of percentage of PHCs functioning on 24x7 bases, CHCs having 24x7 delivery services, number of villages having ASHA and percentage villages having beneficiary under JSY. But Kulgam district is not good enough in case of CHCs having functional operation theatre. Percentage of gynaecologist in CHCs and percentage of PHC having referral services for pregnancies (BEmOC) Basic Emergency Obstetric Care. Kulgam district is far away from J&K. All these facilities are very important for the improvement of women's Health status

4.3.5 Role of Public Sector in District Kulgam

Role of public sector in health is very clear and which cannot be avoided. The public sector has to bear the overall responsibility for improving the health of the community. Health is considered as "merit good". Some specific interventions in health like women health which in turn will improve family health are also like "public goods" with high positive externalities. The provision of health under public sector is a responsibility given by the Central government, State government and Local government. Indeed, women health can lead to conditions in which rapid economic growth is possible.

The primary health infrastructure in the district Kulgam has grown after the formation of district in 2007 carved out from district Anantnag. As for personal health, government health services are obviously not sufficient and are inadequate as discussed above. It is clearly indicated that the growth in Public Health sector is less than the growth of population or its demand for health facilities. Women health is compromised by rapid population growth, directly because of the lack of quantitative and qualitative expansion of health services which are required.

The availability of basic health services required for women's health are provided through public sector like Maternal and Child Health, ANC (Anti Natal Care), PNC (Post Natal Care), vaccination, Family Planning and safe abortion services which specially target the mother's health and population control. Additional services are provided for target group through adolescent health services, health education by (IEC) Information, Education and Communication and curriculum of schools,

universities and technical education of health personnel. Malnutrition is being addressed by ICDS (Integrated Child Development Services), JSY (Janani Suraksha Yojana) programme etc. Effective implementation of these health services is critically dependent on the availability of an ANM (Auxiliary Nurse Midwife) in every Sub Centre, doctor at PHC, gynaecologist at CHC, and fully functional DH, equipped and basic amenities with required medicines.

The study conducted in district Kulgam observed that the Public Health Facilities have not been able to provide adequate health coverage, because they are poorly staffed, poorly equipped and lack in basic amenities, supporting infrastructure and security. Better quality of services would have a higher utilisation rate and this is very important from the policy point because unless the public is satisfied with the provided services by the government, the targets are not achieved.

4.3.6 Role the Private Health Sector in District Kulgam

In general, the Private health sector has assumed significant importance through a wide network**.** Private health sector caters to the needs of people and has expanded widely to meet increasing demand for health like reproductive aged women's specific demands for maternal morbidity, gynaecological morbidity, contraceptive morbidities and other morbidities which affect both sex but have different effect on females.

There is one private hospital situated in district Kulgam but it is functionless. There are number of private Clinics which are currently working in Kulgam district. These clinics are located in different medical blocks of Kulgam district. Even the number of private clinics are increasing due to various factors, such as effective changes in health, lack of proper treatment in Government hospitals due to overloaded patients, interest and satisfaction of the people etc. It is seen that private health facilities are more interested in establishing themselves in developed areas. Whereas their true requirement is in remote areas where there is only PHC or SC available. Hence people of these areas continue to receive limited and substandard health care as opposed to people living in urban areas or medical blocks where they receive better medical facilities. Private institutions are expected to share the burden of the responsibility of maintaining health. This can be achieved by providing free consultancy, basic physical check-up at nominal prices, and expert advice on prolonged illness. Private

Health Facilities are expected to function not only for profit but for societal benefit on humanitarian grounds.

4.4 Conclusion:

The study concludes that there is a shortage of public health facilities, health service providers, medicines, equipment etc. and is a matter of huge concern. Due to these shortfalls found in Health facilities, women health is deteriorating which in turn leads the country in the worst condition. Contradictory evidence observed is that besides all type of shortages, underutilisation of facilities provided at DH level, hospital administration has to provide these facilities to needy women. Private sector has a great responsibility towards society and should provide services to women in a sensible manner not only as profit making unit**.**

Chapter 5

Awareness and Utilization of Health Facilities among Women in Jammu and Kashmir: A study of District Kulgam

CHAPTER 5

AWARENESS AND UTILIZATION OF HEALTH FACILITIES AMONG WOMEN IN JAMMU AND KASHMIR: A STUDY OF DISTRICT KULGAM

5.1 Introduction:

Utilization of available health services by its residents is the prime goal for the government of any country which depends on its demand and supply. The demand for health services is determined to a large extent by the patient's need. Need and demand are not synonymous. Need tends to be self defined and thus represents unconstrained desire, whereas demand is based on willingness to Pay, it does not ignore need completely. Consumer theory cannot be implemented successfully to analyze health care demand under the usual assumption that, income and money prices are the main factors affecting health care decisions because the effects of information and the time prices are also important in decision making process. Utilization of health services is an essential indicator, reflecting the quality of services and health status of women in particular. Demand and Supply of health facilities depends upon consumer choice, economics of information, incentive structure and the channels through which health inputs affect utilization of health facilities by women.

Increased awareness among women, who have health related problems and those women who have health problems but hesitate to spend on it, will aid policy makers and health care providers in developing services for these specific population of women. Supply of health services increases the utilization of health services. In the previous chapter, factors were discussed in the form of availability of health facilities which represent the supply conditions of health facilities in Kulgam district. It is true that increase in utilization of health services results in better health status of women. If there is any constraint from demand or supply of both sides, it results in low utilization of health services and health of women is adversely affected.

It is true that some more factors that affect the health status of women include: age of marriage, age of women at child birth, understanding about own body and its requirements, lifestyle, socio-cultural trends, economic development, environmental

pollution, technological development, government policies etc. utilization of health services at the time of motherhood which is not a health problem but requires some medical services like vaccination, ANC, delivery, PNC etc. are dependent on the culture and tradition of society of which they are an important part. There is need to improve the health of women in general. In Kulgam district, there still exists the 'carelessness' and 'shyness' especially involving certain parts of the body and women are not habitual to utilize health facilities other than related to motherhood.

This chapter has been divided into following sections: **Section 1:** Health Profile of Respondents in Kulgam District, **Section 2: Part A:** Health awareness among respondents in district Kulgam: Area wise, Gender wise and Education wise and **Part B:** Different Categories of Health problems Area, Gender, and Education wise in Kulgam District. **Section 3:** Utilisation/Non-utilisation of Health facilities for Health Problems in District Kulgam: Area wise, Gender wise and Education wise. **Section 4:** Hypothesis testing

5.2 Section 1:

5.2.1 Health Profile of Respondents in District Kulgam

The data which was collected during survey shows health problems of reproductive aged Men and Women. In this chapter, the subsequent paragraphs show the health profile which represents utilization and non utilization of health facilities, awareness and attitude about health facilities in district Kulgam. The data is collected from 5 Rural and 5 Urban areas of 5 medical blocks of Kulgam district by gender (men and women) and on basis of suffering from different health problems. Researcher had collected data from 100 households in which only one member is taken from each household. The total 100 respondents responses are taken into consideration in which 50 are Men and 50 are Women. The researcher had collected data from the respondents on self reported health problems by 100 ailing cases that are divided in three broad categories which are as follows:

Table 5.1 Health Problems Divided into Broad Categories

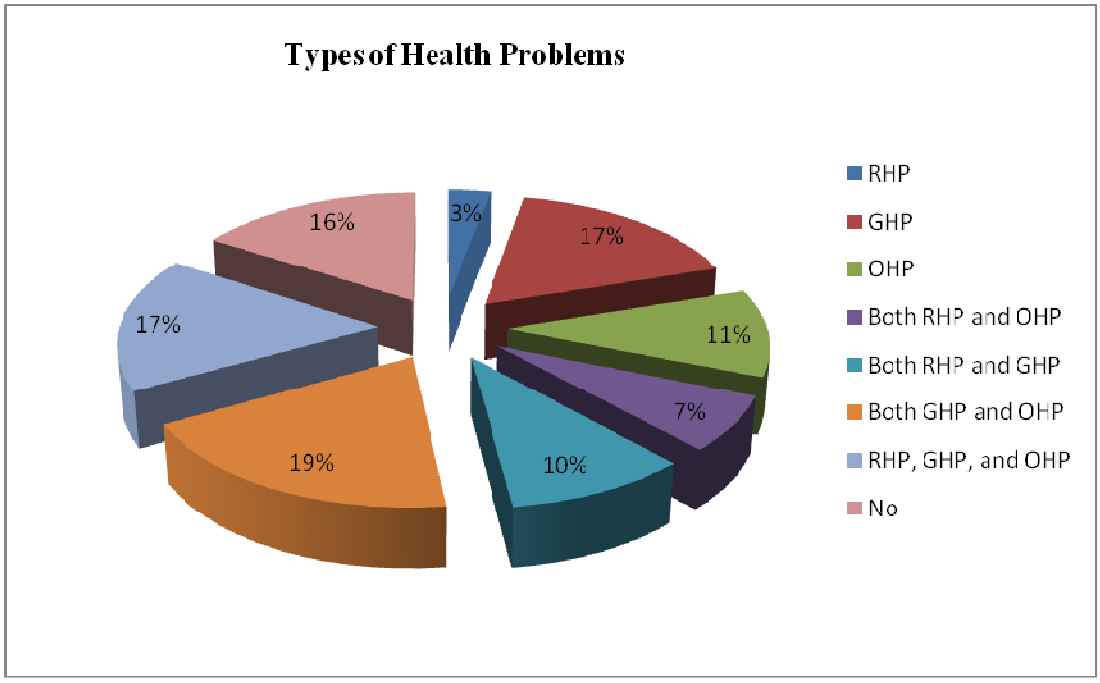
S.No.	Type of Health Problems	Total Ailing Cases
1.	**RHP**	**3** **3.0**
2.	**GHP**	**17** **17.0**
3.	**OHP**	**11** **11.0**
4.	**Both RHP and OHP**	**7** **7.0**
5.	**Both RHP and GHP**	**10** **10.0**
6.	**Both GHP and OHP**	**19** **19.0**
7.	**RHP, GHP, and OHP**	**17** **17.0**
8.	**No**	**16** **16.0**
Total		**100** **100.0**

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

The above table shows the three broad categories of health problems which are; Reproductive Health Problem (particularly seen in women), General Health Problem (which is for short duration period) and Other Health problem (which is for long duration period). The Health problems which are Included in Reproductive Health Problems (RHPs) are as; white or any type of discharge, menstruation related problems, pregnancy complications, DNC/infertility/miscarriage, maternal malnutrition. Pregnancy is also included in this category but is not viewed as a health problem. It has been done to analyze the awareness and utilization of health facilities which are equally required in pregnancy and as well as in other RHPs. The General Health Problems (GHPs) includes problems which are of short duration like; gastro intestinal problem, febrile illnesses or fever of any type, diarrhea, dysentery, cold, jaundice, accident/injuries/fractures, skin disease, eye ailment, disease of urinary system, headache, toothache, anaemic and undiagnosed health problems. Similarly in the category of Other Health Problems (OHPs), those ailments are considered which are of long duration such as; disease of joints and bones, diabetes mellitus,

blood pressure, psychiatric disorder, tuberculosis, cardiovascular disease and respiratory disease. There are more than 50 cases where they have more than one health problem. Out of total 100 respondents 86 respondents are there who are suffering from health problems and 14 left are healthy.

Fig.5.1 Percentage of Categories of Health Problems



The above table and figure shows the frequency and percentage of health problems. The total percentage of respondents suffering from more than one health problems is highest. In both GHPs and OHPs the total ailing cases is 19% which is followed by GHP 17% and all the three types of health problems 17% of RHP, GHP and OHP. 11% ailing cases report Other Health problems whereas 10% report of having both RHP and GHP, percentage of ailing cases having both RHP and OHP are 7% and the total percentage of respondents which reported of having only RHP are 3%. In total 84% are ailing cases and rest 16% are disease free.

