HEALTH SERVICES IN JAMMU AND KASHMIR: A STUDY OF PUBLIC PROVISIONING AND PEOPLE'S ACCESS

Dissertation submitted to Jawaharlal Nehru University
in partial fulfillment of the requirement for the
award of the Degree of

MASTER OF PHILOSOPHY

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2012

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CERTIFICATE

This dissertation entitled '***Health Services in Jammu and Kashmir: A Study of Public Provisioning and People's Access'*** is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work.

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We recommended that this dissertation be placed before the examiners for evaluation.

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Acknowledgement

Writing this acknowledgment page is like an imagination for me that I have successfully completed my dissertation. During writing my dissertation, I felt couple of times, 'I may not complete my dissertation' and likely to dropout from this University. I recollect that sometimes I was preparing my mind to be ready to dropout; the only problem was that there was no better university in India to study next.

However, I did complete my dissertation and it was possible only with the encouragement of my Supervisor Prof. Ritu Priya Mehrotra. I am truly indebted to her for her encouragement through the time of working for this dissertation and thankful to her for best guidance I received, which helped me a lot to improve on my research quality, and improved critical and analytic thinking in me.

I take opportunity to thank all the people without whom this work would have not been possible. I am especially indebted to the people of the village where primary data collection was conducted for this dissertation for their support, hospitality and patience, even in freezing temperature during winter months of my fieldwork. I am thankful to my friends Mohd Yousuf Bhat, Mushtaq Ahmed Malla, Gh Nabi Dobi and Syed Qayoom Geelani for their relentless support which helped me to continue my work in Handwara in sub-zero conditions even when water had stopped flowing through pipes and everything was freezing.

I am thankful to other faculty members at Centre of Social Medicine and Community Health – Prof K. R. Nayar, Prof Mohan Rao, Prof Rama V. Baru, Dr. Sanghamitra Acharya, Dr. Ramila Bisht, Dr. Rajib Dasgupta and Dr. Sunita Reddy, and other staff, for their guidance and willingness to provide inputs whenever I approached them.

To some of my teachers from primary school, Mohd Abbas Shah, Javaid Ahmad Dar, Fayaz Ahmad, Shouqi Ma'am, Ab. Hamid, Gh Mohi-u-ddin, Ashiq Hussain, Wakar Amin

and Shabeen Hussain whom I felt they always believed in me that I may achieve some milestones in my career, and that has always boosted me to move forward.

It is my great pleasure to thank my dear friends, who supported me throughout this time and without whom it would not have been possible to complete this dissertation. They include: Swapnali Patil, Rafia Farooq, Vikas Bhaskar, Suroor Mander, Veda Yumnam, Bhat Iqbal Majeed, Zaheen Maqbool, Kaisar Ahmad Mir, Bilal Ahmad Kaloo, Sameet Panda, M Kumran, Golak B. Patra, Ambreen Bashir, Sheikh Showkat Hussain, Abid Rashid, Ali Mohd, V. Manikandan, Khurram Parvez, Venkat Reddy, Sanjay Tiwari and Anub Mannan. Special thanks to Yasir Hamid for his encouragement and help throughout.

To some of my friends for their constant guidance and inspiration in my career and include Harsh Mander, Shantha Sinha, Biraj Patnaik, Dipa Dixit and Frances Smith. I thank all of you.

Special thanks go to Dipa Sinha for being in-house advisor and counsellor to me, both in my life and my work. Thank you for always coming to my rescue in my confusions in work and life.

To my family - Dad and Mom, Bilkeesa, Mehak, Nawaz and Shumila and some of my lifelong friends – Rouf Abdullah, Dr. Adil Bashir, Gh Jeelani and Mushi, I owe my gratitude for your love, care, support and understanding throughout the years of my life.

And finally, I am hopeful that I would be writing another acknowledgement page, not much late in my life, for PhD thesis.

Tanveer Ahmad Dar

Dedication

This dissertation is dedicated to all the poor people in my state who are not able to access treatment due to negligent health services system; are compelled to sell their little assets, annual crop at compromised prices or borrow money in return of their labor to pay for increasingly expensive treatment; have to travel and wait for hours, days and months to access health services; and to those for whom consequences of treatment are sometime more severe than the physical illness itself.

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	A & N	*Andaman And Nicobar*	
	AAY	*Antodaya Anna Yojana*	
	AD	*Allopathic Dispensary*	
	AIIMS	*All India Institute of Medical Sciences*	
	ANC	*Anti Natal Check up*	
	ANM	*Auxiliary Nursery Midwife*	
	APDP	*Association of Parent of Disappeared Persons*	
	APL	*Above poverty line*	
	ARI	*Acute Respiratory Infection*	
	ASHA	*Accredited Social Health Activist*	
	AWC	*Anganwadi Centre*	
	AWW	*Anganwadi Worker*	
	AYUSH	*Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy*	
	BCG	*Bacille Calmette Guerin*	
	BMO	*Block Medical Officer*	
	BPL	*Below Poverty Line*	
	CD	*Community Development*	
	CHC	*Community Health Centre*	
	CRM	*Common Review Mission* `	
	DH	*District Hospital*	
	DHAP	*District Health Action Plan*	
	DHS	*District Health Society*	
	DK	*Don't Know*	
	DLHS	*District Level Household & Facility Survey*	
	DOTS	*Directly Observed Treatment*	
	DPT	*Diphtheria, Pertussis and Tetanus*	
	EC	*European Commission*	
	ECG	*Electro Cardio Gram*	
	EEG	*Electro Encephalon Gram*	

	EPW	*Economic and Political Weekly*	
	FAO	*Food and Agriculture Organization*	
	FGD	*Focused Group Discussion*	
	FHW	*Female Health Worker*	
	FRU	*First Referral Unit*	
	GDDI	*Gross District Domestic Product*	
	GDP	*Gross Domestic Product*	
	GMC	*Government Medical College*	
	GOI	*Government of India*	
	HH	*Household*	
	HSR	*Health Sector Reforms*	
	ICDS	*Integrated Child Development Services*	
	ICU	*Intensive Care Unit*	
	IFA	*Iron Folic Acid*	
	IMF	*International Monetary Fund*	
	IMR	*Infant Mortality Rate*	
	IPHS	*Indian Public Health Standards*	
	IUD	*Intrauterine Device*	
	J&K	*Jammu and Kashmir*	
	JSY	*Janani Suraksha Yojana*	
	KM	*Kilometres*	
	LHV	*Lady Health Visitor*	
	LOC	*Line of Control*	
	LPG	*Liquefied Petroleum Gas*	
	MAC	*Medical Aid Centre*	
	MDG	*Millennium Development Goals*	
	MDM	*Mid Day Meal*	
	MDMS	*Mid Day Meal Scheme*	
	MLA	*Member of Legislative Assembly*	
	MO	*Medical Officer*	
	MoHFW	*Ministry of Health and Family Welfare*	
	MPW	*Multi Purpose Worker*	

	MRI	*Magnetic Resonance Imaging*	
	MSF	*Medecins Sans Frontieres*	
	MTP	*Medical Termination of Pregnancy*	
	NA	*Not Available*	
	NC	*National Conference*	
	N.D	*No Date*	
	NFHS	*National Family Health Survey*	
	NGO	*Non Governmental Organization*	
	NRHM	*National Rural Health Mission*	
	NSSO	*National Sample Survey Organization*	
	OBC	*Other Backward Class*	
	OOP	*Out of Pocket*	
	OPD	*Out Patient Department*	
	PDP	*People's Democratic Party*	
	PDS	*Public Distribution System*	
	PHC	*Public Health Centre*	
	PGDDI	*Per Capita Gross District Domestic Income*	
	PNC	*Post Natal Care*	
	PTSD	*Post Traumatic Stress Disorder*	
	RGI	*Registrar General of India*	
	RHS	*Rural Health Statistics*	
	RKS	*Rogi Kalyan Samiti*	
	RMP	*Retailed Medical Practitioner*	
	RNTCP	*Revised National Tuberculosis Control Programme*	
	RSBY	*Rashtriya Swastya Bima Yojana*	
	ST	*Scheduled Tribe*	
	SDH	*Sub District Hospital*	
	SNP	*Supplementary Nutrition Programme*	
	SPSS	*Statistical Package for Social Sciences*	
	SKIMS	*Sheri Kashmir Institute of Medical Sciences*	
	SC	*Sub Centre*	
	TB	*Tuberculosis*	

	TT	*Tetanus Toxoid*	
	TV	*Television*	
	U5MR	*Under Five Mortality Rate*	
	UK	*United Kingdom*	
	UNDP	*United Nations Development Programme*	
	US	*United States*	
	UT	*Union Territory*	
	VHP	*Village Health Plan*	
	VHSC	*Village Health and Sanitation Committee*	

INTRODUCTION

Jammu and Kashmir (J&K) holds a special status in the prominent public imagination for its beauty. It also occupies a special status within the constitutional framework of India (because of the terms of temporary accession). The financial arrangements are different and enhanced for J&K as compared to other states in India, an opportunity for the state government to provide best services to its people. Moreover, because of the different legal arrangements of J&K with India, many of the legislations passed in India are not implemented in J&K, unless approved by the State cabinet. In many cases, the State has adopted a very weak version of many social legislations of India. However, this has also given a different policy framework for J&K, as many agendas and policies cannot be implemented in J&K by India directly, unless approved. The neo-liberal policy framework that Government of India has adopted in the last two decades is being pushed in the states as well. Public Distribution System (PDS) provides one of this. In many of the Indian states, food grains were distributed through a universal PDS but the Government of India, under the neo-liberal agenda of the 1990s began to cut their food grains quota for Above Poverty Line (APL) sections, forcing the states to shift from a universal PDS to a targeted PDS in 1997. However, the same policy framework could not be pushed into J&K. Similarly, the health sector reforms that were introduced in India, which resulted in squeezing of public health services and decline in utilisation of public health services, could not be pushed with same rigour into J&K as in other Indian states. Importantly, the neo-liberal policies that lead to land acquisitions and displacement of people on a wider scale in many Indian states could not be introduced in J&K due to the persistent conflict in the region. Many of the international agencies, which have been saviours of neo-liberal policies and have channelized the neo-liberal policies in various States of India, could also not find their way into J&K. This may be because for Government of India, the priority was different in Kashmir, as it wanted to hold the state within the Indian constitution rather than introducing market-oriented neo-liberal policies into J&K to exploit its resources.

However, the state of J&K was ridden by a different set of problems, some of which emerged because of conflict and some were induced in the name of conflict. Kashmir has been witness to different phases of violence and conflict over the last two decades. Although the companies and industries, which grabbed land throughout many villages in India, could not freely enter Kashmir, Indian security forces occupied the land across

Kashmir from the mainland to the hills. Tens of thousands lost life directly to conflict, and many more became victims of mental trauma, stress, anxiety and depression. Roads were blocked completely at night and people were not allowed to travel through, which shut down the nightlife completely in Kashmir. The freedom of people was curbed and its implications on the people especially women were huge, as the freedom to move determines access to health services. As a result, the conflict has resulted into many structural constraints and has created many barriers that shape the access of people to employment, livelihood and essential services. The same conflict, which became a saviour for the masses from many neo-liberal policies, resulted into widespread mass destruction on social, economic and political aspects of development of the state and its people. Many people lost jobs, especially those working in the tourism sector, handicrafts and livestock. The killing and disappearances of thousands of people have resulted into new marginalised groups of widows, half widows and orphans.

The other important impact of conflict has been on the governance and implementation of public health and other programmes of government. Many programmes do not perform well in Kashmir, which is partly because of the different socio-economic, cultural and ecological factors in Kashmir and the incompatible design of policies, and partly because of the mis-governance. Each year huge amount of money is not utilised and of what is utilised a larger part is diverted. Conflict gave a reason for the state to bargain for extra budgetary allocations with Government of India but it also became an alibi for their non-accountability and any failure. J&K lags behind in many of the development indicators as compared with India as a whole. For instance, in 2001, J&K had only 55.52% literacy rate, a 9.3% difference with the Indian level, which stood at 64.84% (RGI, 2001b). Recent provisional figures from the 2011 Census continue to show this pattern. A 5.3% difference remains between J&K (68.7%) and India (74%) in literacy rates (RGI, 2011). Further, 80 per cent of the population of the state is dependent on agriculture directly or indirectly (Zargar, 2008). But 97 per cent of the farmers are small or marginal farmers with an average land holding of 0.7 hectares (Alam, 2008). The per capita income of the state at Rs.17,174, is only two thirds of the national average of Rs 25,907 in India taken as a whole (Dar, 2009). The unemployment rate in the state is 5.21 per cent against a national rate in India of 3.09 per cent (NSSO, 2006). The road length per 100 sq km area in the state is 35.71 kms as against 104.64 kms in India (Kashmir Newz Board, 2007). There has been a worrying deceleration of agricultural production in the state. The valley suffers from a 44

per cent deficit in food grain production, 33 per cent in vegetables and 69 per cent in oilseeds, all of which are imported into the state from the rest of India (Dar, 2009).

However, macro data sets, like NFHS, suggest that Jammu and Kashmir provides a better picture on many of the health indicators as compared to India. For instance, the Neo-Natal Mortality rate in J&K was 29.8 (39 in India), Infant Mortality rate was 44.7 (57 in India), Child Mortality rate was 6.8 (18.4 in India) and Under-five Mortality rate was 51.2 (74.3 in India). Similarly, the proportion of under-weight children less than three years was 29.4 percent, as compared to 40 percent in India[1]; children in the age group of 6-35 months who are anaemic were 68.1 percent, as against 78.9 percent in India; women whose Body Mass Index is below normal were 21.3 percent, as against 33 percent in India; and men whose Body Mass Index is below normal were 19.9 percent, as against 28.1 percent in India (IIPS & Macro International, 2007). As the health status of the population is largely determined by the socio-economic factors, the reasons for J&K to achieve relatively better health outcomes than India as a whole, may be because of the better socio-economic conditions of the people in the state.

Kashmir has been historically a more egalitarian society. The proportion of population living below the poverty line is much lower than the aggregate in India as a whole, the officially estimated level of 5.4 percent in J&K, as compared to 27.5 percent in India as a whole, in 2004-05 (Saxena, 2009). The implementation of land reforms extensively in the state have became one primary factor for reducing the poverty in the state. However, the reduction in poverty does not necessarily imply the general prosperity of the state and its people, as the state lags behind on many of the development indicators.

The governments, both Indian and State, have changed their vision and priority for Kashmir and started bothering more about political problems in the region, after the conflict started in Kashmir in 1989. Similarly, the focus of intelligentsia in Kashmir has shifted towards political aspects of the conflict. Although it is much important but many other important social and economic aspects of development have been ignored, especially through the last two decades. The questions of access of people to essential services, livelihood and employment, and about socio-economic conditions and the ways people have lived within such situations have not been researched and written. The linkages of political problems

[1]There was a change in reference standards after the NFHS data was released and the adjusted figure adds up to 46 percent for India, but the figure was not able for J and K.

and changing political priority with socio-economic development was not much researched. As a result, many of the contemporary writings and academic research in Kashmir has been more on political conflict, with almost no connection of its impact on socio-economic conditions and everyday life of people. Not much research has been conducted into the impact of wide presence of Indian security forces and their occupation of pastures, roads, hills and other land on the socio-economic development of the state. The issues of governance and access to public services, were least attended to. For instance, *Economic and Political Weekly* (EPW), one of the India's premier journals for commentary on current affairs and research in the social sciences, has more than 800 articles, which relate to Kashmir back from 1950s; however, not a dozen of articles are related to issues of socio-economic conditions, poverty, government programmes, issues of health and well-being. A sign that Indian activists, academicians and policy advocates have even abandoned Kashmir for research, probably because undertaking any fieldwork in Kashmir was difficult in the last two decades during the conflict.

