

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

**ABSTRACT  
DISSERTATION**

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## ABSTRACT

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. 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**

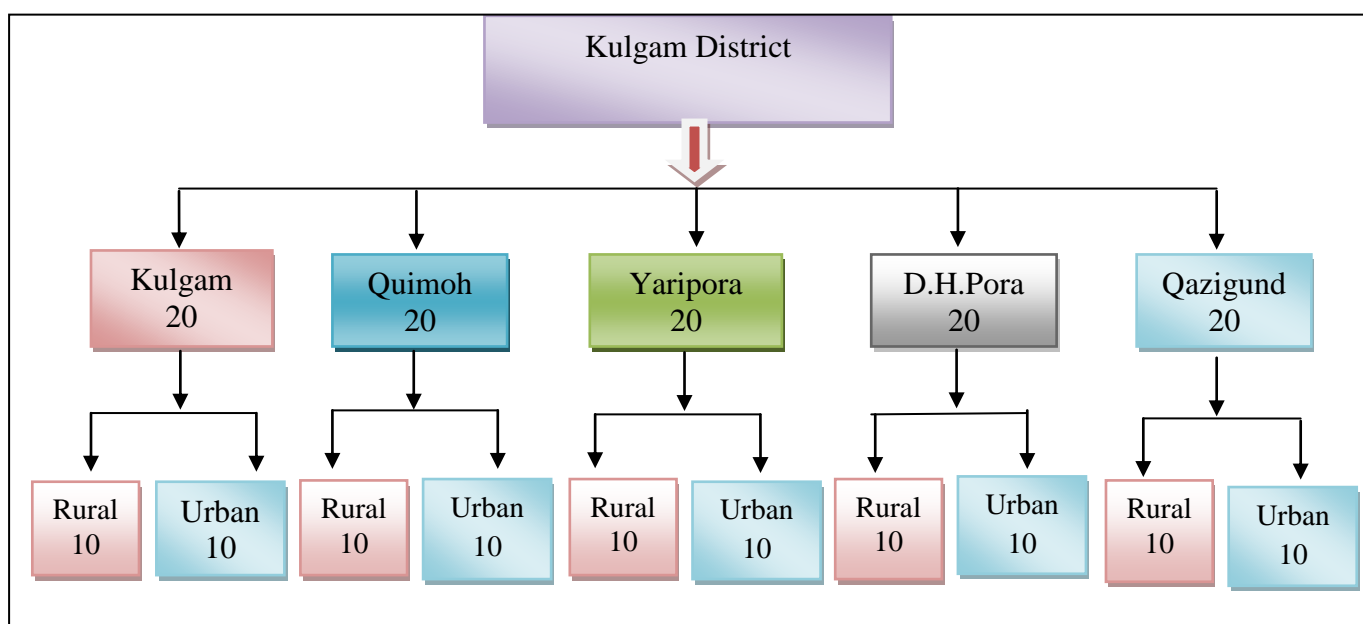
This study is descriptive cum exploratory. The study is based on mixed method. The investigator throw light on some determinants of women's health status such as age, area, education, household size, marital status, education and awareness of women regarding government availability and utilization of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

### **1.8 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).

### **1.9 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.

### **Conclusion:**

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.

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-patients 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 ANC's 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<sup>th</sup> and 11<sup>th</sup> 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-square 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.

**Suggestion 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.

#### **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 inappropriate 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.