5.3 Section 2:

5.3.1 Part A: Health awareness among respondents: Area wise, Gender wise and Education wise.

5.3.1.1 Area and Health Problems:

The below table shows three categories of health problems that people suffer in both rural and urban area of Kulgam district. As shown in the table it is evident from the responses of 100 cases, that GHP is highly prevalent in urban as well as in rural areas

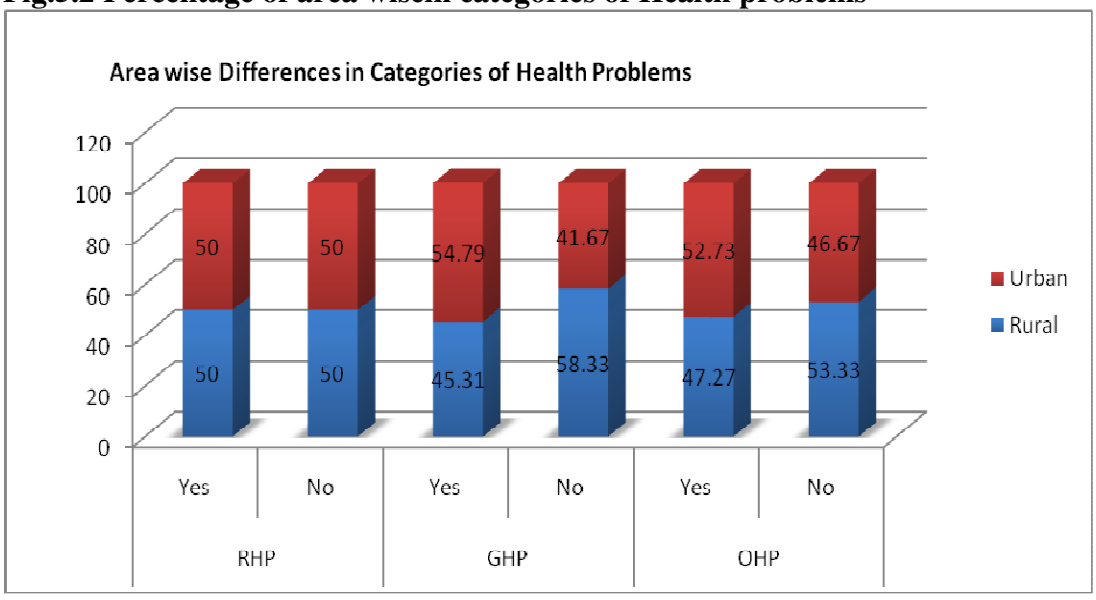
and is dominant in urban area as compare to rural area. Under it, the total percentages of respondents who report GHP are 54.79% and left 41.67% are not suffering. Similarly, in rural areas 45.31% report ailing cases of GHP and 58.33% are not. In case of RHP there are equal percentage of ailing cases in both rural as well as urban areas which comprise 50% in rural and 50% respondents in urban who say yes they are suffering from RHP and 50 % from both rural and urban areas are not suffering. However, in OHP category of health problem, again urban area is dominant in that case, total percentage of 52.73% is suffering and 46.67% is not and similarly in rural areas percentage of ailing cases are 47.27% says yes and 53.33% say no. The reason behind it is that in urban areas due to pollution and over crowdedness, poor and unhygienic living condition, the ailing cases are more found there as compared to rural area.

Table 5.2 Area Wise Differences in Categories of Health Problems

Area	RHP		GHP		OHP	
	Yes	No	Yes	No	Yes	No
Rural	19 50.0	31 50.0	29 45.31	21 58.33	26 47.27	24 53.33
Urban	19 50.0	31 50.0	35 54.79	15 41.67	29 52.73	21 46.67
Total	38 100.0	62 100.0	64 100.0	36 100.0	55 100.0	45 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.2 Percentage of area wisein categories of Health problems



5.3.1.2 Gender and Health Problems:

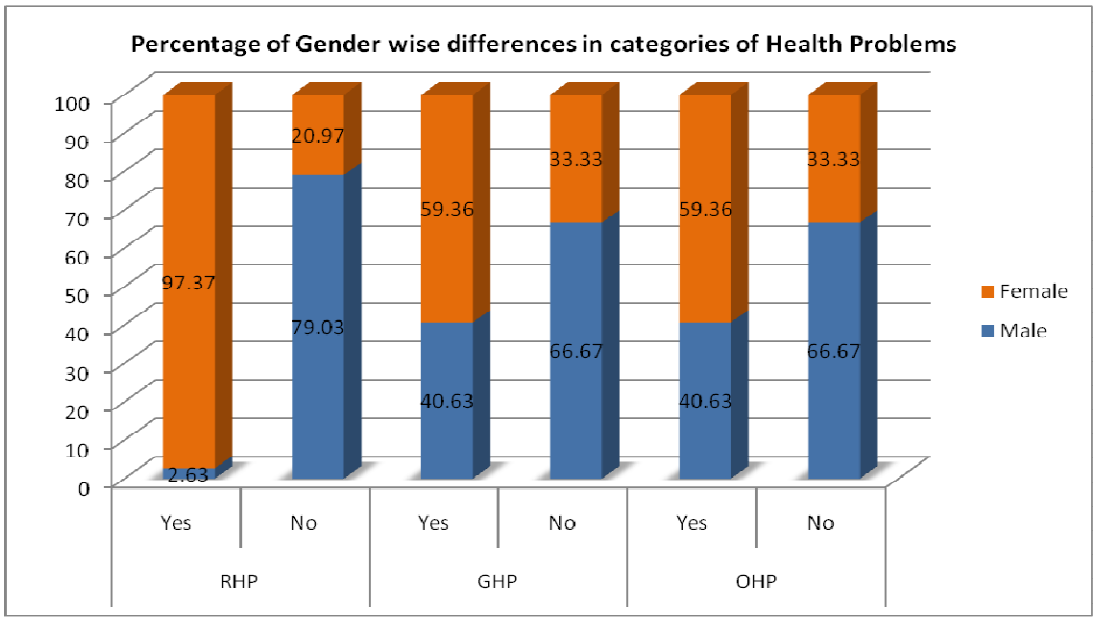
It is a general perception that women are more prone to health problems and the following table given below confirms the same. From the data given in the table below, it is evident that in all the three categories of health problems, women are highly prevalent in health problems as compared to men. In RHP women are highly prevalent as compared to man as only 2.63% men having RHP problem left 79.03% have not and in case of women there, 97.37% women who are suffering from RHP and 20.97% are not. Similarly, in case of GHP there are 59.36% in female category who are suffering from GHP and 33.33% are not and in case of men the percentage is 40.63% are ailing cases and 66.67% are not. Whereas in case of OHP again women are worst sufferers as 59.36% left 33.33% are not and in case of men 40.63% are ailing and left 66.67% are not. Lack of knowledge and carelessness being the primary reason.

Table 5.3 Gender wise difference in categories of Health Problems

Gender	RHP		GHP		OHP	
	Yes	No	Yes	No	Yes	No
Male	1 2.63	49 79.03	26 40.63	24 66.67	26 40.63	24 66.67
Female	37 97.37	13 20.97	38 59.36	12 33.33	38 59.36	12 33.33
Total	38 100.0	62 100.0	64 100.0	36 100.0	64 100.0	36 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.3 Percentage of Gender wise differences in categories of Health problems.



5.3.1.3 Education and Health Problem:

In case of Education, the percentage of different categories of health problems is shown with reference to different categories of education. In case of RHP, the percentage of disease is found to be very high in Higher education (Graduation and Above) 42.10% are sufferers and 35.48% are not, followed by intermediate (11th-12th) 23.68% and 16.13% are not. The percentage of RHP in illiterate respondents is 15.57% are ailing cases and 19.35% are not. Whereas in Primary (upto 5th) and high (9th-10th) it is found to be same 5.26%. says yes they are suffering from RHP and 9.67% are not. In case of Middle education (6th-8th) there is no respondent found to be the sufferer and 9.67% are not.

Similarly, in GHP category Higher education (Graduation and Above) has 34.37% sufferers and 44.44% are not which is followed by illiterate category in which 26.56% are sufferers and 2.77% are not. The percentage of GHP in Intermediate (11th-12th) is 15.62% are found to be ailing cases and 25% are not. In Primary (upto 5th) there is 9.37% respondents suffering and 5.55% are not, in Middle (6th-8th) the percentage of GHP is 6.25% says yes and 5.55% says no and lastly, in case of High (9th-10th) the percentage of GHP is 7.81% ailing cases and 16.66 % are not.

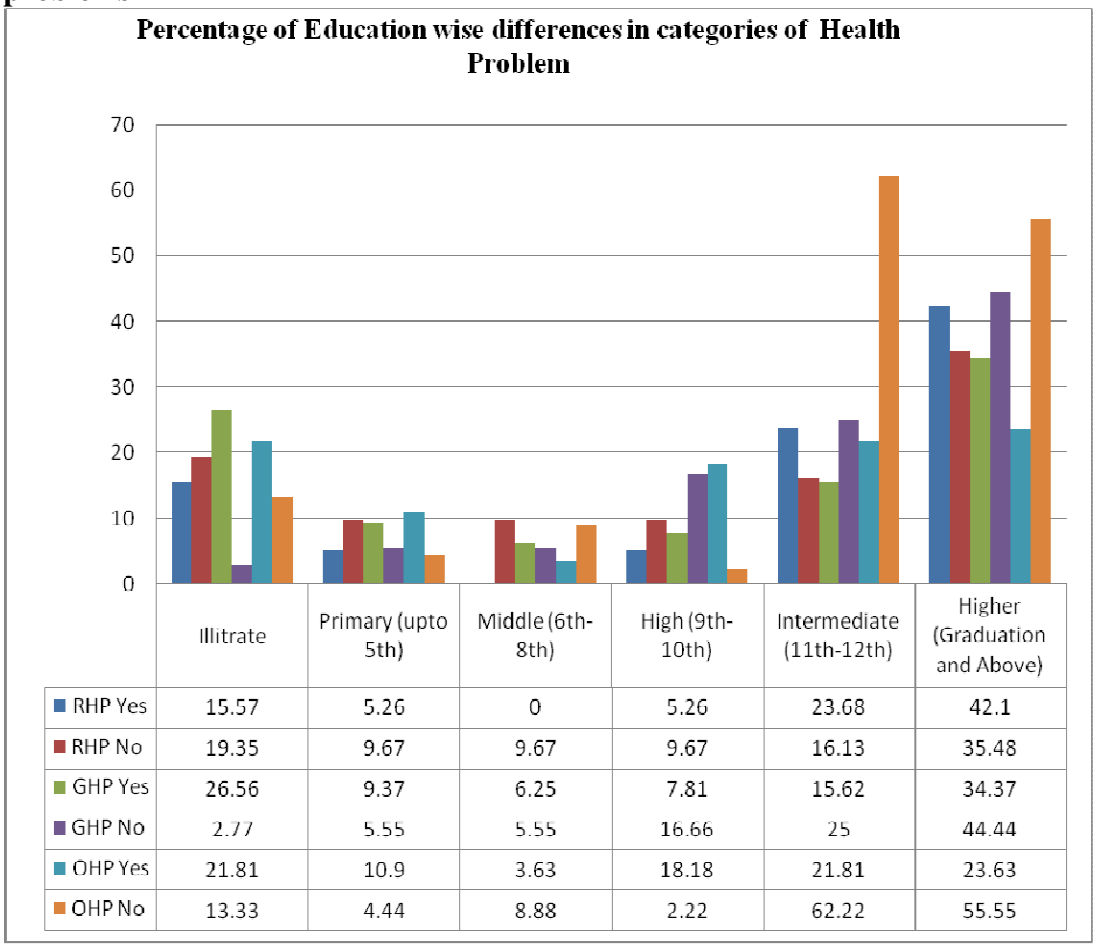
However, in OHP category Higher education (Graduation and Above) has 23.63% sufferers and 55.55% are not followed by intermediate (11th-12th) 21.81% are ailing cases and 62.22% are not and illiterate 21.81% ailing cases 13.33% are not. In High (9th-10th) there are 18.118% sufferers and 2.22% are not, Primary (upto 5th) has 10.90% sufferers and 4.44% are not and lastly Primary (upto 5th) there is 3.63% ailing cases and 8.88% are not.

Table 5.4 Education wise differences in categories of Health Problem

Education	RHP		GHP		OHP	
	Yes	No	Yes	No	Yes	No
Illiterate	6 15.57	12 19.35	17 26.56	1 2.77	12 21.81	6 13.33
Primary (upto 5th)	2 5.26	6 9.67	6 9.37	2 5.55	6 10.90	2 4.44
Middle (6th-8th)	0 0.0	6 9.67	4 6.25	2 5.55	2 3.63	4 8.88
High (9th-10th)	5 5.26	6 9.67	5 7.81	6 16.66	10 18.18	1 2.22
Intermediate (11th-12th)	9 23.68	10 16.13	10 15.62	9 25.00	12 21.81	7 62.22
Higher (Graduation and Above)	16 42.10	22 35.48	22 34.37	16 44.44	13 23.63	25 55.55
Total	38 100.0	62 100.0	64 100.0	36 100.0	55 100.0	45 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig. 5.4 Percentage of Education wise differences in categories of Health problems



5.3.2 Part B: Different Categories of Health problems Area, Gender, and Education wise in Kulgam District:

5.3.2.1 Area wise and differences in Health problems: (Details attached in Appendix Table A)

Area wise Health problems in both Rural and Urban areas are described in three categories of health problems namely; RHP, GHP and OHP. The description of RHP problems in Rural and urban areas are: white type of discharge 10% and 12%, Menstruation related problems 6% and 10%, pregnancy complications 6% and 8%, DNC/infertility/Miscarriage 4% and 0%, Both White discharge and Menstruation problem 12% and 8% and the absence of RHP health problems in both Rural and urban areas percentages are 62% and 62%.

In case of GHP, the description of problems which comes under GHP in Rural and Urban areas are: Gastro-intestinal problem 6% and 10%, Febrile illness (fever of any type) 6% and 8%, cold 2% and 4%, Jaundice 4% and 0%, Accident/Injuries/Fractures 2% and 2%, Skin Disease 6% and 10%, Eye ailment 8% and 4%, Disease of Urinary 4% and 2%, Undiagnosed health problem 0% and 2%, Headache 8% and 12%, Toothache 2% and 0%, Anaemic 10% and 14% and the percentage of absence of GHP health problem in Rural and Urban areas are 42% and 30%.