In this context, when not much research has been conducted on socio-economic conditions and access of people to public institutions and services, the changes in policy framework through the two decades of conflict also do not get examined. Some of the policies and programmes of government of India in same letter and spirit are implemented in Kashmir. Therefore, if they carry an agenda of neo-liberalism in other states, its impact on the region would be obvious.

Health is one of the areas of neglect in Kashmir for government as well for academicians and civil society from the research point of view. Only the mental health aspect has been relatively better researched and written about, since it has very direct relations with political conflict in Kashmir. Nevertheless, the other aspects of physical health like health status and access to health services have not received much attention. Any development and growth of a state must lead to better living conditions of people. Therefore, it is important to research into issues of socio-economic development, people's living conditions and access to services. It is in this context that the present study is focusing on one of the core issues, i.e., '*access of people to health services'*, with an intention that it may contribute in its small capacity to filling the knowledge and research gap on socio-economic aspects of people's life in J&K.

This study has looked into five important questions:

1. *What is the status of availability of health services in the state of J&K?*
2. *What are the regional disparities in the availability and accessibility to health services in the state?*
3. *Whether people face difficulties in accessing health services?*
4. *Whether there are disparities in access to health services along the line of gender and socio-economic class? If so, why and what are the factors that influence the differential access?*
5. *What are the other issues involved with access to health services?*

The study was conducted in two parts: (1) A review of literature and analysis of the data from official surveys and reports, and (2) Primary data collection in one village in Kashmir.

The dissertation is divided into five chapters. The first chapter, titled as '*Provisioning of Health Services in J&K*' primarily explores the first and second research questions. The second chapter delineates the study design and methodology adopted for the village level study. The third chapter analyses the socio-economic and political profile of Kupwara district and Neeligam village, in which the study was conducted. The fourth and fifth chapters present a critical analysis of data collected from the field and attempts to explore the difficulties faced by people in accessing health services and disparities in access to health services. These chapters broadly explore the third, fourth and fifth research questions. The sixth and last chapter summarises the findings of the study and presents a discussion on the issues of access to health services in Kashmir and future prospectus of research into related issues.

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CHAPTER 1: PROVISIONING OF HEALTH SERVICES IN J&K

1.1 Introduction:

The health status of populations have no doubt improved over time but the health indicators show a significant variation across different social groups, class, gender, regions, religions, etc. which unravels the fact that illness and health aren't evenly distributed throughout the population. The empirical data shows that there is a strong relationship between the socio-economic variables-- social groups, class, gender, regions, religions-- and health. The cause of health inequalities are embedded in larger socio-economic inequalities in the society such as poverty, wealth and income distribution, unemployment, housing, poor housing and working conditions is increasingly being agreed upon across the globe, by both scholars and governments (Giddens, 2004). There is ample evidence, which reflects that health inequalities are a function of socio-economic factors. Louis-Reñe Villerme (1782-1863) conducted empirical research, which revealed the linkage between poverty and factors such as elevated mortality rates, short stature, illness and deformities (Nayar, 2007). Later, work of Engels demonstrated how the health of destitute workers and their children was affected by extremely adverse living and working conditions. McKeown also demonstrated the role of non-biomedical determinants, particularly diet, for the decline of mortality rates in England and Wales during the 19th century, which reinforced these linkages and led to further examination of the linkages between environment, socio-economic changes and disease trends (Nayar, 2007). Richard Wilkinson (1996) brought the question of equality into focus and argued healthiest societies in the world are those in which income is distributed mostly evenly. Wilkinson looked into the empirical data from countries around the world and found a relationship between mortality rate and patterns of income distribution (Nayar, 2007). The Black Report in 1980, which was commissioned by the UK Government to review the data on health inequality, highlighted the need for anti-poverty measures and for improvements in education to bridge the health inequalities. The 1998 report 'Our Healthier Nation' brought into focus the diverse influences- social, economic, environment and cultural- for ill-health (Giddens, 2004). More recently, the setting up of *Commission on Social Determinants* of Health brought the social determinants on centre-stage in global public health policy (Nayar, 2007). The Millennium Development Goals (MDG) by the United Nations also pointed to the linkages between poverty and health and the member countries are expected to decrease the proportion of people living on less than a dollar a day and those who suffer from hunger to half by 2015 (Nayar, 2007). There is

enough research evidence that has indicated the possible linkages between development, poverty, quality of life, employment, working conditions, living conditions and the health. Therefore, campaigns to influence individual's life style choices (behavioural) and health education will have a limited impact on improving health status till the larger structural issues which sustain inequality are addressed in the society (Nayar, 2007).

In the Indian context, the health outcomes also show a significant variation across different social groups, class, gender, regions, religions, etc. as reflected by large-scale survey such as NSSO and NFHS, as well as in the micro level household surveys. The provisioning of and access to health services is one of the important components of health system for improving population health and to address the health needs in general and inequalities in health status in particular. There is no doubt that there has been an expansion of facilities in the public and private sectors over the last six decades after independence, but the expansion has been largely inadequate to ensure universal coverage and access to quality care to all the socio-economic groups across all regions (Baru et al., 2010). Until the 1980s, many efforts were made to strengthen the rural infrastructure; investments were also made in other social support programmes like nutrition programmes. However, since the implementation of health sector reforms[2] (1990s) in India a reverse trend has been noticed, which reinforced a selective and targeted approach, declining public investments, increasing use of private care and falling level of efficiency in the public sector. This all led to squeezing out of the poor from access to publicly funded health care, which resulted in increasingly high dependence of people up to 80 percent on the private sector for outpatient health care and is largely due to the weakness in the delivery of public health services (Rao, 2005 cited in Baru et al., 2010).

[2] The health sector reforms (HSR) overturned all the exciting Alma Ata principles on one hand, and dominated the health sector with a completely opposite market led principles on the other hand. The overwhelming objective of Alma Ata declaration of 1978 was ensuring "Health for All" by 2000. The three principles that were core of the Alma Ata policies included comprehensibility, universality of services to whole population irrespective of an individual's ability to pay and a primary health care approach, which envisaged the essential health care based on scientifically sound and socially acceptable methods and technology and the systematic promotion and enhancement of public health through preventive measures, education, immunization, and provision of clean water, nutrition and sanitation (Lister, 2008). Ironically, these principles were replaced by the menu of the HSR, which included: promotion of health service model with a minimal role for state restricted to "essential" package and maximum space for private agencies ; imposition of user fees for most health care services; encouragement of the establishment of various forms of health insurance ; contracting out services to private sector or NGO bodies to build "Public Private Partnerships"; decentralization of health systems; corporatization of health care providers including the public sector hospitals; and consumerist policies such as "patient choice' (Thomson & Dixon, 2006 cited in Lister, 2008).

The health sector reforms (HSR)[3] were implemented in 1980s onwards across many different countries at different points of time as part of the Structural Adjustment Program lead by World Bank and IMF, and have inevitably led to declining public provisioning of health services, increasing utilisation of private care, and thereby increasing health costs to be borne by the people. In India HSR were implemented in 1993. What is important to appreciate is the fact that the health sector reforms adopted were concurrent with other rapid changes in social and economic sectors. The changes in socio-economic polices included significant increases in the prices of basic commodities, the erosion of public subsidies such as those on food like targeting of PDS in 1997 in India, casualization of labour in the economy, inadequate public funding in education and transport, etc. All these aspects are very much central to the notion of public health (Qadeer & Sen, 1998). The UK provides an insightful example where the social polarisation within the country has well advanced in the last few decades, due to the changes in the socio-economic policies in the country. From the mid 1970s to the mid 1990s, the inequalities in living standards increased to a large scale, with only 7 % of the population living below the EC poverty line by mid-1970s, and this proportion increased to 24 % of population by mid-1990s. This increasing proportion of poor households was because of changes in the structure of the labour market and, in particular, a rapid decline in the demand for manual and low skilled work (Graham, 2001). It is well known that the socio-economic factors have a large direct bearing on the health status of people. Therefore, the impact of health sector reforms on the people inevitably aggravated in the backdrop of these large social and economic changes. Moreover, the inequalities in the financing of the health care across many countries have also increased, which added to the increasing health inequalities between nations. For instance, the US alone, which has just 5 per cent of the world's population, accounts for 40 percent of world health expenditure. On the other hand, the poorest countries with 84 per cent of the population and 90 per cent of the disease burden share just 12 per cent of health spending (Woolhandler et al., 2003 cited in Lister, 2008). The increasing health inequalities along the lines of social and economic factors have invited attention of some popular forces, agencies and of many governments. The declaration of 1998 World Health Assembly gave priority to the reduction of socio-economic inequalities in health. However, tackling the health inequalities requires comprehensive strategies, which addresses the

[3] "*Interestingly the very use of the word 'reforms' was misleading because in recent social memory rooted in historical experience, reforms meant measures for the welfare of the majority of the people. The World Bank took advantage of this social perception and never made it explicit for whom their reforms were meant*" (Qadeer 2001, p.29). Like this kind of reforms were the only way to the problems of Third World countries, as it was projected by IMF and WB, the justification for which came from the failures of the government and its policies (Qadeer, 2001).

fundamental socio-economic determinants of health, as is now recognised in many countries including UK and New Zealand (Graham, 2001). This brings us to the question of large forces, which have their own economic interests in health sector and are advocating for increasing public funding and subsidies for private provisioning of health services. *What is important to note is that health embodies a set of unique features, which makes it suitable to serve the logic of capitalism and as a result, has invited huge investments from big corporations*. For instance, the demand for health care is created by doctors; demand for medicine is often given primacy over other commodities; and the association with medicine facilitates a strategic control over a near total consuming public (Mckinlay, 1984). Health care has emerged as the world's largest industry, the second largest industry after arms industry, with a combined turnover of almost US$3.2 trillion annually which amounts to a tenth of global GDP (Lister, 2008). Therefore, with trillions of dollars at stake, the big pharmaceutical corps engages in all methods of constant lobby and advocacy to create demand and to secure markets for their drugs by penetrating into the markets across countries, broadening the definition of ill health, controlling medical research and training, creating ambiguous scientific evidences – if needed, misleading advertising, etc. They resist all attempts that may shift the balance in favour of the public (Panitch & Leys, 2010).

In this context, health care is visualised as an economic transaction, which leads to increasing commodification of health services, which further broke down the whole notions of resource allocation and planning of services according to objectives of equity and efficiency (Lister, 2008). Ironically, this notion has undermined the perception of the established relationship between poverty, inequality and ill health, which in turn had consequences for distribution and equity in planning for health care (Qadeer & Sen, 1998).

Within the nations these HSR strategies further widen the already huge gap and it was seen that the best-resourced health services, which were mostly private tend to be concentrated in localities inhabited by the affluent and influential and in urban areas. While services in rural areas and for the urban poor, women, elderly, and people with mental health problems tend to be seriously lacking in facilities, resources and staff. This is what has been termed by Hart, (1971) as the '*inverse care law*' - those who require maximum services are provided least (Lister, 2008). The research has also shown that where user charges have been imposed, the lowest income groups including women, children and the elderly have

been deterred from accessing treatment (Oxfam, 2006; Human Rights Watch, 2006 cited in Lister, 2008).

1.2. Access to Health Services in India:

The macro-level surveys on the utilisation of health services show that the inequalities prevalent in the larger social system reflect in the health service system as well. Like the health outcomes, the accessibility of different socio-economic groups to health services also reveals wide disparities. For instance, the NFHS-3, 2005-06 survey has revealed that while the all India immunisation coverage has been as low as 44%, there are considerable variations across different socio-economic groups with 71% coverage in the highest income quintile, which is three times higher than that in the lowest quintile as 24.4%. The different caste groups also provided a dismal picture with Scheduled Castes at 39.7%, STs at 31.3% and other castes at 53.8% coverage. Similarly, for treatment of diarrhoea the trend seems to be that the other castes (upper castes) are better off than Scheduled Castes, STs and OBCs. The proportion of STs who did not availed any treatment for diarrhoea stood at 30.5%, followed by Scheduled Castes at 29.3%, OBCs at 25.9% and other castes at 22.3%. The maternity care services also reflect a similar pattern with the proportion of Scheduled Castes (25.9 %), STs (29.4 %), OBCs (25.5%) women who have not availed any antenatal care is considerably higher than other castes, which is 15.2%. The data has also shown that the institutional delivery (including public, private and NGO) is also comparatively lower among these sections with 32.9% for Scheduled Caste women, 17.7 % for ST women, 37.7% for OBC women and 51.0 % for women of others castes (IIPS & Macro International, 2007). These disparities in access to health services arise partly due to uneven availability of health services across Indian States and between different regions, districts and taluks within States, in terms of differences in infrastructure, human resources, supplies and spatial distribution of health services (Baru et al., 2010). However, these disparities are also result of the larger socio-economic inequalities embedded in the society.

The *'issues of access'* has been looked by many scholars in different ways. While some have referred 'Access' it to use of the health care system, others have focussed on the factors influencing use (Penchansky & Thomas, 1981). However, the progressive definitions of *'Access'* consider three important components —availability (physical proximity), social accessibility and economic accessibility (affordability)—which are central to the provisioning of health services and collectively determine the access of

different socio-economic groups to the health services. This section briefly analyses these three important barriers to equitable access to health services in the Indian context.

1.2.1. Availability of Health services:

The public health institutions have been made available at three levels: at primary level, there are sub-centres and primary health centres; at secondary level, there are community health centres and hospitals; and teaching and research hospitals at the tertiary level. Besides there are several public insurance schemes for employees working in the organised sectors such as the employees' state insurance scheme, central government health scheme, railways and posts and telegraph services. There is also a huge proportion of private health services and a relatively smaller proportion of health institutions run by non-profit organisations. After political independence, India has seen an expansion of facilities in the public and private sectors over the time, but the expansion has been inadequate to provide accessible and affordable health care to all the socio-economic groups across all regions (Baru et al., 2010). Further, because the of the health sector reforms, the public health services have reduced to a greater extend in the last two decades, which resulted in increasingly high dependence of people on the private sector for health services (Rao, 2005 cited in Baru et al., 2010). The NSSO data has shown that in 2004 only 21% of people in rural and 19% in urban areas utilised the public sector for outpatient services. Similarly for inpatient treatment the utilisation rates were 42% and 38% in rural and urban areas, respectively, against 60% utilisation of public services in the 1980s (Baru et al., 2010). These figures shouldn't be interpreted to mean that people prefer to use the services of the private sector because the private sector costs are almost three times higher as compared to costs in the public sector – Rs 8,738 for hospitalisation in the private sector as opposed to Rs 3,410 in the public sector and therefore, unaffordable to the poor quintiles. However, due to inadequate facilities available at public institutions people do not enjoy much choice, and use private health care (Meeta and Rajivlochan, 2010). This has been reflected in the recent studies, which have also shown that people are not satisfied with public services and reported the lack of infrastructure, and indifferent and rude behaviour of personnel as important reasons for not using public services (Baru et al., 2010).