The description of OHP problems in Rural and Urban areas are: Joints and bones 14% and 4%, Diabetes mellitus 2% and 12%, Blood pressure 18% and 18%, Psychiatric disorder 0% and 2%, Cardiovascular disease 6% and 8%, Respiratory disease 0% and 2%, **B**oth Joints and bones and Blood pressure 12% and 12% and the percentage of absence of OHP health problems in Rural and Urban areas are 48% and 42%.

5.3.2.2 Gender wise differences in Health Problems: (Details attached in Appendix Table B)

Gender wise Health problems in both Male and Female are described in three categories of health problems; RHP, GHP and OHP. The description of RHP problem in both Male and Female are: white type of discharge 0% and 22%, Menstruation related problems 0% and 16%, pregnancy complications 0% and 14%, DNC/infertility/Miscarriage 0% and 4%, Both White discharge and Menstruation

problem 2% and 18% and the absence of RHP health problems in both Male and Female percentages are 98% and 26%.

In case of GHP, the description of problems which comes under GHP in Male and Female are: Gastro-intestinal problem 16% and 0%, Febrile illness (fever of any type) 6% and 8%, Cold 4% and 2%, Jaundice 0% and 4%, Accident/Injuries/Fractures 2% and 2%, Skin Disease 4% and 12%, Eye ailment 2% and 10%, Disease of Urinary 2% and 4%, Undiagnosed health problem 4% and 4%, Headache 14% and 6%, Toothache 2% and 2%, Anaemic 0% and 24% and the percentage of absence of GHP health problem in Male and Female are 48% and 24%.

The description of OHP problems in Male and Female are: Joints and bones 8% and 10%, Diabetes mellitus 10% and 4%, Blood pressure 10% and 26%, Psychiatric disorder 0% and 2%, Cardiovascular disease 6% and 8%, Respiratory disease 0% and 2%, **B**oth Joints and bones and Blood pressure 4% and 20% and the percentage of absence of OHP health problems in Male and Female are 62% and 28%.

5.3.2.3 Education wise differences in Health problems: (Details attached in Appendix Table C)

The table C shows the different levels of education with different categories of Health problems. The education wise RHP problems in different levels of education are: White type of discharge in illiterate is 16.66%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 21.05% and Higher (graduation and above) 5.26%, Menstruation related problems in illiterate is 5.55%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 27.27%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 5.26%, Pregnancy complications in illiterate is 0%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 13.15%, DNC/infertility/Miscarriage in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 2.63%, Both White discharge and Menstruation problem in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 15.78% and Higher (graduation and above) 15.78% and the percentage of respondents education wiser with the absence of RHP health problems at different levels of education in illiterate is 66.66%, Primary (upto 5^{th}) 75%, Middle (6^{th}-8^{th})

100%, High (9^{th}-10^{th}) 54.54%, Intermediate (11^{th}-12^{th}) 52.63% and Higher (graduation and above) 57.89%.

The education wise GHP problems in different levels of education are: Gastro-intestinal problem in illiterate is 11.11%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 10.52%, Febrile illness (Fever of any type) in illiterate is 16.66%, Primary (upto 5^{th}) 25%, Middle (6^{th}-8^{th}) 16.66%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 2.63%, Cold in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 2.63%, Jaundice in illiterate is 11.11%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 0%, Accident/Injuries/Fractures in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 2.63%, Skin disease in illiterate is 11.11%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 16.66%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th})0% and Higher (graduation and above) 7.89%, Eye ailment in illiterate is 0%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 15.78% and Higher (graduation and above) 2.63%, Disease of Urinary in illiterate is 0%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 2.63%, Undiagnosed health problem in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 5.26% and Higher (graduation and above) 0%, Headache in illiterate is 5.55%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 33.33%, High (9^{th}-10^{th}) 0%, Intermediate (11^{th}-12^{th}) 10.52% and Higher (graduation and above) 13.15%, Toothache in illiterate is 0%, Primary (upto 5^{th}) 0%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 0%, Anaemic in illiterate is 22.22%, Primary (upto 5^{th}) 12.5%, Middle (6^{th}-8^{th}) 0%, High (9^{th}-10^{th}) 9.09%, Intermediate (11^{th}-12^{th}) 0% and Higher (graduation and above) 0% and the percentage of respondents education wise with absence of GHP at different levels is illiterate is 5.55%, Primary (upto 5^{th}) 25%, Middle (6^{th}-8^{th}) 33.33%, High (9^{th}-10^{th}) 54.54%, Intermediate (11^{th}-12^{th}) 47.36% and Higher (graduation and above) 42.10%.

And lastly the education wise OHP problems in different levels of education are: disease of Joints and Bones in illiterate is 11.11%, Primary (upto 5th) 12.5%, Middle (6th-8th) 16.66%, High (9th-10th) 18.18%, Intermediate (11th-12th) 5.26% and Higher (graduation and above) 5.26%, Diabetes mellitus in illiterate is 16.66%, Primary (upto 5th) 0%, Middle (6th-8th) 16.66%, High (9th-10th) 0%, Intermediate (11th-12th) 5.26% and Higher (graduation and above) 5.26%, Blood Pressure in illiterate is 11.11%, Primary (upto 5th) 25%, Middle (6th-8th) 0%, High (9th-10th) 27.27%, Intermediate (11th-12th) 26.31% and Higher (graduation and above) 15.78%, Psychiatric Disorder in illiterate is 0%, Primary (upto 5th) 0%, Middle (6th-8th) 0%, High (9th-10th) 0%, Intermediate (11th-12th) 0% and Higher (graduation and above) 2.63%, Cardiovascular disease in illiterate is 5.55%, Primary (upto 5th) 25%, Middle (6th-8th) 0%, High (9th-10th) 18.18%, Intermediate (11th-12th) 10.52% and Higher (graduation and above) 0%, Respiratory disease in illiterate is 0%, Primary (upto 5th) 0%, Middle (6th-8th) 0%, High (9th-10th) 0%, Intermediate (11th-12th) 5.26% and Higher (graduation and above) 0%, Both Disease of Joints & bones and blood pressure in illiterate is 22.22%, Primary (upto 5th) 12.5%, Middle (6th-8th) 0%, High (9th-10th) 27.27%, Intermediate (11th-12th) 10.52% and Higher (graduation and above) 5.26% and the percentage of respondents education wise with absence of OHP problem at different levels of education are in illiterate is 33.33%, Primary (upto 5th) 25%, Middle (6th-8th) 66.66%, High (9th-10th) 9.09%, Intermediate (11th-12th) 36.84% and Higher (graduation and above) 65.78%.

5.4 Section 3:

5.4.1 Utilisation/Non-utilisation of Health facilities for Health Problems in District Kulgam: Area wise, Gender wise and Education wise.

5.4.1.1 Utilisation/Non-utilisation of Health Facilities and Broadly Categorized Health Problems:

The table below gives the breakdown of utilization of health facilities by the ailing cases in broadly categorized health problems. It is seen that utilization of health facilities in case of GHP is significantly high among all the three categories of health problems, out of 100 respondents, 64% ailing cases reports of having GHP and 36% have not, in which 22% ailing cases do not utilize health facilities and 42% take treatment. Whereas, in case of RHP the total percentage of ailing cases are 38% and

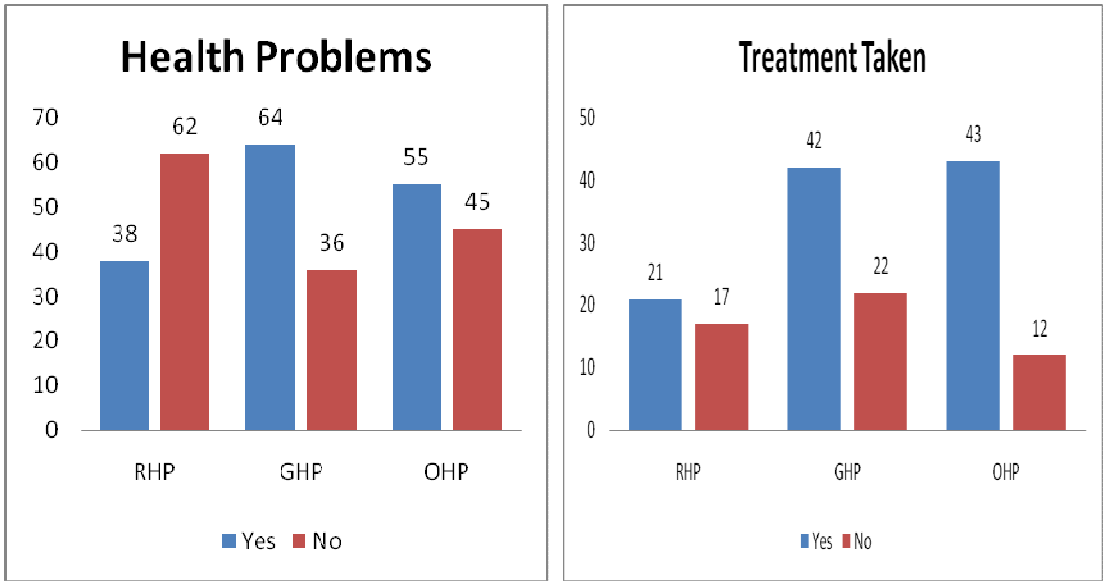
62% have not, in which 21% take treatment and 17% ailing cases do not utilize any health facility. Similarly, in case of OHP the total ailing cases are 55% and 45% is not having this category of health problem. 43% ailing cases utilize health facility and left 12% do not utilize any health facility. Most of the cases avoid treatment because they do not take the problem seriously till the problem disturbs their routine life. In case of GHPs maximum cases are treated because these health problems severely affect the life of a person.

Table 5.5 Utilisation/Non-Utilisation of Health Facilities for Categories of Health Problems.

Types of Diseases	Health Problems		Total	Treatment Taken		Total
	Yes	No		Yes	No	
RHP	38	62	100	21	17	100
	38.00	62.00	100.0	21.00	17.00	100.0
GHP	64	36	100	42	22	100
	64.00	36.00	100.0	42.00	22.00	100.0
OHP	55	45	100	43	12	100
	55.00	45.00	100.0	43.00	12.00	100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.5 Percentage of health problems and utilization/ non-utilization of health facilities for different categories of Health problems



5.4.1.2 Area wise Utilisation/Non-Utilisation of Health Facilities:

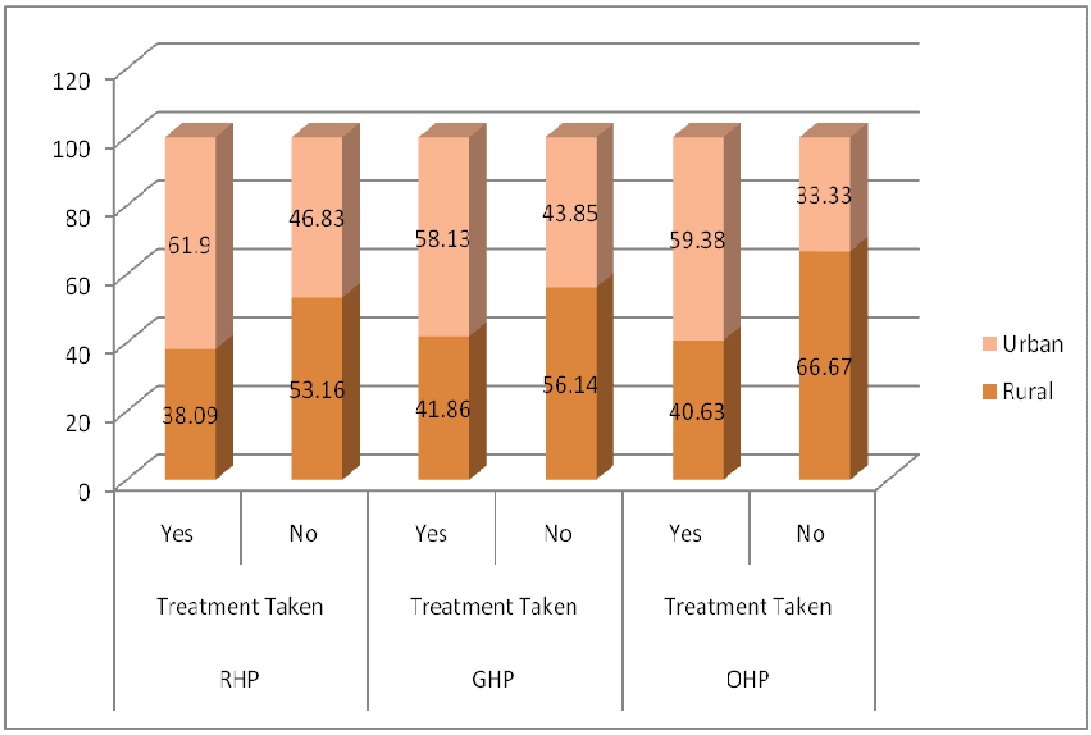
The researcher has also made an effort to analyze whether health facilities are utilized on the basis of area or not. There is a general opinion that urban people utilize health services more frequently or optimally, while in rural areas people lag behind in this regard. The following table shows area wise utilization of health facilities. As there are three categories of health problems and people suffering from each category will go for the treatment. The table below shows the respondents utilization/non utilization pattern in rural and urban areas. Out of the total 100 respondents in all the three categories of health problems (RHP,GHP and OHP), 61.90% ailing cases of RHP in Urban areas are taking treatment and left 46.83% are not taking any treatment and in case of rural area only 38.09% are taking and 53.16% lags behind. The RHP is followed by OHP in which 59.38% ailing cases in urban areas are taking treatment and left 33.33% are not taking any kind of treatment, whereas in case of rural areas only 40.63% are taking treatment and left 66.67% are not. Same is the case with GHP, in urban areas 58.13% are taking treatment and left 43.85% are not taking any kind of treatment and in case of rural areas only 41.86% ailing cases are taking treatment and left 84% are not.