Even where the public facilities exist, the functioning of these institutions and quality of care is compromised to greater extent. The doctor-patient ratio has decreased to a greater level from one doctor for 17,000 people in 1986 to one doctor for 34,000 people in 2006 in

India and this fall in doctor-patient ratio was more in rural areas (Meeta and Rajivlochan, 2010). As a result the doctor-patient as well as the nurse-patient ratio in rural India is amongst the lowest in the world.

1.2.2. Social factors -- Accessibility to Health services:

The centuries old casteism has divided the Indian society into hierarchal layers of social groups, often characterised by exploitation, oppression, and exclusion of lower social groups in that devised hierarchy. The members of lower social group are likely to have less employment opportunities, unequal access to resources and less education, among others. Therefore, they experience higher probability of living under adverse conditions and poverty and hence have a higher probability to belong to lower social class as well. Therefore, in many cases, caste may be considered broadly as a proxy indicator for socio-economic status and poverty (Nayar, 2007). The manner in which the social classes interact and relate with each other in the larger social system will also determine how the upper ruling class (and exploiting) will define the concept of health and what the health services designed by them will actually deliver to the lower (and exploited) class. This is reflective in the health services system in India and was observed by Qadeer (1985) who found a similar pattern of large inequalities, hierarchy and division of labour that have shaped the health services system in India as in the existing unequal and hierarchal larger social system and has developed an elite culture in the health institutions. In a study on the doctors of All India Institute of Medical Sciences (AIIMS) it was found that *90 percent doctors had fathers who were either big land owners, businessman or professionals* (Madan, 1980 cited in Qadeer, 1985, p.207). These findings extend to other institutions as well, as shown by many other studies. In such an elite culture within the health services system the patient, especially if he is common person, becomes the least important. *The class (or caste) differences between the service providers and the service recipients with existing hierarchical larger social system also determines the actual delivery of services to the lower classes* and was also demonstrated by Banerji (1981) who observed that the nurse was seen as a *memsab* by Harijan respondents and reported "*How she can visit us? We are poor. We cannot pay her fees. She visits rich people and spends considerable time in their houses"* [*emphasis added*] (Qadeer, 1985, p.206). Similar experiences were also revealed by Zurbrigg (1984) who reported that Rakku, a woman belonging to lower socio-economic group and living in a far off village, had travelled long way to a city hospital from her village to get her child treated but by the time she reached the hospital gate was already

closed and had to bribe the gate keeper to let her in. The administration of that hospital had not even considered how the people from far off villages could reach that city hospital by 9 am, even with inadequate or no transport facilities to these villages, to get treatment while deciding on the norms for opening and closing of gate of hospital for people. The story of Rakku reiterates many other defunct characteristics of the existing health services system, its restrictive coverage and exclusion of most of the working class people specially those who live in destitution or at a subsistence level**.**

There is ample research evidence that even in cases where the health services are available to the people but certain sections of the society is not able to access them and is being excluded mainly for the reasons, which are social in nature –referred to as social exclusion. The differential access to immunisation services, treatment to diarrhoea, maternity care service, etc. by different social groups, as reported by NFHS-3, give a preliminary idea about least accessibility to health services by the lower social groups, which are excluded from the health services.

However, the disparities in health status and differential access to health services by different socio-economic groups are also because of the lack of affordability. Though the increasing costs and declining public health services has affected both men and women, the impact has been relatively more on women, due to gender-biased norms. It is now well documented how significantly the status of women in the household affects work burdens, health care needs, and access to range of public and private resources, including health care needs. The increasing medical expenses have resulted in growing inequities in access to health care along the lines of gender, caste and class.

1.2.3. Economic factors – Affordability of Health Services:

Due to market-free policies and forcing the state to minimise its role, public health services have reduced to greater extent in the last two decades. With the increasing dependency on private care, the out of pocket (OOP) expenditure on health services have increased drastically. The large-scale data shows that in India, 80% of total health expenditure and 97% of private expenditure are borne through OOP payments. This has not taken the indirect costs, such as loss of earnings due to the illness, into consideration—if included will further hike the OOP proportion of health expenditure (GoI, 2006 cited in Baru et al., 2010). Further, the NSSO data for 1999-2000 shows that a larger part of OOP expenditure

to the level of 70% in urban and 77% in rural areas are spent on medicines (Sakthivel, 2005 in Baru et al., 2010). The 2004-05 NSSO Consumption Survey data also shows that the household consumption expenditure spent on health has increased to 6.6% in rural and 5.2% in urban areas from corresponding figures of 5.4% and 4.6% in 1993-94 (Baru et al., 2010). The other additional concern with private services seen is that over- prescription of drugs is done routinely in India. A study conducted in the district of Satara in Maharashtra found that 19% of the prescriptions were irrational, 47% were unnecessary, 11% were hazardous and unnecessary injections were given in 24% of the cases (Phadke, 1996 cited in Meeta and Rajivlochan, 2010). Another study in Karnataka observed that the mean cost of drugs prescribed was Rs 37 and Rs 74 in public and private sectors, respectively. The over-prescription of drugs not only unnecessary increases the costs of health care but have also deleterious impact on the health of the patient (Meeta and Rajivlochan, 2010).

The increasing OOP costs and overall health expenditure makes the health services unaffordable to the people especially the poor and was also recognised in the 11th five year plan approach paper which states,

> "While both education and curative health services are available in the market to those who can afford to pay, quality sources are expensive and beyond the reach of the common people. Other privately provided services are of highly variable quality. In this situation, access for the mass of our people can only be assured through a substantial effort at public financing of essential services" (GoI, 2006, p.6 cited in Nayar, 2007, p.359).

The increasing dependency on the private sector for health services and high OOP health expenditure has further exacerbated the vulnerability and deprivation of poor people and has pushed many into deep poverty and indebtedness. It is estimated, after adjusting for health expenditure due to OOP payments, an additional 3.5% of the population or 35 million people fell below the poverty line for 2005-06 (Dreze and Sen, 1996 cited in Baru et al., 2010). This has increased over 1999-2000 when 3.25% or 32 million people fell below the poverty line (Garg and Karan, 2005; Bonu et al., 2007 cited in Baru et al., 2010). In another attempt to estimate the impoverishment of the people due to health care expenditure a nationally representative sample survey indicated that an additional 37 million Indians (3.7% of total population) were impoverished in 1999 because of healthcare

costs which increased poverty head counts by 12% (Doorslaer et al, 2006 cited in Meeta and Rajivlochan, 2010).

Baru et al., (2010, p.53) calculated the health expenditure burden on the different consumption classes and stated,

> "Total direct health-related expenditure as a percentage of household consumption expenditure for outpatient care in rural areas is the highest, at around 30%, for the poorest consumption size class. However, it declines only marginally, staying around 25%, for the next seven out of 12 consumption size classes. It is important to note that the first eight consumption size classes account for 60% of the population in rural India. The corresponding burden measure for inpatient care in rural areas is even more striking. While this burden is the highest for the poorest consumption size class, at around 28%, it stays around 20% for the rest of the classes, except for the highest consumption size class. Thus, the burden of expenditure for hospitalisation is substantial for nearly 90% of the population. This trend holds true for outpatient care in the urban areas. The expenditure burden is very high for the poorest two size classes; it stays at around 15%-16% for all but the two richest size classes. The pattern is different for inpatient care. The expenditure burden is very high for the poorest two classes and the three richest size classes. The high burden for the richest sections is because they use private (mostly tertiary) and corporate hospitals on a significant scale where the cost of care is very high compared with other rungs of the private and public sector".

What is interesting to find out is that not only the high health expenditure burden is related with poor incomes; the figures are also heavily skewed against those with the smallest landholdings. The NSSO survey of 2004-05 shows for farmers owning up to 2.5 acres of land (1 hectare), the debt on account of medical treatment was Rs 41, for farmers owning up to one acre of land (0.4 hectare), it increased to Rs 72 and for farmers owning up to one-fourth of an acre (0.01 hectare), it stood at Rs 130 out of Rs 1,000 (Meeta and Rajivlochan, 2010). This further gets increased with the routine exposure of people to farm chemicals in agrarian settings, which increases their health risks. A study of the paddy workers of Kerala has revealed that the workers had to incur an extra of Rs 38 health costs per day due to pesticide exposure against their routine health costs of Rs 3 per day when they were not

spraying and was approximately a quarter of their average daily earnings (Devi, 2007 cited in Meeta and Rajivlochan, 2010).

The question that has to be asked here is *how the poor cope up with high expenditure of health*. As noted earlier, that the public health services have declined over the last two decades, the health expenditure is increasing at the same time, therefore, the proportion of those people who are unable to afford the health services at present rates are increasing. The NSSO reports- 364, 441 and 507 have shown that in rural areas in 1986 the proportion of people who either had no money or were unable to find a local medical facility were 18% and this increased to 40% by 2004. The corresponding figures in urban areas doubled from 10% to 20% in the same period (Meeta and Rajivlochan, 2010). What is noteworthy to mention that poor people depend heavily either on borrowing, on contributions from relatives for such expenditure, or sale of important assets to arrange for health expenditure? The NSSO (2006) data shows that almost a fifth of the health expenses for outpatient care are financed through borrowing in rural areas and it is much higher up to 40 percent for hospitalisation; and the borrowings are significantly higher for the poorer sections of the population compared to the better-off (Baru et al., 2010). The sale of assets in case the debt is to be paid further leads to depletion of resources, which would have been of much help for their future.

A study on farmer's suicide showed that as many as 24% of the farmers who died had suffered from some chronic illness and in 30% of the cases, one member of the immediate family suffered from some chronic illness (Meeta & Rajivlochan, 2006 cited in Meeta and Rajivlochan, 2010). After accounting for cases, which fell in both categories, Meeta and Rajivlochan, (2010, p.43) found that the,

> "Average expenditure on treatment of one such ailment, irrespective of the number of consultations, was as high as Rs 6,636, which was practically the same as the amount spent on a single episode of hospitalisation...These figures do not take into account the expenditure on routine illnesses. They also found several cases where more than one member of the family was severely ill which would amount to even higher costs".

What is worse that all these intricate factors on the poor manifest in the rising number of suicides due to diseases which had decreased from 17% in 1967 to about 12% in 1989 but doubled to 24% of all suicides for India by 2006 (Meeta and Rajivlochan, 2010).

1.3. Inter-state Disparities in Health Outcomes and Access to Health Services:

There are significant variations across states in health outcomes such as infant mortality rate, child mortality, under five mortality rates, maternity mortality rate, nutrition status of children, and anaemia levels in women and children. These variations are due to the significant variations across the different states in number of socio-economic factors across states including status of women, per capita income, levels of poverty, housing status, socio-economic relations between different socio-economic classes, access to livelihood, state provisioning of public health services like water supply, sanitation, food and nutrition programmes, health services, etc. While the IMR for India stood at 57, it is relatively low in Kerala and Goa at 15.3. On the other hand, the States like Chhattisgarh and Uttar Pradesh show a relatively high IMR with Chhattisgarh at 70.8 and Uttar Pradesh at 72.7. Similarly, while the under five-mortality rate (U5MR) stood at 74.3 for India, it was very less in Kerala (16.3) and Goa (20.3). However, the states like Uttar Pradesh and Madhya Pradesh show an extreme with 96.4 and 94.2 U5MR in these two States respectively. While the Neo-Natal mortality is as low as 8 for Goa and 11.5 for Kerala, it is 51.1 for Chhattisgarh and 47.6 Uttar Pradesh. The Child mortality for Kerala is lowest at just 1 and 5 for Goa, while as it is highest for Arunchal Pradesh at 28.8 and Orissa at 27.6 (IIPS & Macro International, 2007). The performance of each individual state on such health indicators- Neo-natal, Child mortality, IMR and U5MR- is given in Appendix –A.

Similarly, like the health outcomes, there are huge variations in access to health services, as revealed by the large-scale data surveys. Almost 92 and 99 percent of deliveries happen in institutions in Goa and Kerala respectively. While as in states like Nagaland, Chhattisgarh, Jharkhand and Bihar the percentage of institutional deliveries are less than 20 percent. Similarly, only 0.1 and 1.1 percent of women in Kerala and Tamilnadu respectively did not receive any ANC for their most recent live birth, while, as it was 65.7 percent for Bihar and 42.6 percent for Arunachal Pradesh. At all India level, 38.7 percent deliveries were institutional, and 22.8 percent women did not receive any ANC (IIPS & Macro International, 2007). The performance of different states is given in Appendix –A.

There are variations in immunisation levels and access to treatment for children like for diarrhoea and ARI across States. At all India level, the proportion of children who were vaccinated was 43.5 percent. In states like Goa and Tamilnadu the vaccination rate has gone up to 78.6 and 80.9 percent respectively, while as in states like Nagaland and Uttar Pradesh the vaccination levels are just about 21 and 23 percent respectively. Similarly, percentage of children with diarrhoea who were taken to a health provider was highest in Haryana at 81.7 and 77.3 in Maharashtra, while as it was just 17.6 in Nagaland and 27.4 & in Mizoram, as against 59.8 percent at all India level. The percentage of children under-five with symptoms of ARI were 14.2 in Tripora and 7.67 in J&K, while as it was lowest in Himachal Pradesh (1.3) and Karnataka (1.7), as compared to 5.8 percent in India as a whole. Further, the percentage of children with ARI for whom treatment was sought from a health facility or provider was highest in Delhi (89.3) and Kerala (88.8) and lowest in J&K (1.6) and Nagaland (27.1), while as it was 69 percent at all India level (IIPS & Macro International, 2007). The performance of each individual state on vaccination levels, treatment levels for diarrhoea and treatment level for those who suffered through ARI is present in Appendix -A.

1.4. Health Outcomes and Health Services in J&K:

The macro data sets suggest that Jammu and Kashmir provides a better picture on many of the health indicators as compared to all India but lag behind many individual Indian states, etc. For instance, the NFHS–3 report shows that the IMR (Infant Mortality Rate) of J&K is 45, as against 57 in India; the proportion of under-weight children less than three years are 29.4, as against 40 percent in India[4]; children in the age group of 6-35 months who are anaemic are 68.1 percent, as against 78.9 percent in India etc. (IIPS & Macro International, 2007). The *Table 1.1* summarises some of the other health indicators in the state, as against India.

Besides, the data also shows that prevalence of some of the health problems is also much lower in J&K than India as a whole. For instance, the prevalence of Tuberculosis (TB) in J&K is 104, as against 445 in India per 100,000 populations (the medically treated TB cases are 96 in J&K and 418 in India). Similarly, in J&K the prevalence of diabetes among women was 540 (278 for men), asthma in women was 897 (816 for men) and goitre or other thyroid disorders in women were 237 (0 for men). While as the counter figures for

[4] There was a change in reference standards after the NFHS data was released and the adjusted figure adds up to 46 percent for India, but the figure was not able for J&K.

India were 881 for diabetes among women (1051 for men), 1696 for asthama among women (1627) and 949 for goitre or other thyroid disorders in women (383 for men) (IIPS & Macro International, 2007). The Planning Commission's study in seven states including J&K found that there has been no death reported due to malaria, kala-azar, dengue and japanese encephalitis in J&K. However, the study reveals that the reported TB cases were 12525, 1848 blindness cases and 217 malaria cases in 2008 (GoI, 2011).