Table 5.6 Area Wise Differences in Utilisation/Non Utilisation of Health Facilities

Area	**RHP Treatment Taken**		**GHP Treatment Taken**		**OHP Treatment Taken**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Rural	8 38.09	42 53.16	18 41.86	32 56.14	26 40.63	24 66.67
Urban	13 61.90	37 46.83	25 58.13	25 43.85	38 59.38	12 33.33
Total	21 100.0	79 100.0	43 100.0	57 100.0	64 100.0	36 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.6 Percentage of Area wise utilization/ non-utilization of Health Facilities



5.4.1.3 Gender wise utilization/ non utilization of Health Facilities:

It is evident from many studies that gender and utilization pattern of health facilities are associated. The table given below shows the utilization pattern of health facilities for different categories of health problems on basis of gender. In case of RHP 100% women are taking treatment and 36.71% are not taking any treatment, in case of men no treatment is taken by any one as only 2% men are suffers from RHP and none of them is taking any treatment. Whereas, in GHP 54.76% women are taking treatment and 46.55% are not taking any treatment.

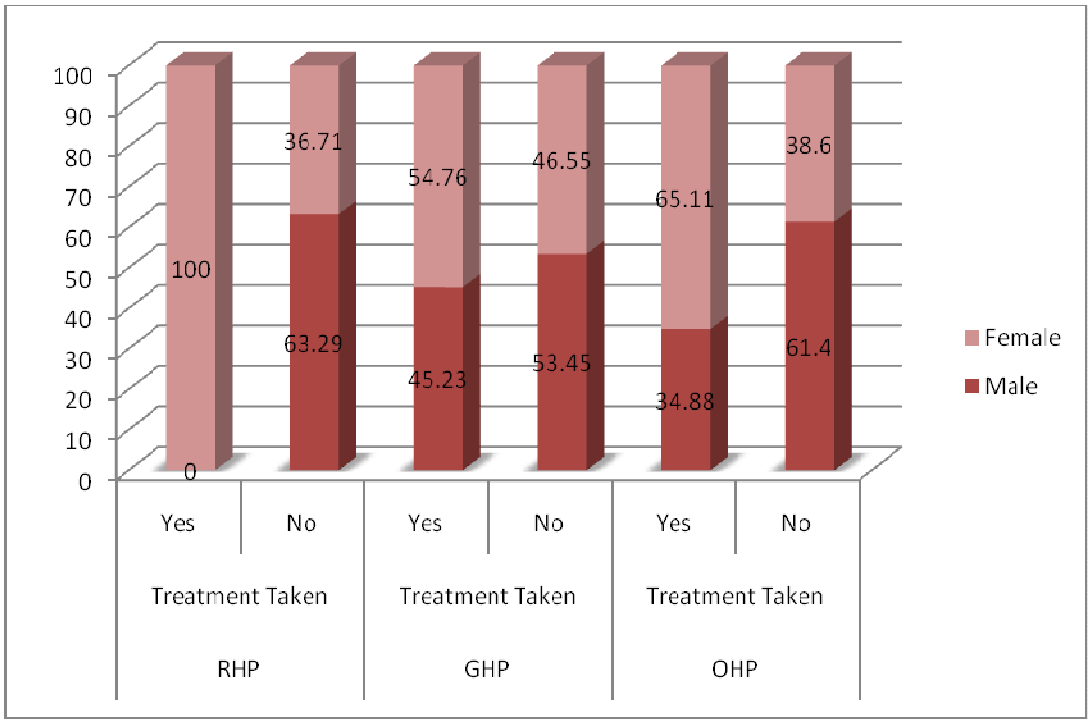
Similarly, 45.23% men are taking and 53.45% didn't take. However, in case of OHP the total percentage in women category taking treatment is 65.11% and 38.60% female are not taking and in case of men 34.88% have taken treatment where 61.40% didn't take any treatment and so on.

Table 5.7 Gender Wise Differences in Utilisation/Non-Utilisation of Health Facilities

Gender	RHP Treatment Taken		GHP Treatment Taken		OHP Treatment Taken	
	Yes	No	Yes	No	Yes	No
Male	0 0.0	50 63.29	19 45.23	31 53.45	15 34.88	35 61.40
Female	21 100.0	29 36.71	23 54.76	27 46.55	28 65.11	22 38.60
Total	21 100.0	79 100.0	42 100.0	58 100.0	43 43.0	57 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.7 Percentage of gender wise Utilization/ non-utilization of health facilities



5.4.1.4 Education wise utilization/ non utilization of Health Facilities:

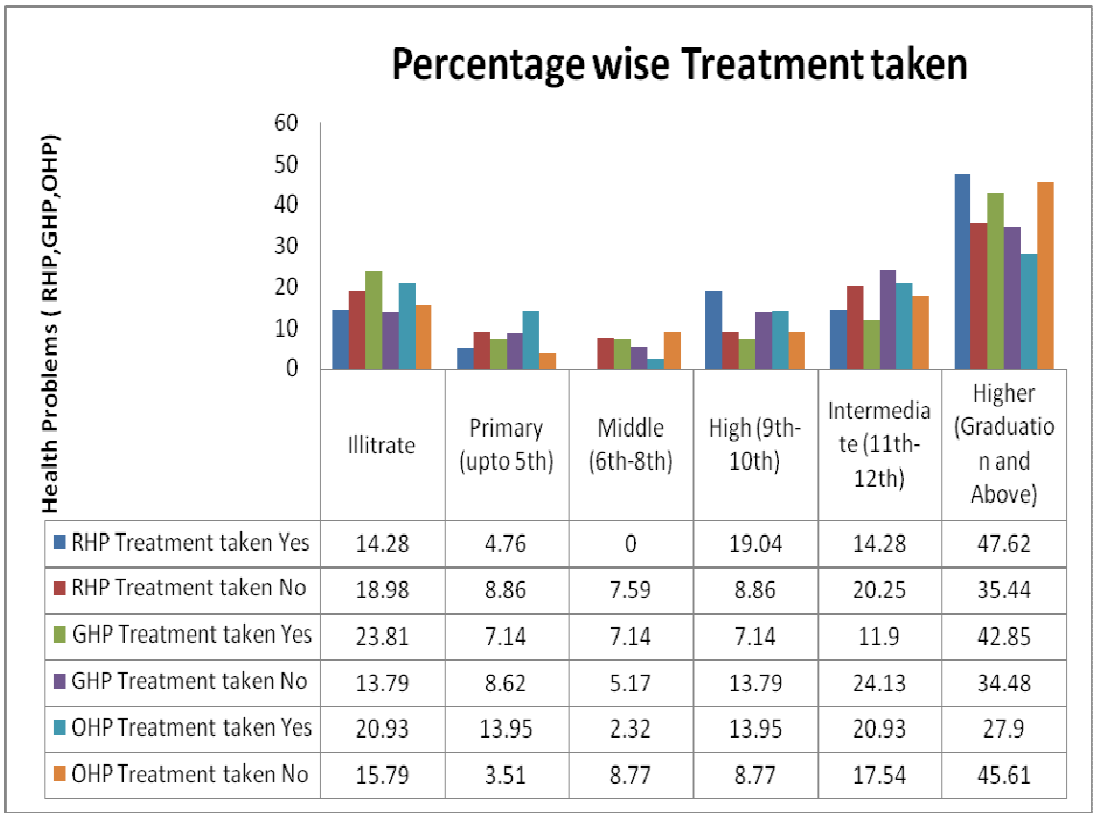
Table 5.8 shows treatment taken as per the status of education for the following health problems like RHP,GHP and OHP. Illitrate who have taken treatment for the three problems is 14.28%, 23.81%, and 20.93%. Primary (upto 5th), 4.76%, 7.14% and 13.95%. Middle (6th- 8th), RHP no one, 7.14%, and 2.32%. High (9th-10th) 19.04%, 7.14%and 13.95%. Intermediate (11th-12th) 14.28%, 11.90% and 20.93%. and lastly, Higher (Graduation and Above) 47.62%, 42.85% and 27.90%.

Table 5.8 Education wise utilization/ non utilization of Health Facilities

Education	RHP Treatment taken		GHP Treatment taken		OHP Treatment taken	
	Yes	No	Yes	No	Yes	No
Illitrate	3 14.28	15 18.98	10 23.81	8 13.79	9 20.93	9 15.79
Primary (upto 5th)	1 4.76	7 8.86	3 7.14	5 8.62	6 13.95	2 3.51
Middle (6th-8th)	0 0.00	6 7.59	3 7.14	3 5.17	1 2.32	5 8.77
High (9th-10th)	4 19.04	7 8.86	3 7.14	8 13.79	6 13.95	5 8.77
Intermediate (11th-12th)	3 14.28	16 20.25	5 11.90	14 24.13	9 20.93	10 17.54
Higher (Graduation and Above)	10 47.62	28 35.44	18 42.85	20 34.48	12 27.90	26 45.61
Total	21 100.0	79 100.0	42 100.0	58 100.0	43 100.0	57 100.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Fig.5.8 Percentage of Education wise Utilization/non-utilization of Health Facilities



5.5 Section 4:

5.5.1 Hypothesis testing:

- Women do not utilize much and do not have much awareness regarding the public health service.

5.5.1.1Association between Area and utilization/non-utilization of health facilities for different categories of Health Problems.

The researcher has postulated the following null hypothesis**.**

H0: There is no difference between Area and awareness of RHP treatment among women.

H1: Area and RHP disease are associated with each other.

From table given below, the tabulation of Area and RHP treatment taken by women in district Kulgam, with 1 degree of freedom at 0.05% level of significance, our tabulated value is 3.84 and calculated value is 1.5069 which is lesser than tabulated value (chi-square cal=1.5069 < chi-square tab=3.84 df =1), therefore we accept null hypothesis which means that there is no difference of Area in utilizing RHP related services.

Table 5.9 Tabulation of Area and RHP

	RHP Treatment Taken		
Area	**Yes**	**No**	**Total**
Rural	8 0.6	42 0.2	50 0.8
Urban	13 0.6	37 0.2	50 0.8
Total	21 1.2	79 0.3	100 1.5

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total
Pearson chi2 (1) = 1.5069 Pr = 0.220 Tabulated value = 3.84

The researcher has postulated the following null hypothesis**.**

H0: There is no difference between area and awareness of GHP among women.

H1: Area and GHP disease are associated with each other.

From table given below, the tabulation of Area and RHP treatment taken by women in district Kulgam, with 1 degree of freedom at 0.05% level of significance, Our tabulated value is 3.84 and calculated value is 10.9050 which is Greater than tabulated value (chi-square cal=10.5090 > chi-square tab=3.84 df =1), therefore we reject null hypothesis which means there is a difference between area in utilizing GHP related services.

Table 5.10 Tabulation of Area and GHP

	GHP Treatment Taken		
Area	**Yes**	**No**	**Total**
Rural	13	37	50
	3.0	2.2	5.3
Urban	29	21	50
	3.0	2.2	5.3
Total	42	58	100

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total
Pearson chi2 (1) = 10.5090 Pr = 0.001 Tabulated value = 3.84

The researcher has postulated the following null hypothesis.

H0: There is no difference between area and awareness of RHP among women.

H1: Area and RHP disease are associated with each other.

From table given below, the tabulation of Area and RHP treatment taken by women in district Kulgam, with 1 degree of freedom at 0.05% level of significance, our tabulated value is 3.84 and calculated value is 19992 which is lesser than tabulated value (chi-square cal=1.9992 < chi-square tab=3.84 df =1), therefore we accept null hypothesis which means that there is no difference of area in utilizing OHP related services.

Table 5.11 Tabulation of Area and OHP

	OHP Treatment Taken		
Area	**Yes**	**No**	**Total**
Rural	18	32	50
	0.6	0.4	1.0
Urban	25	25	50
	0.6	0.4	1.0
Total	43	57	100
	1.1	0.9	2.0

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total
Pearson chi2 (1) = 1.9992 Pr = 0.157 Tabulated value = 3.84

5.5.1.2 Association between gender (Male and Female) and utilization/non-utilization of health facilities for different categories of health problems

The observed frequencies shown in table below represent the different categories of the two attributes namely gender and utilisation/non-utilisation of health facilities for RHP. The researcher has postulated the following null hypothesis.