Table 1.1 : Health Indicators in J&K and India

Health Indicator	***J&K (%)***	***India (%)***
Infant Mortality	57	44.7
Neo-Natal Mortality	*29.8*	*39*
Child Mortality	*6.8*	*18.4*
Under-five Mortality	*51.2*	*74.3*
Women whose Body Mass Index is below normal	21.3	33.0
Men whose Body Mass Index is below normal	19.9	28.1
Ever-married women age 15-49 who are anaemic	53.1	56.2
Pregnant women age 15-49 who are anaemic	54.0	57.9
Ever-married men age 15-49 who are anaemic	17.9	24.3
women (18-29) who were first married by exact age 18 years	16	46

Source: IIPS & Macro International, 2007

Further, the political situation has not been favorable in J&K, and therefore becomes one of the important factors in determining health status of people. J&K has been witness to different phases of violence and conflict over the last two decades. A number of reports and studies reveal that the more than 20-year-old conflict has taken a heavy toll on Kashmir. UNDP reported that civilian adults and children make up ninety percent of war victims (FAO, 1996). The estimates around the number of lives claimed by conflict, number of widows and number of orphans count for a big loss in the state. Although the numbers vary a lot between different sources, even conservative estimates suggest that almost 70,000 people have been killed in the Valley in the last two decades (APDP, 2011) leaving many children orphaned and many women widowed. The death toll also includes thousands of women and children. A study by Medecins Sans Frontieres (MSF) (which took the time frame between 1989 and 2005 in consideration) found that nearly one in ten people (9.4%) lost one or more members of their nuclear family because of the violence. A third (35.7%) indicated that they had lost one or more extended family members (MSF, 2006). There are multiple impacts of such large-scale violence on

the lives of people. The conflict in Kashmir relates to other armed conflicts across many countries in terms of the similar strategies that have been adopted through these conflicts by the combatants and therefore there are similarities in the implications but at the same time, many new patterns of conflict have emerged.

The literature suggests that there has been huge impact on the psychological well being of the people. There is a high prevalence of depression, anxiety and trauma among people living in conflict-affected areas. The levels of despair, unhappiness and hopelessness has increased tremendously to the extent that almost 34 percent of the people interviewed in a study conducted by MSF in 2006, reported that they were unhappy to the extent to having thoughts about ending their life. Further, 73.3% interviewees reported witnessing and 44.1% reported directly experiencing themselves, physical and psychological mistreatment, such as humiliation and threats. In the same period, one in six respondents (16.9%) was legally or illegally detained. A shocking finding is that torture appears to be widespread among those detained (legally or illegally) as 76.7% said they were tortured while they were in captivity. At the time of interview, almost half (48.1%) of the respondents said they felt only occasionally or never safe. Another 11.6% of interviewees said they had been victims of sexual violence since 1989. Almost two-thirds of the people interviewed (63.9%) had heard over a similar period about cases of rape, while one in seven had witnessed rape. Further, high rates of physical complaints including headaches (23.5%), body pains such as joint and back complaints (20.5%), and abdominal complaints (16.9%) were mentioned (MSF, 2006). In another study by Margoob et al. on the prevalence of trauma it has been found that one of most common traumatic event in the sample of 1200 individuals was combat or exposure to war zone and as high as 73.23%, with 75.18% in males and 70.31% in females (Margoob et al. 2006). A study of children conducted by a psychiatric hospital in Kashmir showed that almost 36 percent (37 out of 103) children displayed symptoms of PTSD (Margoob et al., in Dasgupta, 2008).

However, as socio-economic factors also play a greater role in the health status of population, the reasons for J&K to achieve relatively better health outcomes than Indian as a whole, may be because of the better socio-economic conditions of the people in the state. The data at all India level shows that percentage of people living under the official poverty line were only 4.5 percent in 2004-05 in rural J&K, as against 28 percent in rural India (Saxena, 2009). The low poverty rate in the state may be because of the rigorous land

reforms implemented in the state. The proportions of people who are landless are only 33.9 percent in the state (16.8 % in rural and 71.6 % in urban areas), which is quite high, but markedly better than 54.4 percent in India (both rural and urban together). The proportions of households owning farm animals are 63.4 percent as against 48.8 percent in India (IIPS & Macro International, 2007). Although estimated poverty line in India is contested and doubts have also been raised by many academicians and civil society on the quality of data of NSSO estimates in Kashmir for conflict reasons, the better socio-economic conditions in the state are also reflected by the wealth index[5] of NFHS-3. The wealth index of NFHS-3 shows that in J&K only 2.8 percent of population falls in the lowest quintile, and 12.3 percent falls in the second lowest quintile. While as in India, the proportion of households, which fall into the lowest quintile and second quintile, are 20 percent each. On the other hand, the proportion of households which fall into the fourth and highest quintile are 29.5 and 25.6 in J&K while as it 20 percent each in fourth and highest quintile in India (IIPS & Macro International, 2007).

The other aspect of having relatively better health status may be also because of the access to better public health services, including livelihood, food, nutrition, social security, health services, hygiene, sanitation, etc. The Public Distribution System (PDS) is universalized in J&K, among other few states of India, and each household is entitled to subsidized ration every month at differential rates, with AAY and BPL get more subsidy and APL get relatively less subsidy but up to 50 percent of the economic cost of ration (Dar, 2009). Even the officially recognized poor people were only 4.5 percent in rural J&K, the NFHS-3 data shows that the proportion of households owning a BPL card are 27 percent, as against 27.3 percent in India, which had 28 percent poverty as per the Government of India estimates in 2004-05. The proportion of households with electricity is 93.2 percent, as against 67.9 percent in India. The proportion of households having access to toilets is 61.7 percent, as against 45 percent in India (IIPS & Macro International, 2007)

[5] The NFHS-3 wealth index is based on the following 33 assets and housing characteristics: household electrification; type of windows; drinking water source; type of toilet facility; type of flooring; material of exterior walls; type of roofing; cooking fuel; house ownership; number of household members per sleeping room; ownership of a bank or post-office account; and ownership of a mattress, a pressure cooker, a chair, a cot/bed, a table, an electric fan, a radio/transistor, a black and white television, a colour television, a sewing machine, a mobile telephone, any other telephone, a computer, a refrigerator, a watch or clock, a bicycle, a motorcycle or scooter, an animal-drawn cart, a car, a water pump, a thresher, and a tractor (IIPS & Macro International, 2007).

1.4.1: Access to Health Services:

There is hardly any micro-level research study that has been undertaken and is in public domain which reflects the situation of the health services from people's perspective, however, the large scale macro survey regularly undertaken by the different government agencies, such as NFHS, DLHS and NSSO, give a preliminary idea about the functioning of health services in J&K. The section below gives a preliminary idea about the functioning of health services in J&K as reflected by the large-scale macro surveys.

The NSSO report 441 on '*Morbidity and Treatment of Illness'*, (based on the NSSO fifty second round survey in 1995-96) revealed that number of persons reporting any ailment (acute and chronic)[6] during the last 15 days prior to survey in rural J&K were 52 per 1000 persons, as against 55 in India, with a small gender gradient of 53 in females and 52 in males. The report has also revealed that among the ST population, the number of persons reporting any ailment (acute and chronic) during the last 15 days prior to survey in rural J&K were only 35 per 1000 persons, which was very less as compared to Scheduled Caste population, which stood at 62, and other higher castes, which stood at 51. The counter figures for India stood at 42, 54 and 58 for ST, Scheduled Caste and other higher castes respectively (NSSO, 1998). STs have relatively poor living conditions and lower access to health services than other higher castes and therefore should have higher levels of morbidity levels. The mortality figures of STs (including infant mortality rate, child mortality rate and under-five mortality rate) and data on access to health services and other micro-level studies show that STs are disadvantaged as compared to other higher castes (IIPS & Macro International, 2007; Baru et al., 2010). Therefore, what the NSSO report 441 has revealed that STs have reported very less levels of morbidity than the other higher castes (NSSO, 1998) may be due to either differential health consciousness, which is in turn shaped by the experiences of health services, or may be that they have reported only those illnesses in which they have sought treatment. Also, with many disadvantaged groups, the experience of illness is so often that they internalise it as part of life and often do not report some illnesses, as they may see it normal.

[6] Number of persons reporting acute ailment per 1000 population during the last 15 days prior to survey in rural J&K were 43, as against 42 in India, with a small gender gradient of 44 in females and 42 in males. Further, number of persons reporting chronic ailment per 1000 persons during the last 15 days prior to survey in rural J&K were 9, as against 13 in India, with a small gender gradient of 9 in females and 10 in males (NSSO, 1998).

The NSSO report 441 had also made an enquiry into the access to treatment by the persons who reported illness in the last 15 days. The report has found that number of persons per 1000 ailing persons reporting medical treatment of ailment during a period of 15 days were much higher to the level of 937, as against 827 in India, with a small gender gradient of 927 in females and 947 in males. This will account to almost 93.7 percent of ailing person getting treatment, a much higher level of access to treatment. This level of access to treatment is much higher than in Kerala (883) and Tamil Nadu (776), the states known for better provisioning of public health services than rest of India. *Therefore, such higher levels of access to treatment by the ailing persons in rural J&K needs to be studied,* considering that the public provisioning of health services is not better in state as in Kerala and Tamilnadu and its hilly topography. Further, the report shows that among the social groups number of persons per 1000 ailing persons reporting medical treatment of ailment during a period of 15 days were 1000 for STs, 945 for Scheduled Castes and 934 for other higher castes. The counter figures for India were 784, 832 and 830 for STs, Scheduled Castes and other higher castes respectively. Such high levels of access to treatment among STs and Scheduled Castes seems to be contradictory to huge literature which has demonstrated that STs and Scheduled Castes have least access to health services than the other higher castes. The level of discrimination and exclusion based on caste in J&K is not of the level of India but it cannot be denied that the socio-economic conditions of STs are worse than the other higher castes in the state, as result of their least access to resources, employment, livelihood and other public services. Therefore, one would assume that STs would have relatively less access to treatment considering their poorer socio-economic conditions and physical location, far away from towns where mostly the health services are located. Also in other States like Himachal Pradesh, Kerala, Manipur, Punjab and few other UTs, the ailing persons in ST category are reported to have 100 percent access to treatment, therefore, the findings can't be negated for J&K in one go and it needs to be triangulated with findings from other reports and studied at gross roots level (NSSO, 1998). Therefore, it does point out that the higher levels of treatment among the STs is probably due to the fact that they have reported only those illnesses in which they have sought treatment, that is the reason why the report has shown 100 percent treatment for STs among ailing persons. *However, it makes it imperative that such issues of reporting among the STs and their access to health service are to be examined and analysed at grass roots level, if it is a case of under-reporting of morbidity (reporting only those illnesses in which they have sought treatment).*

The NSSO in its 60th round in 2004 enquired again into the morbidity and health care and came out with a report no. 507, titled as *Morbidity, Health Care and Conditions of Aged.* The NSSO report 507 revealed that the number of persons reporting any ailment (acute and chronic) during the last 15 days prior to survey in rural J&K were 70 per 1000 persons, as against 88 in India, with a small gender gradient of 69 in females and 70 in males. The report has also revealed that among the ST population, the number of persons reporting any ailment (acute and chronic) during the last 15 days prior to survey in rural J&K were only 69 per 1000 persons, which was less as compared to Scheduled Caste population, which stood at 79, and other higher castes, which stood at 86. The counter figures for India stood at 58, 88 and 87 for ST, Scheduled Caste and other higher castes respectively (NSSO, 2006). The findings of NSSO report 507 and 441 show that over the period of 1995-96 to 2004 the levels of morbidity have increased over the years considerably from 43 to 70 persons per 1000 people, reporting ailment in the last 15 days prior to survey. Similarly, the reports show the considerable increase for India too from 42 to 88 persons per 1000 people, more than 100 percent increase. *Such a high level of increase in levels of morbidity may be due to higher level of reporting of illnesses, which in turn may be because of the fact the access to health services has increased over the time, which is likely to have its effect on the health consciousness of the people and reporting of illnesses.*

Further, the NSSO report 507 revealed that percentage of spells of ailment treated (non-institutional) among those persons who reported illness in the last 15 days were 82 percent for rural J&K and 94 percent for urban J&K, while it was 82 percent and 89 percent for rural and urban India respectively. This would mean that the levels of access have gone down over the years from 1995-96 to 2004, from 93.7 percent to 82 percent of ailing person getting treatment in rural J&K. This decline in access to treatment is probably because the reporting of illnesses has increased, as it corroborates the high levels of increase in the morbidity over the time.

Besides, the NSSO report 507 reveals that out of those who reported treatment 52 percent reported receiving treatment from government health facilities and 48 percent from private institutions in rural J&K, while as it was 22 percent and 78 percent in rural India respectively. Similarly, for urban J&K, the report reveals that 51 percent reported receiving treatment from government health facilities and 49 percent from private institutions, while

as the corresponding figures for urban India were 19 percent and 81 percent respectively (NSSO, 2006).

The treatment for hospitalisation also shows a trend that a majority of cases received treatment from public health services in J&K. The NSSO report 441 also revealed that the number of persons per 1000 distribution of hospitalised cases who were treated in government health facilities was an overwhelming 977 in rural India (959 for urban), higher than any other Indian state except A. & N. Islands, while as in rural India this figure was only 438 (419 for urban) (NSSO, 1998). Besides, the NSSO report 507 reveals that 913 persons per 1000 distribution of hospitalised cases were treated in public health facilities in rural J&K (865 for urban), as compared to 417 in rural India (382 for urban). Therefore, over a period of almost eight years from 1995-96 to 2004-05, the access to public health services for inpatient care reduced from 977 persons to 913 persons per 1000 hospitalised cases in rural J&K (959 to 865 in urban J&K), while as the decline has been 438 to 417 persons per hospitalised cases in rural India (419 to 382 in urban India).

The NFHS-3 data shows that in J&K, most households up to 63 percent use public sector as the main source of health care. However, in urban areas, the utilisation to public sector declines, where the private sector is the main source of health care for a majority of households up to 58%. This level of access to government health services is much better than the rest of India, where almost 65.6 percent of households generally seek health care from the private sector (IIPA & Macro International, 2007). Besides, the Planning Commission study found that most of the chronic patients (83.5 percent) had access to treatment from public health institutions and 16.5 percent sought treatment from private health facilities (GoI, 2011). *Higher levels of access to government health care in J&K as compared to India, where a major section depends on private health care, may be reason for relatively better access to health services in J&K than in India.*

The NSSO report 507 also reveals that the average expenditure (medical and other related expenditure but excluding loss of household income/wages) for hospitalised treatment per ailing person was 5666 and 6931 for rural and urban J&K, while it was higher at 6225 and 9367 for rural and urban India. Therefore, unlike the outpatient treatment, the inpatient treatment is relatively low in J&K than in India as a whole (NSSO, 2006). The NSSO report 441 revealed a different trend that the average expenditure on hospitalisation was

lesser in J&K than in India in 1995-96. The report shows the average total expenditure incurred by the households per hospitalised case during last 365 days was Rs. 2548 in rural J&K, lesser than in India where the counter figure was Rs. 3203[7] (NSSO,1998). Therefore, over a period of eight years the expenditure on hospitalisation has increased relatively more in J&K than in India.