H0: There is no difference between gender (Male and Female) with respect to awareness in Utilisation /non-utilisation of health facilities for RHP.

H1: Gender and RHP disease are associated with each other

From table given below, the tabulation of Area and RHP treatment taken by women in district Kulgam, with 1 degree of freedom. The value of calculated chi-square has been estimated as 26.5823 and the tabulated value of chi-square at 0.05% level of significance is 3.84 (chi-square cal = 26.5823 > chi-square tab = 3.84 df =1) which is greater than the calculated value of chi-square and is statistically significant. Thus, the null hypothesis has been rejected, showing that there is no statistically significant difference between gender and utilization of health facilities for RHP. It has been found that gender has a significant effect on awareness of utilization of health facilities for RHP.

Table 5.12 Tabulation of Gender and RHP

	RHP Treatment Taken		
Gender	**Yes**	**No**	**Total**
Male	0 10.5	50 2.8	50 13.3
Female	21 10.5	29 2.8	50 13.3
Total	21 21.0	79 5.6	100 26.6

Source: Estimate from Field Survey

Note: Figures in Parenthesis Are Percentage of Total

Pearson chi2 (1) = 26.5823 Pr = 0.000 Tabulated value = 3.84

The observed frequencies shown in table below represent the different categories of the two attributes namely gender and utilisation/non-utilisation of health facilities for GHP. The researcher has postulated the following null hypothesis.

H0: There is no difference between gender (Male and Female) with respect to awareness in Utilisation /non-utilisation of health facilities for GHP.

H1: Gender and GHP disease are associated with each other.

From table given below, the tabulation of Area and GHP treatment taken by women in district Kulgam, with 1 degree of freedom. The value of calculated chi-square has been estimated as 0.6568 and the tabulated value of chi-square at 0.05% level of significance is 3.84 (chi-square cal =0.6568< chi-square tab = 3.84 df =1) which is lesser than the calculated value of chi-square and is statistically significant. Thus, the null hypothesis has been accepted, showing that there is no statistically significant difference between gender (Male and Female) with respect to utilization of health facilities. It has been found that gender has not a significant effect on utilization or non utilization of health facilities for GHP.

Table 5.13 Tabulation of Gender and GHP

	GHP Treatment Taken		
Gender	**Yes**	**No**	**Total**
Male	19 0.2	31 0.1	50 0.3
Female	23 0.2	27 0.1	50 0.3
Total	42 0.4	58 0.3	100 0.7

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total
Pearson chi2 (1) = 0.6568 Pr = 0.418 Tabulated value = 3.84

The observed frequencies shown in table below represent the different categories of the two attributes namely gender and utilisation/non-utilisation of health facilities for OHP. The researcher has postulated the following null hypothesis.

H0: There is no difference between gender (Male and Female) with respect to awareness in Utilisation /non-utilisation of health facilities for OHP.

H1: Gender and OHP disease are associated with each other

From table given below, the tabulation of Area and RHP treatment taken by women in district Kulgam, with 1 degree of freedom. The value of calculated chi-square has been estimated as 6.8951 and the tabulated value of chi-square at 0.05% level of significance is 3.84 (chi-square cal = 6.8951 > chi-square tab = 3.84 df =1) which is greater than the calculated value of chi-square and is statistically significant. Thus, the null hypothesis has been rejected, showing that there is no statistically significant difference between gender and utilization of health facilities for OHP. It has been found that gender has a significant effect on awareness of utilization of health facilities for OHP.

Table 5.14 Tabulation of Gender and OHP

Gender	OHP Treatment Taken		
	Yes	**No**	**Total**
Male	15 2.0	35 1.5	50 3.4
Female	28 2.0	22 1.5	50 3.4
Total	43 3.9	57 3.0	100 6.9

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total
Pearson chi2 (1) = 6.8951 Pr = 0.009 Tabulated value = 3.84

5.5.1.3 Association between Education and utilization/non-utilization of health facilities.

The below table shows the different categories of education and utilization/non-utilization of health facilities. The researcher has postulated following null hypothesis

H0: There is no difference between education and awareness of RHP disease among women

H1: Education and RHP are associated with each other

From the table given below which shows tabulation of education and RHP treatment taken in district Kulgam, with 1 degree of freedom at 0.05% level of significance. Our tabulated value is 11.07 and calculated value is 4.6703 which is lesser than tabulated value (chi-square cal = 6.8951 > chi-square tab = 11.07 df =1), therefore we accept null hypothesis which means that there is no difference between education in utilizing RHP related services.

Table 5.15 Tabulation of Education and RHP

Education	RHP Treatment Taken		
	Yes	**No**	**Total**
Illitrate	3 0.2	15 0.0	18 0.2
Primary (upto 5th)	1 0.3	7 0.1	8 0.3
Middle (6th-8th)	0 1.3	6 0.3	6 1.6
High (9th-10th)	4 1.2	7 0.3	11 1.6
Intermediate (11th-12th)	3 0.2	16 0.1	19 0.3
Higher (Graduation and Above)	10 0.5	28 0.1	38 0.6
Total	21 3.7	79 1.0	100 4.7

Source: Estimate from Field Survey
Note: Figures in Parenthesis Are Percentage of Total

Pearson chi2 (5) = 4.6703 Pr = 0.457 Tabulated value = 11.07

The below table shows the different categories of education and utilization/non-utilization of health facilities. The researcher has postulated following null hypothesis

H0: There is no difference between education and awareness of GHP disease among women

H1: Education and GHP are associated with each other

From the table given below which shows tabulation of education and GHP treatment taken in district Kulgam, with 1 degree of freedom at 0.05% level of significance. Our tabulated value is 11.07 and calculated value is 4.9296 which is lesser than tabulated value (chi-square cal = 4.9296 > chi-square tab = 11.07 df =1), therefore we accept null hypothesis which means that there is no difference between education in utilizing GHP related services.

Table 5.16 Tabulation of Education and GHP

Education	**GHP Treatment Taken**		
	Yes	**No**	**Total**
Illiterate	10 0.8	8 0.6	18 1.4
Primary (Up to 5th)	3 0.0	5 0.0	8 0.1
Middle (6th-8th)	3 0.1	3 0.1	6 0.2
High (9th-10th)	3 0.6	8 0.4	11 1.0
Intermediate (11th-12th)	5 1.1	14 0.8	19 1.9
Higher (Graduation And Above)	18 0.3	20 0.2	38 0.4
Total	42 2.9	58 2.1	100 4.9

Source: Estimate from Field Survey

Note: Figures in Parenthesis Are Percentage of Total

Pearson chi2 (5) = 4.9296 Pr = 0.425 Tabulated value = 11.07

The below table shows the different categories of education and utilization/non-utilization of health facilities. The researcher has postulated following null hypothesis

H0: There is no difference between education and awareness of OHP disease among women

H1: Education and OHP are associated with each other

From the table given below which shows tabulation of education and RHP treatment taken in district Kulgam, with 1 degree of freedom at 0.05% level of significance. Our tabulated value is 11.07 and calculated value is 8.1682 which is lesser than tabulated value (chi-square cal = 8.1682 > chi-square tab = 11.07 df =1), therefore we accept null hypothesis which means that there is no difference between education in utilizing RHP related services.

Table 5.17 Tabulation of Education and OHP

Education	**OHP Treatment Taken**		
	Yes	**No**	**Total**
Illitrate	9 0.2	9 0.2	18 0.4
Primary (upto 5th)	6 1.9	2 1.4	8 3.3
Middle (6th-8th)	1 1.0	5 0.7	6 1.7
High (9th-10th)	6 0.3	5 0.3	11 0.6
Intermediate (11th-12th)	9 0.1	10 0.1	19 0.1
Higher (Graduation and Above)	12 1.2	26 0.9	38 2.0
Total	43 4.7	57 3.5	100 8.2

Source: Estimate from Field Survey

Note: Figures in Parenthesis Are Percentage of Total

Pearson chi2 (5) = 8.1682 Pr = 0.147 Tabulated value = 11.07

5.5.2 Binary Logistic Regression model:

The econometric model Specification

$$Y_i = \beta_0 * X_i + \epsilon_i \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots 5.1$$

Y_i = is the dependent Variable. This is a dichotomous variable 1=Treatment taken and 0= no Treatment β_0=is the vector of explanatory variables.

X_i = is the associated vector of parameter to be estimated and

E_i= error Term.

Binary Logistic Regression Model:

The following equations of Binary Logistic Regression model are

$$logit(p) = \frac{P}{(1-P)} = \beta_0 + \beta_1 * X_1 + \beta_2 * X_2 + \beta_3 * X_3 \ldots + \beta k * xk \ldots\ldots\ldots\ldots\ldots\ldots (5.2)$$

$$logit(p) = \frac{P}{(1-P)} = \beta_0 + \beta_1 * Area + \beta_2 * Gender + \beta_3 * Education + Ei \ldots\ldots\ldots (5.3)$$

Description of the study variables

Variable	Description
RHP Treatment Taken GHP Treatment Taken OHP Treatment Taken	{1=Treatment Taken, 0=No Treatment}
Area	1= Rural, 0=Urban
Gender	1=Male, 0=Female
Education	1=Up to 10th, 0=Higher Education

In our study, we have used dependent variables RHP Treatment Taken, GHP Treatment Taken and OHP Treatment Taken, to check the probabilities of taking treatment or utilizing the health facilities for different categories of health problems among respondents of district Kulgam. Our dependent variables are dichotomous (1= Treatment Taken and 0= No Treatment). We have used Binary Logistic Regression Model to investigate or to check the determining factors responsible for taking treatment or utilizing health facilities. We have developed our econometric model to analyze the role of these variables in Taking Treatment for different categories of health problems. All explanatory variables are dichotomous, which are Area (1=Rural, 0=Urban), Gender (1=Male, 0=Female) and Education (1= up to 10, 0=Higher Education). The reference category taken in our model is considered the dichotomous value '1'

The Binary Logistic Regression Model, we have calculated Odd Ratio with the help of Stata 14 Software. We have used the command logistic for Odd Ratio Results and we used logit command to calculate coefficients. We have interpreted our results on the basis of Odd Ratio. Therefore, results for our Model are as follows:

Therefore from the output results of logistic regression model with respect Area (1=Rural, 0=Urban), keeping 'Rural' as reference category, as per Odds ratio in

respect to our reference category there are 0.44% of chances to 'Urban' people as compared to Rural people to take treatment for RHP. However, it has been found statistically insignificant at 5% level of significance. Similarly, in case of Education (1= up to 10, 0=Higher Education) keeping 'upto 10^{th}' as reference category, there are 0.26% of chances to higher education people as compared to education upto 10^{th} people to take treatment for RHP. It has been found statistically significant at 5% level of significance.

Table 5.18 RHP Treatment Taken

1		
VARIABLES	Treatment Taken	Treatment Taken
	Dummy RHP {1=Treatment taken, 0=No Treatment}	Dummy RHP {1=Treatment taken, 0=No Treatment}
	Coefficients	**Odd Ratios**
Area	-0.803 (0.190)	0.447 (0.190)
Education	-1.357** (0.046)	0.257 (0.046)
Constant	0.506 (0.277)	1.658 (0.277)
Observations	50	50
R-Squared	0.951	0.951

Standard errors in parentheses
***** p<0.01, ** p<0.05, * p<0.1**

The output results of logistic regression model with respect Area (1=Rural, 0=Urban), keeping 'Rural' as reference category, as per Odds ratio in respect to our reference category there are 0.22% of chances to 'Urban' people as compared to Rural people to take treatment for GHP. However, it has been found statistically significant at 5% level of significance. Similarly, in case of Gender (1= Male, 0= Female), keeping male as reference category, there are 0.73% chances for Female to take treatment for GHP, however it has been found statistically insignificant at 5% level of significance. Whereas, in case of Education (1= up to 10, 0=Higher Education) keeping 'upto 10^{th}' as reference category, there are 2.12% of chances to higher education people as compared to education upto 10^{th} people to take treatment for GHP. It has been found statistically insignificant at 5% level of significance.

Table 5.19 GHP Treatment Taken

2		
VARIABLES	Treatment Taken	Treatment Taken
	Dummy GHP {1=Treatment taken, 0=No Treatment}	Dummy GHP {1=Treatment taken, 0=No Treatment}
	Coefficients	**Odd Ratios**
Area	-1.511***	0.221
	(0.001)	(0.001)
Gender	-0.315	0.729
	(0.471)	(0.471)
Education	0.748	2.11
	(0.119)	(0.119)
Constant	0.301	1.351
	(0.438)	(0.438)
Observations	100	100
R Square	0.1025	0.1025

Standard errors in parentheses
***** p<0.01, ** p<0.05, * p<0.1**

And lastly, the output results of logistic regression model with respect Area (1=Rural, 0=Urban), keeping 'Rural' as reference category, as per Odds ratio in respect to our reference category there are 0.51% of chances to 'Urban' people as compared to Rural people to take treatment for OHP. However, it has been found statistically insignificant at 5% level of significance. Similarly, in case of Gender (1= Male, 0= Female), keeping male as reference category, there are 0.34% chances for Female to take treatment for OHP, however it has been found statistically significant at 5% level of significance. Whereas, in case of Education (1= up to 10, 0=Higher Education) keeping 'upto 10^{th}' as reference category, there are 1.56% of chances to higher education people as compared to education upto 10^{th} people to take treatment for OHP. It has been found statistically insignificant at 5% level of significance.

Table 5.20 OHP Treatment Taken

3		
VARIABLES	Treatment Taken	Treatment Taken
	Dummy OHP {1=Treatment taken, 0=No Treatment}	Dummy OHP {1=Treatment taken, 0=No Treatment}
	Coefficients	**Odd Ratios**
Area	-0.679	0.507
	(0.116)	(0.116)
Gender	-1.088**	0.337
	(0.011)	(0.011)
Education	0.449	1.566
	(0.329)	(0.329)
Constant	0.429	1.535
	(0.266)	(0.266)
Observations	100	100
R Square	0.0739	0.0739

Standard errors in parentheses
***** p<0.01, ** p<0.05, * p<0.1**

5.6 Conclusion:

The ailing cases of health found in district Kulgam by addressing RHP, GHP and OHP is 3%, 17% and 11%. Besides these some cases were found in collation in which both RHP and OHP is 7%, both RHP and GHP is 10%, both GHP and OHP is 19% and all the three RHP, GHP, OHP is 17% and the respondents without any health problem contains 16%. Area wise health problem was also investigated in which we find RHP 19 each cases in Rural and Urban areas, GHP 29 and 35, OHP 29 and 29 cases respectively. Gender wise Health problems of RHP are 2.63% in Male and 97.37% among Females, GHP 40.63% Male and 59.36% Female, OHP 40.63% Male and 59.36% in Female. Education wise Health problems are RHP, GHP and OHP, for Illiterates 15.57%, 26.56% and 21,81%, for Primary 5.2%, 4.37%, 10.90%, for Middle nill, 6.25%, 3.63%, for High 5.26%, 7.81%, 18.18%, for intermediate 23.68%, 15.62% 21.81% and for Higher 42.10%, 34.37% and 23.63%.

Utilization/ non-utilization of Health facilities for different categories of Health problems to the respondents are RHP 38%, GHP 64% and OHP 55% and the treatment taken for these problems is 21%, 42% and 43%.

The statistical significance demonstrated by the help of chi-square test with the help of Stata software shows that all variables have significant impact on health utilization and awareness. Except gender wise RHP, GHP and education wise RHP. Therefore we conclude that all the variables are defining health utilization. The binary lgostic regression results of all these three models showed that Area, Gender and Education are insignificant, but the individual contribution of all the three variables are either negatively significant or significant, which means the differences of Area, Gender and Education does not have impact in utilizing the Health Facilities, where people are unaware, having regions problems i.e. lack of Health facilities and Education becomes negligible before the limited available health facilities

5.6 Appendices

Table A. Area wise Percentage of Health Problems in District Kulgam

RHP Problems	**Area**		**Total**
	Rural	**Urban**	
White type of discharge	5 10.00	6 12.00	11 11.00
Menstruation related problems	3 6.00	5 10.00	8 8.00
Pregnancy complications	3 6.00	4 8.00	7 7.00
DNC/infertility/Miscarriage	2 4.00	0 0.00	2 2.00
Both White discharge and Menstruation problem	6 12.00	4 8.00	10 10.00
No	31 62.00	31 62.00	62 62.00
Total	50 100.0	50 100.0	100 100.0
GHP Problems	**Area**		**Total**
	Rural	**Urban**	
Gastro-intestinal problem	3 6.00	5 10.00	8 8.00
Febrile illness (fever of any type)	3 6.00	4 8.00	7 7.00
Cold	1 2.00	2 4.00	3 3.00
Jaundice	2 4.00	0 0.00	2 2.00
Accident/Injuries/Fractures	1 2.00	1 2.00	2 2.00
Skin Disease	3 6.00	5 10.00	8 8.00
Eye ailment	4 8.00	2 4.00	6 6.00
Disease of Urinary	2 4.00	1 2.00	3 3.00
Undiagnosed health problem	0 0.0	2 2.0	2 2.0
Headache	4	6	10

	8.0	12.0	10.0
Toothache	1 2.0	0 0.0	1 2.0
Aneamic	5 10.0	7 14.0	12 12.0
No	21 42.0	15 30.0	36 36.0
Total	50 100.0	50 100.0	100 100.0
OHP Problems	**Area**		**Total**
	Rural	**Urban**	
Joints and bones	7 14.00	2 4.00	9 9.00
Diabetes mellitus	1 2.00	6 12.00	7 7.00
Blood pressure	9 18.00	9 18.00	18 18.00
Psychiatric disorder	0 0.00	1 2.00	1 1.00
Cardiovascular disease	3 6.00	4 8.00	7 7.00
Respiratory disease	0 0.00	1 2.00	1 1.00
Both Joints and bones and Blood pressure	6 12.00	6 12.00	12 12.00
No	24 48.00	21 42.00	45 45.00
Total	50 100.0	50 100.0	100 100.0

Table B. Gender wise Percentage of Health Problems in District Kulgam

RHP Problems	**Gender**		**Total**
	Male	**Female**	
White type of discharge	0 0.00	11 22.00	11 11.00
Menstruation related problems	0 0.00	8 16.00	8 8.00
Pregnancy complications	0 0.00	7 14.00	7 7.00
DNC/infertility/Miscarriage	0 0.00	2 4.00	2 2.00
both 1 and 2	1 2.00	9 18.00	10 10.00
No	49 98.00	13 26.00	62 62.00
Total	50 100.0	50 100.0	100 100.0
GHP Problems	**Gender**		**Total**
	Male	**Female**	
Gastro-intestinal problem	8 16.00	0 0.00	8 8.00
Febrile illness (fever of any type)	3 6.00	4 8.00	7 7.00
Cold	2 4.00	1 2.00	3 3.00
Jaundice	0 0.00	2 4.00	2 2.00
Accident/Injuries/Fractures	1 2.00	1 2.00	2 2.00
Skin Disease	2 4.00	6 12.00	8 8.00
Eye ailment	1 2.00	5 10.00	6 6.00
Disease of Urinary	1 2.00	2 4.00	3 6.00
Undiagnosed health problem	0 4.00	2 4.00	2 2.00
Headache	7 14.00	3 6.00	10 10.00
Toothache	1 2.00	0 2.00	1 1.00
Anaemic	0	12	12

	0.00	24.00	12.00
No	24 48.00	12 24.00	36 36.00
Total	50 100.0	50 100.0	100 100.0
OHP Problems	**Gender**		**Total**
	Male	**Female**	
Joints and bones	4 8.00	5 10.00	9 9.00
Diabetes mellitus	5 10.00	2 4.00	7 7.00
Blood pressure	5 10.00	13 26.00	18 18.00
Psychiatric disorder	0 0.00	1 2.00	1 1.00
Cardiovascular disease	3 6.00	4 8.00	7 7.00
Respiratory disease	0 0.00	1 2.00	1 1.00
both 1 and 3	2 4.00	10 20.00	12 12.00
No	31 62.00	14 28.00	45 45.00
Total	50 100.0	50 100.0	100 100.0

Table C. Education wise Percentage of Health Problems in District Kulgam

RHP	Educational level						Total
	Illitrate	Primary (upto 5th)	Middle (6th-8th)	High (9th-10th)	Intermediate (11th-12th)	Higher (Graduation and Above)	
White type of discharge	3 16.66	1 12.5	0 0.00	1 9.09	4 21.05	2 5.26	11 11.00
Menstruation related problems	1 5.55	1 12.5	0 0.00	3 27.27	1 5.26	2 5.26	8 8.00
Pregnancy complications	0 0.00	0 0.00	0 0.0	1 9.09	1 5.26	5 13.15	7 7.00
DNC/infertility/ Miscarriage	1 5.55	0 0.00	0 0.00	0 0.00	0 0.00	1 2.63	2 2.00
Both White discharge and Menstruation problem	1 5.55	0 0.00	0 0.00	0 0.00	3 15.78	6 15.78	10 10.00
No	12 66.66	6 75.0	6 100.0	6 54.54	10 52.63	22 57.89	62 62.00
Total	18 100.0	8 100.0	6 100.0	11 100.0	19 100.0	38 100.0	100 100.0

GHP	Educational level						Total
	Illitrate	Primary (upto 5th)	Middle (6th-8th)	High (9th-10th)	Intermediate (11th-12th)	Higher (Graduation and Above)	
Gastro-intestinal problem	2 11.11	1 12.5	0 0.00	0 0.00	1 5.26	4 10.52	8 8.00
Febrile illiness (fever of any type)	3 16.66	2 25.0	1 16.66	0 0.00	0 0.00	1 2.63	7 7.00
Cold	1 5.55	0 0.00	0 0.00	0 0.00	1 5.26	1 2.63	3 3.00
Jaundice	2 11.11	0 0.00	0 0.00	0 0.00	0 0.00	0 0.00	2 2.00
Accident/ Injuries/ Fractures	1 5.55	0 0.00	0 0.00	0 0.00	0 0.00	1 2.63	2 2.00
Skin Disease	2 11.11	1 12.5	1 16.66	1 9.09	0 0.00	3 7.89	8 8.00
Eye ailment	0 0.00	1 12.5	0 0.00	1 9.09	3 15.78	1 2.63	6 6.00
Disease of Urinary	0 0.00	0 0.00	0 0.00	1 9.09	1 5.26	1 2.63	3 3.00

GHP	Educational level						Total
	Illitrate	Primary (upto 5th)	Middle (6th-8th)	High (9th-10th)	Intermediate (11th-12th)	Higher (Graduation and Above)	
Undiagnosed health problem	1 5.55	0 0.00	0 0.00	0 0.00	1 5.26	0 0.00	2 2.00
Headache	1 5.55	0 0.00	2 33.33	0 0.00	2 10.52	5 13.15	10 10.00
Toothache	0 0.00	0 0.00	0 0.00	1 9.09	0 0.00	0 0.00	1 1.00
Aneamic	4 22.22	1 12.5	0 0.00	1 9.09	1 5.26	5 13.15	12 12.00
No	1 5.55	2 25.0	2 33.33	6 54.54	9 47.36	16 42.10	36 36.00
Total	18 100.0	8 100.0	6 100.0	11 100.0	19 100.0	38 100.0	100 100.0

OHP	Educational level						Total
	Illitrate	Primary (upto 5th)	Middle (6th-8th)	High (9th-10th)	Intermediate (11th-12th)	Higher (Graduation and Above)	
Joints and bones	2 11.11	1 12.5	1 16.66	2 18.18	1 5.26	2 5.26	9 9.00
Diabetes mellitus	3 16.66	0 0.00	1 16.66	0 0.00	1 5.26	2 5.26	7 7.00
Blood pressure	2 11.11	2 25.0	0 0.00	3 27.27	5 26.31	6 15.78	18.00
Psychiatric disorder	0 0.00	0 0.00	0 0.00	0 0.00	0 0.00	1 2.63	1 1.00
Cardiovascular disease	1 5.55	2 25.0	0 0.00	2 18.18	2 10.52	0 0.00	7 7.00
Respiratory disease	0 0.00	0 0.00	0 0.00	0 0.00	1 5.26	0 0.00	1 1.00
both 1 and 3	4 22.22	1 12.5	0 0.00	3 27.27	2 10.52	2 5.26	12 12.00
No	6 33.33	2 25.0	4 66.66	1 9.09	7 36.84	25 65.78	45 45.00
Total	18 100.0	8 100.0	6 100.0	11 100.0	19 100.0	38 100.0	100 100.0

Chapter 6

Summary, Suggestions and Recommendations

CHAPTER 6

SUMMARY, SUGGESTIONS AND RECOMMENDATIONS

In this study an attempt was made to analyze the health status and factors affecting women's reproductive health (aged 15 to 49) in Kulgam district of Jammu and Kashmir. The focus in this research has been on understanding different problems in the reproductive years of their lives related to women's health. The researcher has made an effort to analyze the availability and utilization of Health facilities.

It becomes evident from the review of the literature discussed in the first chapter that there are many studies on women's health, but several questions remain unanswered. Therefore, the following objectives have been made of the present study:

- To study government's policies (central and state) and programmes regarding women's Health and the performance of women health programmes in Jammu and Kashmir.
- To analyze the availability of health facilities for women in Kulgam District of Jammu and Kashmir.
- To analyze awareness, attitude and utilization of women about Public health services of various levels, towards women's health in Kulgam district of Jammu and Kashmir.

6.1 Observations:

General health problems in this study relate to short-term or seasonal health problems, and other health problems refer to long-term health problems that affect both men and women. Specific Reproductive Health Problems (morbidity) refer to reproductive system disorders which may or may not necessarily be a reproductive consequence. The following major indicators were taken into account in the present study to analyze the health status of women in Kulgam district of J&K:

Mortality Indicators

- **Maternal Mortality Ratio (MMR):** In Kulgam District MMR is 4.0 per 1,00,000 live births (CMHO 2018-19). Mortality is much higher in rural areas. It is connected to many factors and one of the biggest factors is accessibility of health services.