However, the NSSO report 507 reveals that the average expenditure (medical and other related expenditure but excluding loss of household income/wages) for non-hospitalised treatment per ailing person was surprisingly high as Rs. 394 and 478 for rural and urban J&K, while it was only Rs. 285 and 326 in rural and urban India (NSSO, 2006). *That would mean outpatient health care is much expensive in J&K than India.* The same trend was also shown by the NSSO report 441 which revealed that the average total medical expenditure for treatment per ailment (not treated as inpatient of hospital) during last 15 days was Rs. 188 in rural J&K. While as the figures for rural India are Rs 128 for all rural population, lesser than in J&K (NSSO, 1998). *If instead of relatively expensive health care in J&K, a significant of ailing persons is able to access health care than India, the ability to access health care seems to be a function of better socio-economic conditions as well.*

But there is another angle to this, as though the average expenditure in J&K is more for both government and private health care in case of outpatient care, the gradient difference is minimal for government health care (Rs 13 and 4 for rural and urban J&K, and Rs 11 and 7 for rural and urban India). Therefore, a majority of more than 50 percent of ailing persons in J&K accessed health services from government sector at cheaper rates, while as only 20 percent of ailing persons accessed treatment from government sector at cheaper rates. Vice versa, only little less than 50 percent ailing persons in J&K have to pay for very expensive health services for their treatment from private care, while as a majority of 80 percent ailing persons in India have to pay for expensive treatment from private care. That implies that a majority of people have to pay smaller amount to access treatment in J&K, while as a majority of people have to pay much higher amount to access treatment in India, even though the average treatment costs are higher for J&K than India. *This leads to the conclusion that it may be because of higher levels of access to government services in J&K that resulted into higher levels of access to treatment in the state as compared to India.*

[7] The expenditure was little less, Rs. 2554 in rural J&K and Rs. 2080 in India, in government health facilities than in other non-government services, mostly private, where an average of Rs. 2608 (Rs. 4300 for India) have to be incurred per hospitalised case (NSSO, 1998).

However, the fact that a significant proportion of about 48 percent of ailing persons have received treatment from private facilities, which are much more expensive than in India. Therefore, the ability to pay for costly treatment cannot be negated, and would explain that it may not be just the accessibility to government health services in J&K, which lead to higher levels of access to treatment but the relatively better socio-economic conditions of people in the state than India as a whole would also play a significant role. *Therefore, the likely plausible explanation for a higher level of access in J&K than India to treatment seems to be a combination of better accessibility to government health services and better socio-economic conditions of people in J&K as compared to India.* However, this has to be examined at the grassroots level, if it is better accessibility to public health services or better socio-economic conditions or an inter-play of both factors, that leads to higher levels of access to treatment in J&K.

The NSSO also enquired about the reasons for not availing treatment. The NSSO report 441[8] found that among those who didn't access treatment in rural areas, 14.3 percent reported there was '*no facility'* available in neighbourhood (8.8 % for India); 4.4 % reported *'long waiting hours'* (5 % for India); a higher number of 73.3% reported '*ailment not serious'* (51.1 % for India); a minimum of only 0.3 % reported '*financial reasons'* (24.2 % for India); and 7.7 % reported other reasons (99% for India). There was not a single person who had no faith on the treatment, while as there were 3.7% in India who reported not having faith on treatment as the reasons for not availing any treatment for the illness (NSSO, 1998).

This signifies instead of higher medical expenditure to be borne by the people on their treatment for outpatient care in J&K than India, the people who reported financial reasons for not availing treatment were only 0.3 percent in rural J&K. While as people who reported financial reasons for not availing treatment were 24.2 percent in rural India even, a much higher proportion than in J&K, even when the expenditure was lesser in India than J&K. *This might be because of the higher proportion of people being able to access public health services, which are much cheaper, in J&K, as compared to India where a majority of about 80 percent access private health care, which is much expensive. It also reflects the capacity of people to afford health services in general as compared to India, which may be because of the better the socio-economic conditions in J&K. But it may be also that those*

[8] The NSS0 report 507 don't present state wise picture, therefore, only the findings of NSSO report 441 are analyzed in this section.

who are poor and can't afford health services have recorded their answers as 'ailment not serious', may be because they experience the illness as often that they internalised it as normal event in their life and can't afford to seek treatment frequently. While as 14.3 percent reported that there was no health facility available in the neighbourhood in rural J&K as reason for not being able to access treatment, the proportion was relatively lesser in India – only 8.8 percent. J&K has hilly topography and in addition, the political conflict in Kashmir has created fear among the people of moving alone, and many roads are blocked through the night by the security forces, therefore, making it much difficult to access health services during the night-time. In such case, the transport facilities are not available at all times and in all areas. Therefore, the distance becomes a major issue to access health services, even if the health facilities are located at nearer distances.

The 73.3 % reported '*ailment not serious'* (51.1 % for India) may be because they didn't feel the need to access health services for minor ailments or they experience such illness as often that they have internalised it as normal, and don't seek treatment. *It may be also because they would have tried local remedial practices (non-medical) for cure but that is not classified as medical treatment in NSSO survey.*

All these issues including poor quality of health services, limited outreach of grassroots level workers, costly treatment, inability to pay, lack of nearby facility or inconvenient timings, long waiting hours, among others, which affect the access of people to public health services may also push the people to access health care from private sector. In the NFHS survey, households, which do not access government health facilities people were asked the reasons, and 55.3 percent reported poor quality of care as the main reason for not accessing government health facilities (46.8 % for India). Further, 33.2 percent reported lack of a nearby facility (46.8 % for India), 22.4 percent long waiting times (24.8 % for India); 9.3 reported facility timing not convenient (13.1 % for India); 5.9 percent reported health personnel often absent (9.2 % for India); and 7.3 reported other reasons (3.9 % for India) (IIPS & Macro International, 2007). In the Planning commission study, people who suffered through chronic diseases reported non-availability of medicines in public health facilities, public health facilities located far and emergency as major reasons (67.7 %) in J&K for availing treatment from private health facilities. However, 32.4 percent also reported that availability of better treatment at private sector as the main reason (GoI, 2011). The question arises that the private health sector also does not given free medicines,

and then why not providing medicines have become a reason for not accessing treatment. A major part of expenditures to be incurred on treatment is on medicines, and if medicines are to be purchased from market the actual difference between receiving treatment from public health services or private services if just the consultation fee in major cases (Rs 50 to 150 in most cases in Kashmir), but paying this consultation fee may get them to receive treatment in a short span of time and don't have to wait for hours of time, as in public health sector. In many cases, people may be giving more value to saving time as compared to cheaper but longer waiting hours of the public facility. The cost could range from Rs 50 to 150 for consultation fee at a private clinic.

The NFHS survey gives an account of access to maternal and child health services, and morbidity levels and access to treatment. The NFHS -3 data, as can been seen from the table 1.2 reveals that the only 50 percent of women had delivery in a health facility (38.7 percent in India). Among women with a live birth in the five years preceding the survey, the percentage of women who had access to three or more antenatal check-ups (ANC) during the pregnancy for their most recent live birth were 73.5 percent (52 percent in India). However, the percentage of women who received all recommended types of antenatal care (three or more antenatal check-ups, with the first check-up within the first trimester of pregnancy; received two or more tetanus toxoid injections; and took iron and folic acid tablets or syrup for three or more months) were only 17.5 percent (15 percent for India). The percentage of deliveries with a postnatal check-up (PNC) was only 51.6 percent (41.2 for India). Further, only 66.7

Table 1.2 : Access to Maternal and Child Health Services in J&K & India

Health service	*J&K (%)*	*India (%)*
Institutional deliveries	50.2	38.7
Three or more Ante Natal Checkups for their last birth	73.5	52.0
No Ante Natal Checkup	14.7	22.8
One Post Natal Checkup	51.6	41.2
Children 12-23 months fully immunized (BCG, measles, and 3 doses each of polio/DPT)	66.7	43.5
Children with diarrhoea taken to a health provider	67	59.8
Children with ARI for whom treatment was sought from a health facility or provider	71.6	69

Source: IIPS & Macro International, 2007

percent of the children have reported to be vaccinated (43.5 percent for India). Among the children who had diarrhoea, only 67 percent were taken to a health provider (59.8 % for India). Moreover, the percentage of children with ARI (Acute Respiratory Infections) for whom treatment was sought from a health facility or provider were only 71.6 percent (69 % for India). The percentage of children under six -years of age who had received any service from an Anganwadi centre (AWC) in the past year prior to survey were only 16.6 percent (28.4 % for India)[9] (IIPS & Macro International, 2007). The Planning Commission study has also reported that 28 percent of women had access to full ANC and only 50 percent of the women had their delivery in a health facility. Institutional deliveries have increased from 0.9 to 1.53 lakhs, however, the JSY beneficiaries have gone marginally up from 0.02 to 0.08 lakhs in 2008-09. The report further reveals that only 30.8 percent women had access to PNC (GoI, 2011).

Some proportion of women reporting they have not utilised the maternity health services, could be for both reasons - there is no 'need felt' as well as not being able to access maternity health services, which includes the compromised quality of services, limited outreach of maternity health services, affordability as well as socio-cultural factors. The concept of 'felt need' is important in context of maternity services. For instance, not all women who had all the three recommended ANCs and institutional delivery would have had three PNCs, because not all of them feel the need to have three postnatal check-ups after delivery. They may feel to have a minimum of one PNC and not necessarily going for three PNCs. Women may choose to give birth at home and may not feel necessarily going to a health facility, irrespective of availability and accessibility to health facilities. *Therefore, whether need is felt for maternity services by women is one of the important factors for utilisation of maternity health services.*

However, the utilisation of maternity services also depends on the quality of services, outreach of maternity health services, affordability as well as socio-cultural factors, which determine the access of women to maternity health services. As the health behaviour of people is shaped by their experiences and perceptions about the health services and by the quality of care, they receive, therefore, the role played by the grassroots health functionaries is also very important. For instance, in areas where ANM, ASHA and AWWs have contacts and reaching out to more women, there is higher probability of increased

[9] AWC services include distribution of supplementary food, growth promotion, immunizations, health check-ups, health and nutrition education, and pre-school education.

access to ANC, delivery and PNC care as well as for immunization and treatment for diarrhoea. However, the NFHS-3 data revealed that the percentage of women with any contact with a health worker (auxiliary nurse midwife, lady health visitor, anganwadi worker, or community health worker) in the three months prior to the survey were only 4.1 percent in J&K, as against 17.3 in India. Further, in the Planning Commission study people were also asked if any health camps was organized at village/community/ block level, and only 33.6 percent confirmed that such health camps are being organised (GoI, 2011). This less proportion of women with any contact with a health worker in J&K signifies the limited outreach of health functionaries at the gross root level in J&K (IIPS & Macro International, 2007). This may be one of the reasons for low levels of access by women to all recommended types of ANC, low access of children with ARI to treatment and low levels of access to ICDS services in the state because these services depend heavily on the functions of grassroots level health workers. However, levels of contact of women with health workers would have now increased after ASHA scheme was introduced under NRHM in 2006. Further, the data has revealed that there is severe gap between women who had three or more ANCs (73.5 %) and women who had received all recommended ANCs at proper time, two or more tetanus injections and iron folic acid tablets/syrup (17.5 %) and this points to the fact there are quality issues with ANCs, which would certainly be affecting the utilisation of maternity health services (IIPS & Macro International, 2007).

More importantly, the access of women to maternity health services depends on status of women and their freedom to travel alone (or accompanied by other person) to health facility, which are always outside the village (in many cases Sub-centres do not function properly and ANM/AWW/ASHA do not meet women at village level). The NFHS-3 data reveals that there is a high exposure among women to media regularly in the state to the level of 82.4 percent, and it is seen that the gender gap in the exposure to media is also low (about 4.8 percent). The data on other indicators of women's autonomy and decision-making powers also shows a better picture in the state than in other parts of India. The percentage of women allowed to go to three specified places (market, to the health facility and places outside the village/community) alone were 51 percent, which ranks J&K at 3rd position among the Indian States. The percentage of women who have money that they can decide how to use were 55.4 percent, ranking J&K at 6th position among Indian States. The

percentage of women who participate in specific household decisions[10] were relatively less of 25.2 percent, much lesser than Indian level of 36.7 percent (IIPS & Macro International, 2007). This, however, give a picture that the mobility of women is relatively better in J&K than India, which are a crucial factor for accessing health care, and may be the reasons for higher levels of utilisation of maternity services in J&K than India.

Although the NFHS data on women's empowerment provides a better picture, it fails to record the influence of the conflict in the state on the mobility of people especially women. The armed conflict has had its effect on the mobility of women very drastically, especially in far off and rural areas, where movement sets with the sunset bringing death like silence to Kashmir. The mobility of women has affected after the conduct of rapes and sexual harassment of women in the state by Indian security forces in many instances which started early in 1990s. The other ways where the establishment of security forces in the state have affected the mobility and access to health services is by blocking the roads completely by putting barricades and gates on the roads after the sunset and frequent frisking of vehicles on the road in the daytime. There are two famous Army camps in Kupwara district, one locks the Lolab valley, which cuts it from the district head quarter, after sunset, and another locks the Zachaldara medical block and cuts it from its adjoining tehsil and district headquarters, after the sunset[11]. There are many such instances in Kupwara and other districts of Valley. In such instances, the women employees also felt unsafe travelling to field areas. Therefore, this has hampered the access of women to maternity health services to some extent, and one of the reasons for women health providers not to travel to field areas, especially those located at far off places. In this context, the Planning Commission finding that only 3 percent of ASHA were residing in the serving village would mean that most of the ASHA might not be accompany pregnant women to accompany to health facility for delivery or visit them for ANCs and PNCs.

The conflict has also affected the health services in other ways. One is at the macro-level, due to the diversion of finances by the state for managing political conflict in the state and due to the failure of generating economic avenues. Secondly, is at the micro-level, by directly affected the people and public health services. For instance, conflict had a drastic impact on the food and livelihood security of many families especially those who have lost

[10] Decisions regarding own health care, making major household purchases, making purchases for daily household needs and visits to her family or relatives

[11] These are based on the observation of this researcher during his recent visits to Kupwara district in May-June 2011.

their primarily bread earners. As mentioned earlier, it is estimated that almost 70,000 people died in the state due to armed conflict. The loss of a bread earner, who is a male member in most cases, has emerged as a serious issue especially in the rural and far off villages where the women were mostly less educated and find it difficult to get any kind of work. Many who were engaged in the tourist and handicraft sector lost jobs because of decline in the tourism and related activities during conflict. All these instances lead to deteriorating socio-economic conditions of many families, which had its impact on their health status and access to health services.

There are also incidents of Indian security forces barging into hospital premises and creating an environment of fear, stopping ambulances and beating up the medical staff, and breaking the panes of ambulance, especially during strikes and protests in Kashmir. A fact-finding report by a team of academicians and activists recounts that in 2010 during four month long protests in Kashmir, Indian security forces intruded into a SDH (CHC) hospital at Pattan tehsil (Baramulla district), immediately after several injured civilians had been brought to the hospital for urgent medical attention. They broke the windows, doors, panes and destroyed vital medical equipments, and medical staff was thrown into a state of fear, some had locked themselves inside bathrooms to escape threat. The chief medical officer's car and recently acquired ambulance was damaged. They even shot dead a 12-year old boy who already had one bullet in his shoulder and was under treatment in the hospital (Bhatia et al., 2011). These instances create a state of fear among the health providers and would certainly hamper their travel to field areas during times of strikes and in other cases.