- **Infant Mortality Rate:** The IMR in district Kulgam is (49) per 1,000 live births, in which majority are from rural areas as we know that more than 70% of the population of Kulgam lives in rural areas. It is also found that IMR is greater in females (29) as compared to male (20).

- **Neo-Natal Mortality Rate:** NNMR in district Kulgam is 22 per 1000 live births, according to Chief Medical Officers Office 2018-19.

Morbidity Indicators

- **Specific disease morbidity rate:** Indicators of morbidity are used to supplement mortality rates and define the population's health status. Since mortality indicator does not expose community's burden of ill health. It was found that the morbidity among women was higher than men. The percentage of women patients was almost 75% in total, the disease specific morbidity was of the reproduction problem. The government has to consider the matter for broader policy concerns.

- **In-patient and Out-patient attendance rates:** Data on attendance at Kulgam District's Public Health Facilities show that more men than women were treated as outpatients, while more women were treated as inpatients**.** The total number of out-patients increases from 2014-2018, from 355584 increase up to 1020224. On the other hand total in-patients increase from 23918 to 56148. The total number of in-patents was more from female as compared to male. Thus it can be concluded that increase in the number of women in-patients is more than the out- patients. Current study reveals that this increase is due to the government policy of free delivery at institutions and also because women generally ignore their health related problems and are hospitalized at the last moment.

Utilisation indicator

- **Antenatal care:** It is evident that Kulgam district is better from the average of J&K in accordance to NFHS-4, 89.5% of women delivered in an institution. Except in case of home delivery assisted by an expert, Kulgam district performs well. The proportion of pregnant women who receive ANCs in their first trimester in Kulgam district is 87.2%; it is 90.2% in rural area. Only 2.1% have their home deliveries supervised by a trained birth attendant. In Kulgam, 95.1% of women made at least 4 visits for antenatal care. The more antenatal visits, higher the chance of the birth occurring in a health facility or in the presence of a skilled personnel.

- **Family Planning Method:** Kulgam district has only 60.4% residents who use contraceptives, total unmet need for family planning is 9.3%, of which 2.9% for spacing and 6.4% for limiting.

Environmental Indicator

In terms of infrastructure in district Kulgam, nearly 97% areas have electricity and only 50.9% have access to toilet facilities. As for piped drinking water (which affects women's health indirectly) 85% of rural areas and 89% in total have this facility. Public infrastructure investment has direct positive influence on the lives and routine of women.

Socio- economic indicator

The socio-economic indicators for women's reproductive health include female literacy rate, sex ratio, age of marriage, dependency ratio, work participation rate, food availability and standard of living. The female literacy rate in Kulgam district is 61.8% which is good for women health. The sex ratio in Kulgam district presents the status of women in society which is 982 females per 1000 males. Decline in child sex ratio presents the status of women in society. Adverse sex ratio presents prolonged neglect of women. In Kulgam district age at marriage is 3.5% which is quite low and this has a positive impact on the health outcome**.**

Health Policy indicator

Different goals have been determined in 10^{th} and 11^{th} plan, National Population Policy, National Health Program and Millennium Development Goals for Infant Mortality Rate, Total Fertility Rate, Maternal Mortality Rate and institutional

delivery. Kulgam district is not performing well in some indicators from achieving goals laid out in these plans. The government plans and policies should be designed in accordance with the target of fulfilling it, rather than nourishing the gaps in between. Setting realistic goals will provide a motivation for their fulfilment.

With respect to the health indicators mentioned above, the study focused on the health status of women of reproductive age. It has been found that the status of women's health in Kulgam district is not satisfactory when analyzing secondary data. The researcher designed the above indicators to perform an in-depth study of women's health status in Kulgam district. Consequently, it also seemed necessary to review public health policies of government and state. Besides this, it is important to study the implementation of these policies in terms of improving women's health status. Such policies, however, do not emphasize the need to improve the health status of women.

Implementation and effectiveness of women's health policies and programs

In recent decades, women's health issues have achieved greater global attention and renewed political commitment In chapter three, some of the policies like National Population Policy 2000, National Health Policy 2002, National Health Policy 2017, National Women's Empowerment Policy 2001 and programs that were important in determining women's health status under the National Rural Health Mission and Integrated Child Development Scheme are addressed. The major paradigm shift from the earlier target to a Target-Free Approach (TFA) in 1996 to a customer centred and demand driven Community Need Assessment (CNA) approach (which was later renamed Reproductive and Child Health (RCH) approach in 1997) was introduced in order to translate the promises made in Cairo into policies and program actions in India.

Women's Reproductive Health problems other than pregnancy attracted the policymaker's special attention. The introduction of free market concepts to health services has reduced the gap between rich and poor/male and female in access to health care services. It is appreciable that the gaps are being reduced on a path. The policymakers realize that development cannot take root if it bypasses women, who are the very core around which social changes have to take place.

The five year plans have drawn special attention to the welfare of women, emphasizing all aspects of their overall status. Many departments have different plans, both directly and indirectly, to improve the condition of women. The ultimate goal of health programs is to achieve gender sensitivity. Gender mainstreaming in public health means addressing the role of social cultural and biological factors affecting health outcomes and, in doing so, it is important to improve program efficiency coverage and implementation. The programs have their limits due to limited resources.

The National Population Policy 2000 analyzes the high rate of population growth. Stabilizing the population is a requirement for promoting sustainable development. The policy has the key objective of reducing the fertility rate to the rate of replacement by 2010 and achieving a stable population by 2045. The main goal of the revised National Health Policy 2002 was to achieve an acceptable standard of good health among the country's general population and set goals for 2015 to be achieved. National Policy for Empowerment of women 2001 speaks as an example of gender disparity of the declining female-male sex ratio. The National Policy for Empowerment of Women 2001 has committed itself to eliminating all kinds of violence against women.

In J&K, the main women's health programs and schemes are the Family Welfare Programme, the Integrated Child Development Scheme, the National Rural Health Mission, and recently introduced Ayushman bharat. The adolescent girl child has been given special attention in the Integrated Child Development Scheme.

Janani Suraksha Yojana and Janani Shishu Suraksha Karyakaram are another important component under National Rural Health Mission. janani suraksha yojana is a centrally sponsored scheme to benefit pregnant women. The government has introduced the JSY to provide comprehensive medical care during pregnancy, childbirth and postnatal care and thus try to improve the rate of institutional deliveries in low performing states to reduce maternal mortality. Whereas, Janani Shishu Suraksha Karyakaram was introduced to encouraging all pregnant women to deliver in public health facilities and fully fulfilling the commitment to achieve 100% institutional deliveries. JSSK aims to mitigate the burden of out-of-pocket expenses incurred by pregnant women and infants and acts as a major factor in enhancing

access to institutions of public health and helping to reduce maternal and infant mortality.

Pradhan Mantri Surakshit Matritva Abhiyan and Village Health and Nutrition Days were also initiated in J&K with the goals of providing quality ANC to every pregnant woman and to provide an effective platform for the provision of primary health care for first contact. Last but not least Pradhan Mantri Jan Arogya Yojana (PM-JAY) was introduced in J&K, which aims to provide health insurance coverage of Rs. 5 lakhs per family per year for hospitalization in secondary and tertiary care to over 10,74 poor and vulnerable families. In district Kulgam the scheme is also playing its role in DH Kulgam, CHC Yaripora, CHC Qazigund and CHC DH Pora with total of 44215 eligible families.

The Indian women's health sector has been filled with resounding policy and study silences, misdirected and partial approaches and insufficient attention to critical issues such as co-morbidity or the reversal of the traditional health gender paradox. These issues in India in many ways reflect a global lack of attention to health gender equity. But the acute nature of gender inequality and preference for son in the country has made their consequences even more severe.

Availability of Health Facilities

It is clear that, particularly during reproductive age, women have a high mortality and morbidity rate. The availability of the required health facilities is important for improving the health status of women. The researcher discussed the available health facilities in chapter four, which includes infrastructure human resources and public health services.

Public health services are provided in Kulgam District by Sub Centres, Primary Health Centres, Community Health Centres, and District Hospital. All services need to be placed in accordance with Indian Public Health Standards (IPHS). It is obvious that these health facilities are not enough to provide quality-oriented and sensitive health care to women's specific needs. Public health programs, primarily of a preventive and promotional nature such as selected disease control programs, Family Planning and Reproductive and Child Health programs (contraception, immunization,

Ante Natal Care (ANC), Post Natal Care (PNC), and Janani Suraksha Yojana etc.) are special features of public health services.

As per the 2018-19 data, the projected population of Kulgam district is 531335. According to Indian Public Health Standard norms, there is a requirement of 6 Community Health Centres, 26 Primary Health Centres and 177 Sub Centres. The Functioning of different health facilities in Kulgam district are as follows:

Public Health Facilities:

- **Sub Centres:** A total of 117 Sub Centres are presently functional, the 60 Sub Centres shortfall and the services they provide are well below IPHS standards. Kulgam district, where more than 70% of the population lives in rural areas, Sub Centre is the first point of contact and ANM is the resource person who satisfies the demands of reproductive-aged women for health services. A woman faces so many demand and supply challenges. Initially there are no key persons in a sub-centre, especially to provide care counselling for women with reproductive health problems. There is a lack of techno-medical knowledge regarding their health needs; even ANMs and LHVs are unable to provide them with services properly.

  Because of the absence of male health workers at Sub Centres, most Sub Centres work with only one ANM (60 shortfall). The centres are usually open for only two to three days in a week for half of the day. The ANMs spend their maximum time on field visits followed by record-keeping, meetings, immunization, clinical work and travelling.

  In this situation it is more difficult to have access to healthcare providers at Sub Centres. It is equally difficult to deal with all women's health problems. There are no deliveries at these centres; the majority of sub centres are not equipped to deliveries. The success of any health program is largely dependent on the Sub Centre's well-functioning.

- **Primary Health Centre**: The number of working PHCs is 19. PHCs are the backbone of rural health services - a first contact to a qualified doctor for female and those who report directly or are referred from the sub-centres. PHCs are unable to perform at the expected level due to reasons such as the

non-availability of doctors at PHCs, in particular the Lady Medical Officer who, although posted, does not stay at the PHC headquarters and the lack of established standards for monitoring the quality of care.

- **Community Health Centre (CHC):** There are only 3 operational CHCs while total number required is 6. The condition of 3 CHCs, supposed to provide specialized medical care, is not so good**.** According to IPHS norms Kulgam district with 3 operational CHCs requires 3 surgeons and there are 3 surgeons present, but the condition of CHC D.H Pora is appalling with no surgeon and no gynaecologist. In the case of Physician only one is posted in CHC Yaripora hence there is a shortfall of 2 Physicians in CHCs of Kulgam district. Similarly, in case of paediatricians on 2 are posted and CHC D H Pora is again in shortfall.

- **First Referral Unit (FRU):** There is a provision of First Referral Unit (FRU), but no institution is functioning as a FRU and there is no facility of blood transfusion services in CHCs. There is a benchmark set by Ministry of Health and Family Welfare (GOI), for the Health Facilities which are functioning as FRUs. In the year of 2017-18 the functionality of First Referral Units (FRUs) as in hilly states are that for District Hospital an average of 6 C-sections per month and for CHC in an average 3 C-section per month should be done. But the situation is different in district Kulgam here out of 3 CHCs, which are CHC Qazigund, CHC Yaripora and CHC DH Pora only CHC Qazigund performs this function. There has been tremendous load on CHCs due to increase in institutional deliveries. In district Kulgam on one CHC out of 3 CHCs perform function of FRU. As per the benchmark set up by the MoHFW, GOI only CHC Qazigund and DH Kulgam perform the function. According to the data of 2017-18 the total number of deliveries was 3319 in which highest number was of DH Kulgam which was 2570 followed by CHC DH Pora 459 and the CHC Qazigund with 207 and then CHC Yaripora with 83 total number of deliveries were done. The C-sections in total was 1079 in which 1009 were done in DH Kulgam and 70 were taken in CHC Qazigund.

  For the improvement of women's health and increase in the utilisation of health facilities used by women, it is important to increase the availability of

health care providers i.e., an obstetrician and a gynaecologist. There are only two gynaecologists at CHC Yaripora and CHC Qazigund, while more are needed to be recruited.

- **District Hospital:** The district hospital is the secondary level referral centre for the public health institutions. The functioning of the Kulgam district hospital is not up to the expectation especially in relation to service availability, accessibility, quality, the staff strength, equipment and drug supply. The bed strength of DH Kulgam is 72 beds. District hospital has one separate operation theatre especially for gynaecological purpose, laboratories, X-ray and ultrasound are available, one aseptic labour room, linkage with District Blood Bank. Only District Hospital has Blood bank facility in the district. District Hospital Kulgam has 2 Gynaecologists, 2 Anaesthetist, 2 Surgeons, 2 Physicians, 1 Paediatrician, 1 ENT specialist, 2 Dentists and there is not any Pathologist in DH Kulgam. OPD services, Emergency services and referral services are also available.