As a result, the conflict has resulted in many structural constraints and has created many barriers that are likely to shape the access of people to health services. Though the conflict has affected all sections of population, the impact has been relatively more on women and lower socio-economic sections. This may have resulted in growing inequities in access to health care along the lines of gender and class. *What needs to be explored are the processes of how the conflict has affected the socio-economic conditions and access to public services including health services in a more systematic and comprehensive way*?

1.4. 2: Deficits in Human Resources and Infrastructure:

The reports show that there is a severe shortage in infrastructure and human resources in public health sector, which would be affecting the quality of services, and therefore on the

access of people to health services. People who may have accessed a health facility near to home in presence of health providers may not be able to reach out to a far health facility, located away from his home.

a) Human Resources: Table 1.3 below shows that there are deficits in human resources against the required staff in different levels of health facilities in J&K. There was a deficit of almost 76 percent in male health assistants at PHC and about 76.5 percent in female health assistants at PHCs. Besides, a deficiency of 14 percent among nursing staff at PHCs and CHCs would mean that the nursing services are compromised to greater extent in public health facilities. There is a deficiency of almost 45 percent in medical officers at CHCs. Besides, specialists at CHCs also seem to be not present in majority of cases as there is a deficiency of 46 percent specialists (MoFHW, 2010). The DLHS-3, 2007-08 reported has also shown that out of 73 CHCs surveyed; only 45.2 percent had obstetric/gynaecologist, 19.2 percent had paediatrician, 54.8 percent had anaesthetist, and 9.6 percent had health manager. Further, the DLHS-3 reported revealed that out of total 222 PHCs surveyed, only 51.8 percent had Medical officers, 39.2 percent had Lady medical officers and 34.2 percent had AYUSH medical officers (IIPS, 2010).

Table 1.3 : Deficits in Human Resources in J&K

Staff	***Required***	***In Position***	***Shortfall***	***% Shortfall***
Health Worker (F)/ ANM at Sub-Centre	1907	1705	202	10.59
Health Worker (F)/ANM at Sub-Centre & PHCs	2282	2064	218	9.55
Health Worker (M) at Sub-Centre	1907	565	1342	70.37
Health Assistants (F) / LHV at PHCs	375	88	287	76.53
Health Assistants (M) at PHCs	375	90	285	76.00
Total Specialists at CHCs *(out of 77 CHCs, 37 have all the four specialists)*	308	165	143	46.43
General Duty Medical Officers (Allopathic) at CHCs	539 (Sanctioned)	294	245	45.45
Laboratory Technicians at PHCS	452	457	72	15.93

and CHCs				
Nursing Staff at PHCs & CHCs	914	783	131	14.33
Block Extension Educator at PHCs	109 (Sanctioned)	51	58	53.21
Notes— F denotes Female and M denotes Male				
Source: MoFHW, 2010				

The Planning commission's study of NRHM in seven states including J&K has also taken an account of severe shortages in human resources in the health facilities in the state. The study was undertaken in five districts of state – Jammu, Udhampur, Doda, Budgam and Baramulla- and included visiting 5 DHs, 10 CHCs, 20 PHCs and 40 Sub-centres (SCs); and a household survey in 40 villages, which covered 800 families. In 165 SCs there was no ANM appointed. The second ANM was less than in 5 sub-centres. Although most of the PHCs in state are reported to have more than one doctor (182 PHCs have 2 doctors; 85 have 3 doctors and 28 have 4 or more doctors), 10 PHCS have no doctors at all (GoI, 2011). The DLHS-3 findings go contradictory to this as they reveal that only a little above 50 percent PHCs surveyed had medical officer, as can be seen from the *table 1.8.*

b) Infrastructure: There are only 14 district hospitals against 22 districts in the state. The reasons, however, seem to be that the six new districts were carved out in 2006. The Planning commission report also gives an account of the infrastructure and health facilities available in J&K. The study reveals that average distance of households from SC was 6 kms, from PHC was 13.7 kms and from CHC was 28.7 kms. Further, the study reveals that Intensive care unit (ICU) was not available in any district hospital surveyed except Udhampur. Drainage and Sanitation system were not functioning properly in Doda district hospital. There was no environment clearance from pollution control board in three districts- Udhampur, Baramullla and Budgam in the state. The district hospital in Doda is not disabled friendly. The mobile medical units are not functioning and emergency transport system is inefficient (GoI, 2011).

The study revealed that all the CHCs covered under the survey had availability of 24-hour service for conducting delivery, as against 93% in all seven states taken together, which were covered under this study. However, emergency obstetric care, caesarean and other surgical interventions were available to be provided in only two CHCs of Jammu, out of total 10 CHCs surveyed (28 % in seven states together). The emergency care for sick

children was available in only 4 CHCs- two in Udhampur and two in Baramulla (55 % in seven states together). Obstetrician/ Gynecologist were not available in 4 CHCs (out of 10 CHCs surveyed) including CHC at Beerwah in Budgam district (this was 69 % in seven states together) (GoI, 2011).

Further, the study finds that the functioning of PHCs was quite low in state. In only 50 percent of PHCs, adequate medicines were available (73 % in seven states together). Adequate chemicals and equipments were available in only 30 percent of PHCs (53.4 % in seven states together). Family welfare clinic was run in only 65 percent of PHCs (55.4 % in seven states together). Separate labour room was available in only 55 percent of PHCs (55.4 % in seven states together). Operation Theater and casualty was available in only 15 percent of PHCs (24.3% in seven states together). The emergency transport facility was available in only 55 percent of PHCs (41% in seven states together). However, 80 percent of PHCs had facilities for in-patient treatment (60.8% in seven states together). Newborn care services were available in 65 percent services (66.9% in seven states together). Rehabilitation services were being provided in only 15 percent PHCs (21.6% in seven states together). Nevertheless, in almost 65 percent PHCs were providing AYUSH services (37.8% in seven states together) (GoI, 2011).

The Planning Commission's study also revealed that though all the SCs are established in buildings, only 30 percent had government owned buildings (47.3% in seven states together). Only 50 percent SCs have drinking water (56% in seven states together), 50 percent have toilet facilities (52% in seven states together) and only 45 percent have electricity connections (40% in seven states together). A very less proportion of SCs of about 7.5 percent had residential facilities for the staff (47.3% in seven states together). Only half of the SCs were providing ANC services (77.6% in seven states together) and 85 percent were providing PNC services (83.7% in seven states together). 90 percent were providing newborn checkups (58.8% in seven states together). Nevertheless, all the SCs were providing contraceptive services (94.6% in seven states together), 98 percent were DOTS centres (67.3% in seven states together) and 100 percent providing immunization services (98.3 % in seven states together). Most importantly, the report brings out that almost 73 percent SCs had availability of adequate medicines all the time (78.2% in seven states together), which signifies that SCs are more equipped than PHCs with medicines facilities, as the same study revealed that only 50 percent PHCs had adequate medicines.

The reports also says that 73 percent of the ASHAs provide common medicines to people, however, at the same time, the report says that only 11 percent of ASHAs reported that common medicines are available all the time. However, as an important aspects, the study reveals that only three percent of ASHA in the villages surveyed were residing in the serving villages (95% in seven States together), though the criterion for selection was to belong to serving village, which would certainly be restricting their engagements with people in the villages (GoI, 2011). As the honorarium of ASHA is incentive based and amounts to be minimal for a month, the travel cost for coming from another village may be difficult to be borne by the ASHA to visit the serving village regularly. Therefore, in the context of most ASHAs not residing in the serving villages, the outreach services to be facilitated by ASHA and the linking of women to health services (especially for ANC, delivery and PNC care and child health services) would be severely affected in most villages. In addition, it would be especially difficult for ASHAs residing in other villages to accompany the women to health facility for birthing during the night hours.

The Planning Commission report also points out that the political interference in appointment of ASHAs and transferring of ANMs that makes it difficult for effective functioning of grassroots level health workers, which might be the reason that why most ASHA belong to different villages (GoI, 2011).

The report reckons the lack of facilities at PHC and SC level. The PHCs and CHCs, which were being run for 24 hours throughout seven days, were less than 30 percent and less than 50 percent respectively. The total health facilities that run for 24 hours throughout seven days were only 135, and total First Referral Units (FRUs) were 53. The report also found that not even a single delivery has been conducted in SC in the surveyed villages, and deliveries at PHC level have gone very much down. The report finds that the institutional deliveries are being conducted in few PHCs without privacy, proper equipments, water supply, etc. It further points out that lack of privacy in health facilities hampers the access to obstetric care (GoI, 2011).

The decentralization introduced under NRHM seems to be only on paper. Although the *District Health Societies (DHS)* have been established, their functioning seems to be limited. The planning commission report reveals that no decision had been taken on the PHC health committee reports in Udhampur district. There was no participation in

development of district health plans in Udhampur and Doda districts. Moreover, no health facility survey has been done by district health societies in the state. Although all 375 PHCs have established *Rogi Kalyan Samiti* (RKS) committees, and Village Health and Sanitation Committees (VHSC) have been constituted in most villages, these decentralized institutions appear to be dysfunctional. Only 55 percent ASHAs work with VHSC (73.3% in seven states together) and only about one third of ASHAs (35% in seven states together) participate in preparation of Village health plans (VHP) (55 % in seven states together). The study also revealed that only 26 percent VHSCs participate in preparing VHP (57% in seven states together), and only 13 percent analyze the issues/problems related to village health and nutrition (38% in seven states together). However, not a single VHSC reported that they maintain any village health calendar (15 percent in seven states together). Only 37 percent had received untied funds (65% in seven states together). Interestingly, not a single gram panchayat member out of 38 interviewed in the surveyed villages reported existence of VHSCs. Further, only 60.7 percent of the people in surveyed villages were aware of any VHSCs in their village (41.7 % in seven states together). Therefore, it appears, as reflected by Planning Commission's study that the integration of community with public health system remains incomplete. The study also claimed that panchayats did not have full awareness of NRHM program across all the seven states surveyed, which has resulted in their non-participation in NRHM. *However, in J&K the panchayats have been recently elected in 2011 only, the question arises how the plans are made at village level and block level and who were the members of the VHSC and RKS in absence of panchayats and how they were elected? Are they oriented towards the NRHM by the health department?* (GoI, 2011).

The other aspect that the Planning Commission report throws light on was the financial aspect. The full utilization of funds has never been achieved since inception of NRHM. The fund flow has been untimely and irregular, especially under JSY, which has results in less coverage of beneficiaries under JSY as compared to the occurrence of institutional deliveries. The study has also observed that untied funds are utilized in many places without the consultation of VHSC, rather with BMOs, and as these funds remain underutilized in many places, therefore, the report suggested that there is need to provide simple and transparent guidelines for utilizing untied funds at SC, PHC and CHC (GoI, 2011).

The reports points out that the public-private partnership has remained very limited in the state except in Baramulla under JSY, where six private institutes which has been accredited under JSY (GoI, 2011).

Importantly, people's perspective was also reflected in the Planning Commission report about the functioning of health services. People were asked whether they observed any improvement after launching of NRHM and a majority of 71.2 percent said 'No'. Among those who said yes, only 1.7 percent reported that there is improvement of hospital infrastructure/ better cleanness; 6.6 percent doctor & workers attend proper / good medicines; 8.3 percent said benefits of JSY/ Institutional delivery; and 83.3 percent reported improvements in immunisation (GoI, 2011).

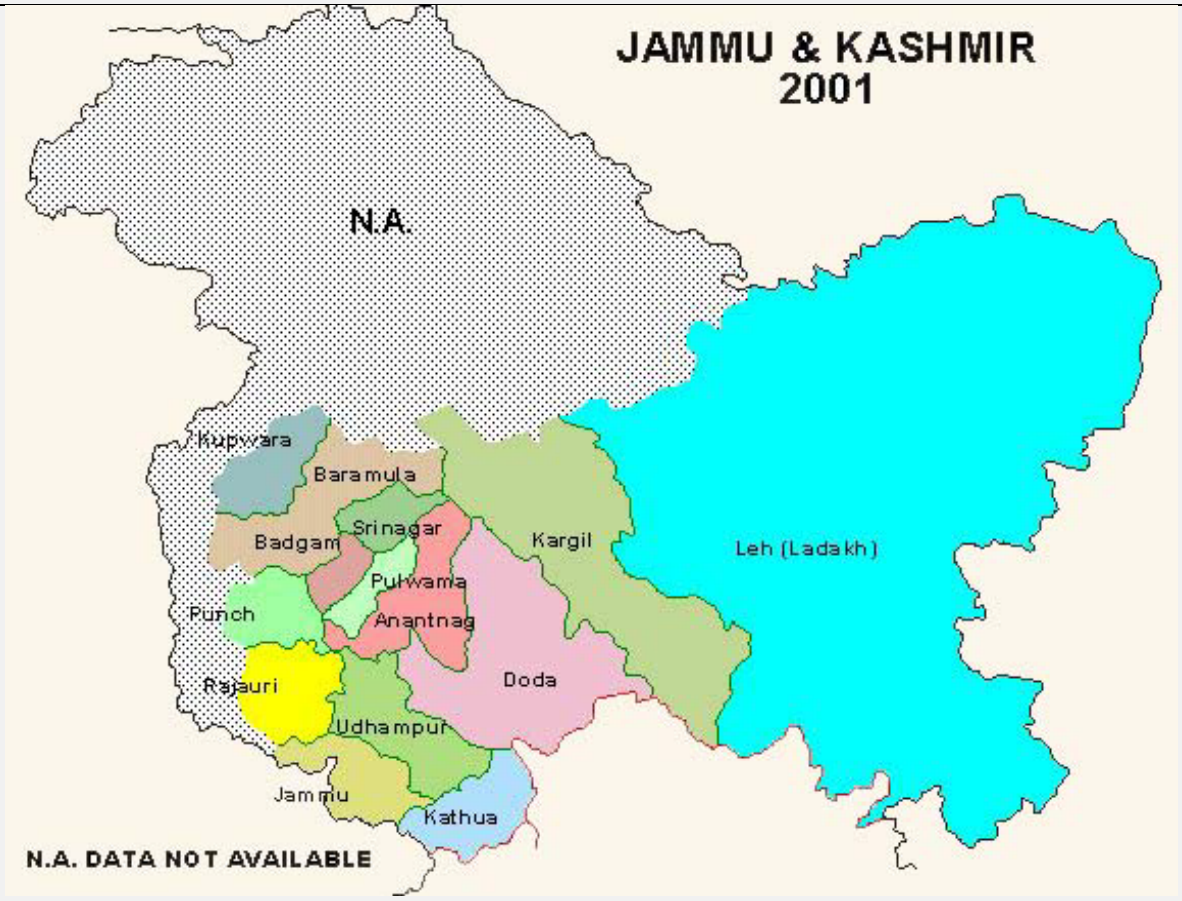
The AYUSH seem to be given some priority in the state as is reflected by the level of infrastructure raised. There are two Ayurvedic hospitals, 273 Ayurvedic dispensaries in the state, two Unani hospitals and 235 Unanai dispensaries in the state (MoHFW, n.d).

Therefore, in the context of severe shortages in the human resources and health infrastructure as pointed out by Planning commission study and other reports, it could be assumed that the quality of services in J&K are compromised. This might be the reason that a majority of population of about 71 percent perceived that there has been no improvement in the health care after NRHM was started. Its implications would be diverse, from creating impediments and affecting the access of people to health services to increasing dependence of people on the private health care. *However, it remains to be explored, if the shortages in health infrastructure and staff affect the access of people to health services, and in what ways?*

1.4.3 Inter-regional Disparities in Health Services in J&K:

Jammu and Kashmir is a very diverse state with three regions Jammu, Ladakh and Kashmir. J&K consists of 22 districts. Jammu has 10 districts, Ladakh has 2 districts and Kashmir has 10 districts. Until 2006, there were only 14 districts with Kashmir had six districts, Jammu with 6 districts and Ladakh two districts. However, for administrative purposes the state is divided into two administrative divisions: Jammu division and Kashmir division. Ladakh is treated as part of Kashmir for administrative purposes. The geographical map of the state showing the three regions is given below:

Figure 1.1: Geographical Map of J&K



Source: RGI, 2001a.

The three regions vary a lot in terms of geography, population composition, culture – food habits, climatic conditions, political situation, nature of economic activities etc. They are also dealt separately by administration in terms of implementation of government programmes with each government department having two directorates, one dealing with Jammu division and another with Kashmir division (including Ladakh). Jammu and Ladakh regions had also panchayats in place from 2001 to 2006, but in large sections of Kashmir, the panchayat elections were never conducted in the last 22 years until recently in 2011.The socio-economic indicators also show differences across the regions. Therefore, these regions are characterised by diversities in demographic, socio-economic, cultural and political context as well as in the development patterns and public services. These variations make the three regions different from each other and may have its impact on the health system, health status of people and access to health services. However, very little information is available on the inter-regional disparities in health status, availability of health services and access of people to health services in J&K. Therefore, providing the rationale for examining if there are disparities in health status and access to health services,

which this review attempts to do. The Ladakh region (Leh and Kargil districts) is administratively governed by Kashmir division. However, it is being recognized that Ladakh is entirely different from Kashmir as a region in terms of socio-economic, cultural, political and ecological factors, and therefore, it is examined separately in this section. Nevertheless, the data is also complied for Kashmir division and Jammu division (which is region as well) and is given in the Appendix – B for any comparison, if one wants to make.

The disparities in socio-economic conditions, health outcomes and access to health services are not at the state or regional level only, but are of severe nature at further disaggregated level down to the district level. In fact, it is the inter-district disparities, which give rise to the inter-regional disparities. Kupwara, as an illustration, provides a picture of how some of the districts show a completely different picture than the state as a whole. For instance, the crude birth rate and death rate of Kupwara district are 28 and 8, as against 18.9 and 5.5 in the state. The IMR in Kupwara was 60, as against 50 in the state in 2005 (SRS, 2005 cited in District Administration Kupwara, 2007). Similarly, the socio-economic conditions of the people living in Kupwara are not as good as in rest of the state. Kupwara is one of the backward and poor districts of Kashmir. The poverty ratio in the district is 31.8 percent, as against 21.6 percent in the state. The per capita income in the district is only about Rs. 12672 at Current Prices for the 2004-05, as against Rs 22642 in the state (Govt of J&K, 2009). The literacy rate in the district was 43.2 percent, as against 55.5 percent in the state. Female literacy was just 28.7 percent, as compared to 43 percent in the state (RGI, 2001b). All the districts show disparities in terms of socio-economic context, health infrastructure, and access to public health services. Therefore, it is important that the district level disparities are also highlighted and not assuming that regions are homogenous. Therefore, this section highlights some of these disparities across districts in J&K. However, as the village study was conducted in Kashmir, this section focus on the districts in Kashmir, in comparison to Kashmir as a whole, and J&K. The details of each individual district in all the three regions of J&K on each issue that is analyzed in this section are put together in Appendix - B for further reference.

To make any analysis of regional disparities in the context of socio-economic and political differences, it would require data from different sources to be triangulated to infer the reasons for disparities. However, it was very difficult to find even a single article related to such disparities in J&K. The larger sample surveys like NSSO and NFHS provide data only

at the state level. This paper relies on the data from Census, J&K official reports and DLHS mostly, which doesn't provide adequate information about health services, health infrastructure and other public health services, to investigate into the inter-regional disparities in availability of health services and access of people to health services in the framework of macro socio-economic and political determinants of health.

a) Socio-economic Indicators in J&K: The socio-economic indicators show difference across the regions with Kashmir having only 0.05 percent Scheduled caste population, Ladakh with 0.32 percent Scheduled caste population and Jammu with 17 percent Scheduled caste population, as compared to 7.6 percent at state level. Kashmir has scheduled tribe population of almost 5.81 percent, Ladakh has 85.2 percent and Jammu has almost 13 percent, as compared to 10.9 percent at state level (RGI, 2001b). The Kashmir region is inhabited by mostly Muslims and Hindus are only 1.8 percent, while as Jammu region is mostly inhabited by Hindus with 65.2 percent Hindu population, as against 29.6 percent at state level. Ladakh has a mix of Muslims and Budhists with only 6.2 Hindu population (RGI, 2001b).

Among the districts, Jammu district had the highest proportion of 24.8 percent Scheduled caste population, followed by Kathua with 23.15 percent. All the districts in Kashmir and Ladakh have Scheduled caste population less than one percent as they are inhabited by mostly Muslims in Kashmir and Muslims and Budhists in Ladakh. Further, among the districts, both Leh (82.04%) and Kargil (88.32 %) had more than 80 percent ST population; in Kashmir Anantnag had the highest proportion of 8.63 ST population and Budgam with least ST population of 2.31 percent. In Jammu region, Punch had 39.9 percent ST population and Jammu district had lowest ST population of 3.36 percent (RGI, 2001b).

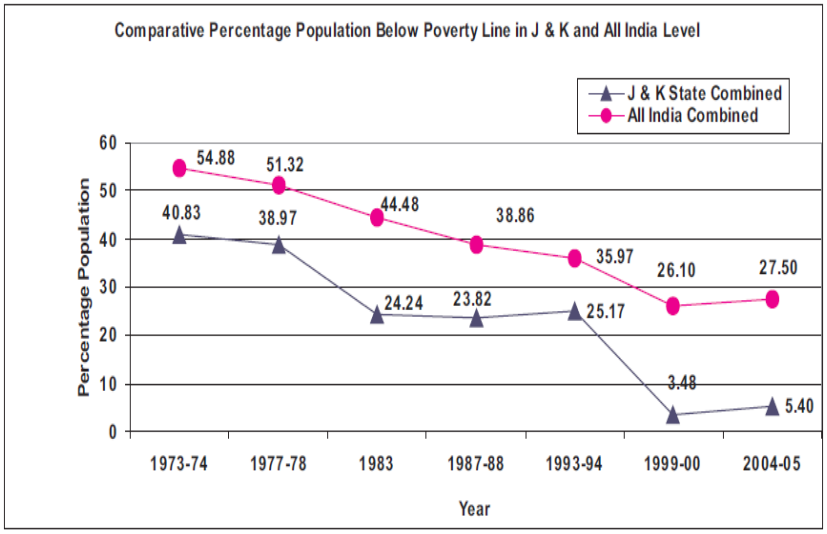
Within the Jammu region, Udhmapur, Kathua and Jammu are predominantly inhabited by Hindus and other districts have majority of Muslim population.

The regions also vary in terms of per capita gross district domestic income (PGDDI) with Kashmir (including Ladakh) having an average of Rs 23125 and Jammu an average of Rs 25260, as compared to 24398 Rs at state level (Govt of J&K, 2009). The state level survey shows that poverty ratio of these two regions does not show any significant variation with Jammu region having a poverty ratio of 21.67 percent, Kashmir having 21.37 percent and

Ladakh having poverty ratio of 27.03 percent, highest among all the three regions, as compared to 21.6 percent at state level (Govt of J&K, 2008).

Within the Kashmir region, Srinagar has the highest PGDDI with 30,052 Rs and Kupwara has the lowest with Rs 16,360. The poverty ratio is highest in Kupwara with 31.82 percent classified as living under the poverty line, while as Srinagar has the lowest poverty ratio of 15.37 percent (Govt of J&K, 2008).

Figure 1.2: Trends in Poverty Ratio in J&K and India



Source: Govt. of J&K, 2008

At state level, the agriculture and allied sectors contribute almost 27% of state income; however, over 65% of the population depend on agriculture and allied sectors (Govt. of J&K, 2008-09). The state was one of the regions, which implemented land reforms extensively, which was one of the primary factors for reducing the poverty in the state, as can be seen from Figure 1.2 (Dar, 2009). The Planning Commission of India has estimated that the poverty ratio in J&K was 4.5 percent in rural areas (5.4 for whole state), as compared to 28.3 percent poverty ratio in rural areas of India, (Saxena, 2009). Further, the proportion of households who own some land are 66.1 in total with 28.4 percent in urban areas and 83.2 percent in rural areas (IIPS & Macro International, 2007).

b) Prevalence of Illness: The DLHS-3 data shows disparities in the prevalence of diarrhea and ARI (*ARI- Acute Respiratory Infection including fever)* among children, who had taken birth since 1st January 2004, with Kashmir having more prevalence of diarrhea and ARI among children. For instance, almost 15.6 and 17.6 percent children had suffered from diarrhea and ARI, in the last two weeks prior to survey in Kashmir respectively, while as

the corresponding figures for Jammu were 9.8 and 5.06 percent, and for Ladakh it was 9.8 and 5.0 only (IIPS, 2010).

Table 1.4 : Prevalence of Morbidity by Districts in J&K

District/ Regions	Prevalence of Morbidity			
	Tuberculosis (1)	***Malaria (2)***	***Partial Blindness***	***Complete Blindness***
Kupwara	869	19	1664	43
Baramula*	0	0	0	11
Srinagar	213	130	2275	269
Badgam	104	20	942	59
Pulwama	845	11	1773	34
Anantanag	82	198	678	73
Kashmir	***N.A***			
Leh	60	136	217	214
Kargil	273	209	337	246
Ladakh Region	***N.A***			
Doda	27	14	26	15
Udhampur	129	25	390	190
Poonch	18	18	18	34
Rajauri	25	160	373	80
Jammu	96	139	161	619
Kathua	401	376	249	871
Jammu Region	***N.A***			
J&K	234	108	799	248

Notes --(1) & (2)Prevalence Rate is per 100000 populations.

Reference period: January 1999 to survey date (December 2002) for phase-1 and January 1st, 2001 to survey date (December2004) for phase-2. However, for Malaria, reference period is last two weeks prior to the survey

**It is not possible that there would be not a single case for TB and other diseases. It seems that it is data error.*

Source: IIPS, 2002-04

Within Kashmir, the disparities were not too significant with Pulwama having 19.4 children suffered from diarrhoea, and Budgam being least with 12.3 children who suffered through diarrhoea. However, the disparities were markedly significant with prevalence of ARI (Acute Respiratory Infection) among children. In Kupwara, almost 33.4 percent children had suffered from ARI, while as it was low as 10.3 percent in Srinagar.

Table 1.4 gives a picture about the prevalence of tuberculosis (TB), malaria, partial blindness and complete blindness. The data at the regional level is not available; but it gives impression that tuberculosis and partial blindness are more prevalent in Kashmir than Ladakh and Jammu

regions. However, the malaria seems to be more prevalent in Ladakh and complete blindness seems to be more prevalent in Jammu (IIPS, 2002-04).

Within the Kashmir region, Kupwara has had the highest prevalence of Tuberculosis (TB) to the level of 869, almost 10 times more than Anantnag (82). But Anantnag has the highest prevalence of malaria of about 198 and least in Pulwama (11). The prevalence of partial blindness is almost three times more in Srinagar (2275) than in Anantnag (678). Complete blindness is more in Srinagar (269) and least in Baramulla (11).

c) Access to Health Services and Basic Amenities: The DLHS-3 data on antenatal checkups, child vaccination, children who suffered diarrhea and sought treatment, and children who suffered ARI and sought treatment shows disparities between the three regions of Kashmir, Ladakh and Jammu, with relatively more access of people to these services in Kashmir than in Jammu region. Among the women who had given birth to any child since 1st January 2004, 35.5 percent in Kashmir had access to all ANC[12] checkups, while as the figure for Jammu was 24 percent and for Ladakh it was only 17 percent, as compared to 29.1 percent at state level. Similarly, in Kashmir almost 90.9 percent of the women had an access to any of the ANC checkups, while as it was only 77 percent in Jammu and 86.7 percent in Ladakh, as against 84.3 percent at state level (IIPS, 2010).

Within Kashmir, Srinagar has the highest proportion of women (99.3) who have had any ANC checkup and Kupwara had the least proportion (81 %). However, proportion of women who had access to all ANC checkups was highest in Anantnag (48.8 %) and least in Budgam (27.3 %), a difference of almost 20 percent.

Only 39.3 percent women had institutional delivery in Jammu region, while as it was very high in Ladakh and Kashmir, with Ladakh had 63.2 percent institutional deliveries and Kashmir had 69 percent, as against 54.9 percent in J&K. Within Kashmir, Srinagar performs better with 87.3 percent institutional deliveries and Baramulla is at the poor side with only 54.7 percent institutional deliveries, a difference of almost 30 percent.

[12] At least three visits for antenatal check-up, at least one TT injection received and 100+ IFA tablets/ syrup consumed.

Among the children who were aged 12 to 35 months, almost 65 percent had access to all doses of vaccination[13], while as in Jammu it was only 55 percent and highest in Ladakh (83.1%), as compared to 62.2 percent at state level. Similarly, only 2.4 percent of them in Kashmir and 0.7 percent in Ladkah had not accessed even a single dose of vaccination while as it was more than three times (7.87 percent) in Jammu, against 4.2 % at state level . In addition, almost 58.5 percent children had received one dose of Vitamin 'A' in Kashmir and 72.6 % in Ladakh, the corresponding figure was only 49.10 percent for Jammu against 56 percent at state level (IIPS, 2010),

Within the Kashmir, the highest proportion of children who accessed full vaccination was in Srinagar (78.1 %) and least in Baramulla (53.4 %) with a difference of almost 25 percent. Further, in Srinagar, 71.4 percent children accessed a minimum of single dose of vaccination while it was 42.2 % in Anantnag, a difference of almost 19 percent.

Among the children who suffered from diarrhea and ARI in the last two weeks prior to survey, almost 72 and 86.7 percent children in Kashmir sought treatment for diarrhea and ARI diseases respectively. The corresponding figures were 66 and 79 percent for Jammu, and 56.3 and 79.2 percent in Ladakh, as compared to 68.7 and 84.1 percent at state level (IIPS, 2010).

Within Kashmir, the 84.2 percent of children who suffered diarrhoea accessed treatment, while it was 54.2 percent in Kupwara, a difference of almost 30 percent. Further, among children who suffered ARI, 92.7 percent received treatment in Anantnag, while only 82.1 percent children received treatment in Budgam district, a difference of almost 10 percent (IIPS, 2010).

Within Kashmir, Srinagar has performed better than other districts on most indicators and is because of multiple reasons including better availability of health services in Srinagar, better physical accessibility (road connectivity), better socio-economic conditions and favourable political factors (as a city gets preference). The other districts in Kashmir show wage relations with availability of sub-centres, PHCs, doctors, any government facility, ASHA and AWW. However, other contributing factors like socio-economic conditions, physical accessibility and political influences are yet to be explored.

[13] All doses of vaccination include BCG, three injections of DPT, three doses of Polio (excluding Polio 0) and measles.