  From the above data it is clear that in Kulgam district, there is a huge challenge to meet the shortfall for rural health infrastructure, specially the manpower. To rectify the mismatch between the number of specialists needed, and the availability in different disciplines, in order to meet the requirements of the Public Health Facilities, certain policy initiatives are immediately needed. Additional Sub Centres, PHCs and CHCs required meeting population norms. Inadequacies in the existing health infrastructure have led to an unmet need of health services, and obvious gaps in coverage and outreach. It was found during the study that mostly women's health programs were implemented very well, depending on the socio-economic conditions of the district. There are, however, various other issues that need to be addressed in relation to reproductive-aged women. There should be availability of medicines and support services that include mainly medical requirements and MTP at all facilities.

Utilisation of Health Facilities by Women

Chapter Five analyzed the association of variables with the help of the Chi-squire test and Regression Model in order to understand the pattern of utilization. Women in

Kulgam district have been found to face many health problems, sometimes these health problems are not as serious or life threatening as they take it as part of life.

Self reported health problems are collected and broadly divided into three categories, namely Reproductive Health Problems (RHP), General Health Problems (GHP), and Other Health Problems (OHP). White discharge, menstruation-related issues, pregnancy, DNC, infertility, miscarriages and nutrition are included in Reproductive Health Problems (particularly seen in women). The General Health Problems (GHPs) includes problems which are of short duration like; gastro intestinal problem, febrile illnesses or fever of any type, diarrhea, dysentery, cold, jaundice, accident/injuries/fractures, skin disease, eye ailment, disease of urinary system, headache, toothache, anaemic and undiagnosed health problems. Similarly in the category of Other Health Problems (OHPs), those ailments are considered which are of long duration such as; disease of joints and bones, diabetes mellitus, blood pressure, psychiatric disorder, tuberculosis, cardiovascular disease and respiratory disease.

Total 100 samples were taken from 5 medical blocks of district Kulgam. In which 50 samples were taken from Men and 50 from women category. The percentage of respondent reporting RHP is 3%, the percentage of ailing cases reporting GHP is 17% and the percentage of ailing cases having OHP is 11%. In addition of this there were cases found who are suffering from more than one type of disease. The percentage of ailing cases having both RHP and OHP is 7%, the percentage of ailing cases having both RHP and GHP is 10%, percentage of ailing cases having both GHP and OHP is 19% and lastly the percentage of ailing cases suffering from all the three health problems RHP, GHP and OHP is 17%. In total there are 84% ailing cases and rest 16% are disease free. Main findings of the survey can be summarized as below, Statistical test was done on 95% confidence level:

- From the responses of 100 respondents, it has been found that Area and Health problems treatment taken are not statistically significantly associated when treatment taken or utilization of health services are taken in broad three categories. But when taken separately, they show significant statistical association in case of RHP and OHP treatment taken between these two variables. In case of Reproductive Health Problems (RHPs) treatment taken

and Area, there is no difference found. This means that there is no difference of Area in utilizing RHP related services. In case of General Health Problems (GHPs), there is a difference between Area in utilizing GHP related services. Similarly, in case of Other Health problems (OHPs) there is no difference of Area in utilizing OHP related services.

- In case of finding association between Gender and treatment taken or utilization of health services, the results for the three types of Health problems treatment taken are as follows ; in case of RHP there is no statistically significant relationship between the two variables which means that the difference between gender and utilization of health facilities for RHP has a significant effect or in other words, gender difference has a significant effect on awareness of utilization of health facilities for RHP. On the other hand in case of GHP, there is no statistically significant difference between gender (Male and Female) with respect to utilization of health facilities. It has been found that gender has not a significant effect on utilization or non utilization of health facilities for GHP. And lastly, in case of OHP, there is no statistically significant difference between gender and utilization of health facilities for OHP. It has been found that gender has a significant effect on awareness of utilization of health facilities for OHP.

- In order to see the association between Education and utilization of health facilities or treatment taken for different categories of health problems, all the categories are statistically significant, the results which were calculated are as follows; in case of RHP, there is no difference between education in utilizing RHP related services. On the other hand in case of GHP, there is no difference between education in utilizing GHP related services. And similarly, for OHP, there is no difference between education in utilizing RHP related services.

- The regression results of all these three models showed that Area, Gender and Education are highly significant, but the individual contribution of all the three variables are either negatively significant or insignificant, which means the differences of Area, Gender and Education does not have impact in utilizing the Health Facilities, where people are unaware, having regions

problems i.e. lack of Health facilities and Education becomes negligible before the limited available health facilities.

6.2 Suggestions and Recommendations:

Better quality of public services will lead to a higher rate of utilization and cost reductions for women, especially lower class. This is very important from the policy point of view because unless the public is satisfied with the public services they do not use such facilities even if they need health services, and then the government's efforts would be wasted. Policy makers will address factors responsible for the spread of diseases as well as the socio-cultural dimensions of women health. More innovative and systematic intervention is required. There are some recommendations as follows:

- It is recommended that the level of public expenditure should be significantly increased. Many policy statements, including the National Health Policy (2002) and the National Rural Health Mission (2005-2012), recommended increasing health expenditure to around 3% of GDP. For immediate effect, this recommendation should be adopted.

- Reduce the gap in health services between rural and urban areas. It is important to step up the pace of implementation of the National Rural Health Mission in order to improve access to health services by rural people in general and particularly the poor.

- The government should fill all vacant posts of medical personnel, particularly doctors and nurses, improve the quality of facilities and the availability of medicines in order to improve the quality of health services on a priority basis. In order to improve reproductive health indicators it is necessary not only to ensure that 100 percent of villages are covered by Sub Centres but they also have adequate medical supplies, and technically sound manpower.

- Gender-specific resources and capacity building efforts are also needed. Improved sensitivity to gender may be achieved by a proactive approach to gender balance within the social system.

- Recommendations include upgrading PHC infrastructural facilities, continuing medical education for PHC doctors and ANMs, improving medication supplies at PHCs, and re-evaluating the connection between emoluments and quality of care received by medical and Para-medical personnel.

- It is suggested to improve the image of the services of the Public Health Centres in the community's minds. This study shows that in every sense we are far short of meeting the needs of reproductive health care.

- There may be different types of awards emphasizing different aspects of healthcare service quality such as cleanliness, cure prevention of disease, happiness of patients, etc. to motivate health service providers. All such awards in the winning health facility should be distributed among the relevant employees.

- It is also expected that the public-private partnership will improve the efficiency of the health care delivery system, while the optimal use of existing infrastructure will help improve women's health status.

- The availability of reliable data sets related to key social, economic demographic and health indicators is essential to the planning and monitoring of specific development goals for the area.

- Premarital and marital counselling will reduce reproductive aged people's misconceptions and overcome the related health problems. Limited knowledge of reproduction contraception family planning, dietary intake during different phases of development of the body or lack of it due to no permission to open discussion on it, women automatically suffer which affects the health of women. Proper male and female counselling can overcome the problem.

- The findings suggest that there is no significant influence of government policies on the overall health status of women. Lack of awareness and reluctance to use these facilities is one of the root causes of women's current poor status in rural areas. So the government must concentrate on it.

- Lack of information is the major barrier to effective access to services. It is suggested to intensify Information Education Communication activities especially for those people who are not well connected with media, focusing on the benefits of the government run programmes with special attention to clearing the myths and misconceptions rooted in cultural practices. Different agencies should be involved to raise awareness among the illiterate people of the region.

- ASHAs have little knowledge of concepts components and supply related to JSY. All recruited ASHAs, AWWs, and ANMs should be trained in a timely manner to more user-friendly treat reproductive women's reproductive health concerns. The three above are similar to rural villagers and are often sought after for health problems.

- Health facilities should be updated and strengthened to satisfy the increased public requirements in compliance with IPHS requirements, because successful introduction of government programs is only feasible when these specific requirements are actually achieved and not on documents.

6.3 Limitations of the Study:

Every research has its limitations such that when any further research is conducted the limitations given below may be taken into consideration.

1. The study has been restricted only to the Kulgam district.
2. The sample size is too small to generalize the overall results.
3. The population of the study is inconsistent in their response. Mostly they are unaware about the issues and problems related to health which they are facing.
4. Some of the results may be spurious due to in appropriate information given by the respondents.
5. Analysis of the study is based on sample observation and we have make use of advanced tools of statistics and econometrics, due to small sample size the results are no so significant.

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Appendices

APPENDICES

HOUSEHOLD INTERVIEW SHEDULE

(For-Availability and Utilization of Health services)

By- Asma Farooq for M.phil work.

From-BBAU Lucknow

Date of survey: / / 2019

Block……

1. Name of Village / Town ……

2. Type of Village/Tow… DH-01/PHC-02/CHC-03/SC-04/ None of these -05

3. Area Rural-1, Urban-0

General profile

1. Name of the respondent———————————————————
2. Gender ———————— Man-0, Women-1
3. Age ————————
4. Marital status ————————
   Unmarried – 01, Married– 02, Widowed– 03, Divorced– 04
5. Educational level————————
   Illiterate–01, Literate–02, Primary Education–03, Secondary Education–04, Higher Secondary Education–05, College–06, Post graduation– 07, Others–08
6. Usual activity status————————
   Agriculture-01, Government service-02, Private service-03, HouseWife-04, Student–05, Labour-class–06, Business–06, Unemployed–07, Others–08.
7. Religion ————————
   Hindu-01, Muslim-02, Sikh-03, Others-04
8. Social Group————————
   General-01, SC-02, ST-03, OBC-04, Others-05
9. House Hold size————————

10. Profile of respondent's household

S. No.	Name	Relation with respondent	Age	Gender	Education	Occupation	Income (monthly)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Health problems, Availability and Utilization/Non-Utilization of Health Services

1. Whether any health related problem/ pregnancy during last 1 year? ☐
   Yes-1/No-2

If yes, type of health problem

- RHP
  White or any type of discharge -01
  Menstruation related problems-02
  Pregnancy complications-03
  DNC/infertility/miscarriage-04
  Maternal malnutrition-05

a) Duration of illness_____
b) Treatment taken from any institution? ☐
   Yes-1/No-2
c) If yes, treatment taken from?
   Public medical facility (SC, PHC, CHC, DH, Others)-01
   Privet medical facility-02
   Chemist-03
   Untrained practitioner-04

d) If no, why? more than one option ☐
Facility available but no treatment sought owing to lack of faith-01, Long waiting-02, Financial reasons-03, Not serious-04, Domestic treatment-05, Appropriate health facility is not available-06, Need not felt-07, others-08

e) If taken, why from here? More than one option ☐
Nearby-01, Confidence-02, Recognized health facility-03, Free of cost-04, Emergencies-05, Low cost-06, Others-07.

f) Whether treatment completed? ☐
Yes-1/No-2

g) How far do you live from health centre?

h) Are you satisfied with the services rendered by the health centre? ☐
Yes-1/No-2

i) In your opinion, which health centre provides the better services? ☐
Government-01, private-02

- GHP
  Gastro–intestinal problem-01
  Febrile illnesses (fever of any type)-02
  Diarrhoea /Dysentery and fever -03
  Cold-04
  Jaundice-05
  Accident/injuries/fractures-06
  Skin disease-07
  Eye ailment-08
  Disease of urinary-09
  Undiagnosed health problem-10
  Aneamic-11

a) Duration of illness_____

b) Treatment taken from any institution? ☐
Yes-1/No-2

c) If yes, treatment taken from?
Public medical facility (SC, PHC, CHC, DH, Others)-01
Privet medical facility-02
Chemist-03
Untrained practitioner-04

d) If no, why? more than one option ☐
Facility available but no treatment sought owing to lack of faith-01, Long waiting-02, Financial reasons-03, Not serious-04, Domestic treatment-05, Appropriate health facility is not available-06, Need not felt-07, others-08

e) If taken, why from here? More than one option ☐
Nearby-01, Confidence-02, Recognized health facility-03, Free of cost-04, Emergencies-05, Low cost-06, Others-07.

f) Whether treatment completed? ☐
Yes-1/No-2

g) How far do you live from health centre?

h) Are you satisfied with the services rendered by the health centre? ☐
Yes-1/No-2

i) In your opinion, which health centre provides the better services? ☐
Government-01, private-02

- OHP(long duration problems)
  Joints and bones-01
  Diabetes mellitus-02
  Blood pressure-03
  Psychiatric disorder-04
  Tuberculosis-05
  Cardiovascular disease-06
  Respiratory disease-07

a) Duration of illness_____

b) Treatment taken from any institution? ☐
Yes-1/No-2

c) If yes, treatment taken from? ☐
Public medical facility (SC, PHC, CHC, DH, Others)-01,
Privet medical facility-02,
Chemist-03,
Untrained practitioner-04

d) If no, why? more than one option ☐
Facility available but no treatment sought owing to lack of faith-01, Long waiting-02, Financial reasons-03, Not serious-04, Domestic treatment-05, Appropriate health facility is not available-06, Need not felt-07, others-08

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