It is well recognized that access to basic amenities like electricity, water and sanitation etc influence the health status and experiences of morbidity of people. For instance, one of the main reasons for diarrhea is the contaminated water and therefore, the source of drinking water and sanitation conditions have huge influences in determining the prevalence of diarrhea in a community (not considering the diarrhea due to malnutrition, which would have access to nutrition as a major determining factor). The condition of housing and adequate space has large bearing in the transmission of diseases within the families. Households with Katcha houses will be more vulnerable to environmental stresses like heavy rainfall or snow (as in Kashmir and Ladakh) and households living in one room will have more probability of transmitting diseases from infectious member to other members within a household. The data has also shown disparities in access to basic amenities like possessing pakka house, LPG, toilet facility, drinking water and electricity facilities and access to BPL card, with Kashmir reflecting a better picture as compared to Jammu, as can be seen in *Table 1.5*

Table 1.5 : Access to Basic Amenities in J&K

Regions (1)	***Electricity***	***Drinking Water (2)***	***LPG***	***Toilet Facility (3)***	***Pakka House***	***BPL Card***	***Sample Households***
Kashmir	94.3	82.8	89.9	21.4	59	44.7	7430
Jammu	89.3	71.1	21.0	22.1	35.0	32.10	8075
Ladakh	90.7	66.4	96.8	38	17.5	43.7	2353
J&K	91.4	75.1	22.8	60.2	43.5	38.4	17858

Notes---2: Includes piped water, public tap/sand pipe, hand pump, tube well/bore well;

3: improved source of sanitation, or flush not to sewer/septic/pit/twin pit, or pit without slab or dry toilet.

1: *Calculations based on data from DLHS-3, 2007-08*

Source:IIPS, 2010

However, what seems contradictory is that in spite of relatively better access to drinking water, toilet, pakka houses, etc. Kashmir has more burden of diarrhea and ARI among children, and tuberculosis among population. This should not be interpreted that there is no connection between the access to basic amenities and the disease experiences but reflect the influence of other factors in determining these diseases, in addition to these set of basic amenities. This could be because of greater diagnosis and relatively more reporting of such illnesses in Kashmir as compared to Jammu, considering the levels of treatment were high in Kashmir.

Other important issues, which need to be highlighted, related to the poverty ratio, which did not show much disparities across Kashmir (21.37 %) and Jammu (21.67 %) regions, but there are significant disparities in access to BPL ration cards. Almost 44.7 percent households had BPL ration card in comparison to 32.1 percent respectively. As BPL card entitles a household with subsidized ration every month from a PDS shop, its distribution always involves political interferences. The fact that higher proportion of households had BPL card in Kashmir than in Jammu seems to be because of the political influence of Kashmir over Jammu region. (Kashmir is politically strong region than Jammu).

Within Kashmir, the districts do not show much differences in electricity connections as all of the district have more 90 percent electrified households. But the access to drinking water shows disparities with Kupwara having only 64.5 percent households which had access to drinking water, and in Srinagar, 97.4 percent have access to drinking water. Further, in Srinagar 98.7 percent had toilet facility, while in Anantnag only 69.3 percent had toilet facility. The LPG connection shows marked differences across districts. In Srinagar, 51.8 percent households have LPG connection, while it was least in Pulwama with 12.1 percent. Pulwama had the highest proportion of households with pakka houses, and Baramulla with least (32.2 %) (IIPS, 2010).

Besides, the BPL cards show disparities across districts, with Kupwara having the highest proportion of households (66.7 %) holding a BPL card and least in Srinagar (18.9 %). As mentioned earlier that BPL card distribution involves political interference. Although Kupwara had highest poverty ratio and Srinagar the lowest in Kashmir, the data doesn't seem to show that the poverty ratio is the only determinant for BPL cards. For instance, Baramulla has 26.49 poverty ratio and Budgam has 26.64 poverty ratio, but in Baramulla 51.1 percent households had a BPL card, and in Budgam only 43.7 percent had one. Similarly, even though Anantnag has only 18.6 percent poverty ratio, 45 percent households have reported holding a BPL card (IIPS, 2010).

d) Availability of Health Facilities: The importance of availability of health facilities within proximal distances are very important in shaping the experiences of people with health services and is one of the determining factors in access of the people to health services and also influence the health status in a population. However, the quality and cost of health services, providers' attitudes are among the other factors, which influence the

access of people to health services. The DLHS-3 report gives an account of the health facilities available in the surveyed villages, and provides a comparative picture of the three regions. As can be seen from *Table 1.6,* in Kashmir, almost 46.3 percent of the surveyed villages had a sub-centre, 16.8 percent had PHC, 74.6 percent had ASHA, 97 percent had AWW, and 10.9 percent had Village Health & Sanitation Committee (VHSC). While in Jammu, only 39.7 percent of the surveyed villages had a sub-centre, 11.4 percent had PHC, 67 percent had ASHA, 89 percent had AWW and 7 percent had VHSC. In Ladakh, 78.63 percent of the surveyed villages had a sub-centre, 11.2 percent had PHC, 83.0 percent had ASHA, 96.8 percent had AWW, 1.3 percent a doctor and 19.3 percent had Village Health & Sanitation Committee (VHSC) (IIPS, 2010).

Table 1.6: Availability of Health Facilities* in J&K

Regions (1)	***Sub-centre***	***ANM/FHW at Sub-centre***	***PHC***	***Any Govt. Facility****	***Doctor***	***ASHA***	***AWW***	***Sample Villages***
Kashmi	46.3	55.1	16.	60.4	9.8	74.6	97.	233
Jammu	39.74	75.03	11.	55.1	3.95	66.9	88.	254
Ladakh	78.6	86.9	11.	93.0	1.3	83.0	96.	84
J &K	47.6	68.8	12.	62.2	6.5	72.9	93.	571

*Notes -- *Facilities as reported by village pradhan/any other panchayat member/teacher/gram sevak/aganwadi worker; ** Includes Sub-Centre, Primary Health Centre (including Block PHC), Community Health Centre or referral hospital, government hospital, and government dispensary within the village.*

Source: IIPS, 2010

Within Kashmir, Srinagar had the highest proportion of villages with Sub-centre (54.5 %), PHCs (36.4%), VHSCs (18.2 %) and any government facility (72.7 %), while as the Baramulla had lowest proportion of villages with Sub-centre (38.1 %) and PHCs (7.1 %) and any government facility (45.2 %); Anantnag had lowest proportion of villages with doctors (2.6 %) ; and Srinagar and Budgam had lowest proportion of villages with ASHAs (63.6 % each) [14] (IIPS, 2010).

For Kupwara the data shows only 8.3 percent villages had a doctor against 20.8 percent villages with PHCs. This may be due to the fact that doctors are not willing to travel to hilly

[14] However, there seems to be some problems with data as not a single village in Srinagar had reported to have doctor in the village, even when 36.4 percent villages had PHC.

and far off places in Kupwara, particularly since Kupwara has many areas, which get snow locked for few months in winter (IIPS, 2010).

Table 1.7: Coverage of Population by Health Institutions in J&K

Region (1)	**Average Population covered by**		
	Sub-centre	***PHC***	***CHC***
Kashmir	4334*	32903	94838
Jammu	3044	22559	94903
Ladakh	840	4289	28672
J&K	3499	25802	89659

***Notes -- ****The average coverage of a sub-centre in Baramulla has been reported to be 42650, which seems to be a data error, and the value has been assumed to be around 4265 for this table, otherwise if considered the original value of Baramulla, the average population coverage by Sub-centre will be* 10732 *in Kashmir and 6011 in J&K.*

(1) Calculations for Kashmir, Jammu and Ladakh are based on data from IIPS, 2010

Source: IIPS, 2010

The data also shows some differences in the catchment area of sub-centres, PHCs and CHCs in the three regions of J&K, as can be seen in the *Table 1.7,* In Kashmir the average population covered by a sub-centre, PHC and CHC is more than in Jammu and Ladakh. The reasons for this seem to be because of the disparities in village strength across regions in J&K. Although Kashmir region has 53.99 percent of total state population, the total proportion of number of villages in Kashmir is only 43.4 percent, while as Jammu region has 43.67 percent of total state population, the total proportion of number of villages in Jammu is 52.9 percent. Ladakh has 2.33 percent of total state population; the total proportion of number of villages in Ladakh is 3.7 percent. Further, among the total villages in Kashmir, 25.1 percent are such villages with population less than 500 persons, while it is 40.4 percent in Jammu and 43.5 percent in Ladakh, as compared to 33.9 percent at state level. The middle population villages – 500 to 999 persons- don't show significant differences across regions. However, in Kashmir, 45 percent villages have population with 1000-4999 persons, while it is 32.6 percent in Jammu, and 29.7 percent in Ladakh, as compared to 37.9 percent at state level (IIPS, 2010). Therefore, as the villages are bigger in Kashmir than Jammu and Ladakh, the average population coverage by a sub-centre, PHC and CHC is likely going to be more in Kashmir than in other two regions.

The same logic seems to be valid for availability of health facilities at village level across regions including sub-centre, doctor, PHC, any government facility, ASHA, AWW, that a

relatively more villages in Kashmir have such facilities in villages than in Jammu. However, for Ladakh with relatively better availability of village level facilities the reasons seems to be the hilly terrain that villages and even population with villages is scattered, therefore, that makes it a requirement to have more facilities within villages itself, as the physical accessibility is limited between villages in Ladakh.

Within Kashmir, Pulwama (29.4 %) has highest proportion of smaller villages with population strength of less than 500 persons and Anantnag (17 %) has lesser proportion. But Pulwama has the higher proportion of villages (35.1 %) with population between 500 to 999, and Anantnag has lowest proportion of villages (23.8 %) with population between 500 to 999. However, Anantnag has higher proportion of villages (55.37 %) with population between 1000 to 4999 and Pulwama has least (34.7 %). Nevertheless, the availability of facilities like sub-centre, ASHA, doctor, AWW, PHC and average population covered by a sub-centre, PHC and CHC doesn't follow the village strength logic, and it points to other underlying causes especially political reasons (IIPS, 2010).

Therefore, in this context, the disparities across regions in J&K have also to be looked at from the same perspective. Between regions, Kashmir holds an important and influential position in the state and it's planning, and therefore, may be contributing to the disparities in the availability of health facilities at village levels across districts and regions towards favour of Kashmir.

What is also important to note is that just availability of health institutions does not make a difference until the institution is equipped with adequate medical, para-medical and other staff. The three regions of J&K show stark disparities in the availability of ANMs at sub-centers, and doctors at PHCs. As can be seen from the *Table 1.6* among the villages, which had sub-centers, only 55 percent had ANM/FHW available in Kashmir, while Jammu shows a better picture relative to Kashmir with 75 percent of sub-centers had availability of ANM/FHW, and in Ladakh almost 87 percent sub-centres had ANM/FHW (IIPS, 2010).

The *Table 1.8* shows that more number of PHCs in Kashmir had medical officers, woman medical officers and AYUSH medical officers than PHCs in Jammu. In Kashmir, 58.6 percent PHCs had medical officer and 42 percent had lady medical officer, as against 49 percent PHCs with medical officers and 36.5 percent with lady medical officers in Jammu.

While in Jammu, more PHCs have AYUSH medical officers as data has shown that 46.1 percent had AYUSH medical officer in Jammu against 26.8 percent in Kashmir. The availability of pharmacists does not show any significant difference (IIPS, 2010). Ladakh seems to be relatively worst in availability of medical officers at PHCs among the three regions.

Table 1.8 : Availability of Human Resource at PHCs in J&K

Regions (1)	*MO**	*Lady MO*	*AYUSH MO*	*Pharmacist*	*Sample PHCs*
Kashmir	58.6	42.0	26.8	95.4	105
Jammu	49.04	36.54	46.15	95.19	104
Ladakh	32.5	35.0	10.0	93.8	13
J and K	51.8	39.2	34.2	95.0	222

*Note -- * MO = Medical Officer.*

(1) Calculations for Kashmir, Jammu and Ladakh are based on data from IIPS, 2010

Source: IIPS, 2010

Within Kashmir, in districts like Srinagar (83.3 %), Anantnag (60 %) and Baramulla (70 %) there are relatively more medical officers than Kupwara (52.6 %) or Pulwama (33.3 %), which seems to be because Anantnag and Baramulla are at ease to Srinagar and very close to Srinagar city and Kupwara and some parts of Pulwama are hilly and far, and not many medical officers would be ready to work there. However, the lady medical officers are relatively more in Srinagar (50%), Baramulla (55 %) and Pulwama (44.4 %) than Kupwara (26.3 %) (IIPS, 2010). This also shows the same trend of those districts having better accessibility that are closer in proximity to Srinagar city.

The CHCs have prominent importance in the referral chain of the primary health care and acts as first referral unit up from PHC. Therefore, the availability of specialists is one of the major determinants of a CHC to serve as a proper referral unit. However, the data shows stark differences in the availability of specialists at CHCs in the three regions of J&K. The *Table 1.9* shows that the CHCs in Jammu have relatively more availability of specialist than CHCs in Kashmir. The data shows Ladakh is worst in terms of availability of specialists at CHCs, with no pediatrician, anesthetist and health manager at 4 CHCs centres surveyed, and only CHC centre had one obstetric/ gynaecologist (IIPS, 2010). Ladakh is mostly hilly region and has not much connectivity to Srinagar that patients can be referred

within hours to super speciality hospitals, as do in Kashmir and Jammu, and therefore, would require more specialists at CHCs and DHs. As specialists are usually short in the state, most of them may not be willing to go to Ladakh and as there is also a high demand for them in other two regions of state, they could easily escape their postings in Ladakh. However, it has the active presence of Sowa-Rigpa (Tibetan medicine) practitioners, on whom data could not be obtained.

Table 1.9 : Availability of Human Resource at CHCs in J&K

Region(1)	***Obstetric/ Gynaecologist***	***Paediatrician***	***Anaesthetist***	***Health Manager***	***Sample CHCs***
Kashmir	34.3	8.3	56.4	7.6	39
Jammu	63.3	36.7	66.7	10.0	30
Ladakh	16.7	0.0	0.0	0.0	4
J&K	45.2	19.2	54.8	9.6	73

(1) Calculations for Kashmir, Jammu and Ladakh are based on data from IIPS, 2010

Source: IIPS, 2010

Within Kashmir, Srinagar and Anantnag are the only two districts where all CHCs surveyed together had any of the three specialists like obstetric/ gynaecologist, pediatrician, and anesthetist. In other four districts like Kupwara, Baramulla, Pulwama and Budgam, not a single CHC had any pediatrician.

e) Factors influencing the Availability and Access to Health Services and Basic Amenities: The data suggests that disparities exist between the Kashmir, Ladakh and Jammu regions with Kashmir having relatively better availability and access to health services and other basic amenities. The data also suggests that there are disparities in the availability of health facilities and human resources, and socio-economic indicators between these regions. This leads us to the last question *what are the possible explanations for such inter-regional disparities in access to health services.* It could be assumed that the possible reasons may be social and economic determinants; availability of health facilities and medical staff, and importantly political factors.

The disparities in availability of health facilities and human resources would certainly contribute to the disparities in access of people to health services between the two regions. Therefore, with Kashmir having relatively better availability of village health facilities like

sub-centres, PHCs, doctors, ASHA, AWW, and other government facilities, the access of people would likely be better than other regions, as data has shown that the access to ANC, institutional delivery, vaccination, and treatment to children suffering from diarrhoea and ARI was better in Kashmir than Jammu.

However, that would not explain the disparities in access to basic amenities like pakka houses, electricity, drinking water, toilet facility and LPG for cooking, but those are functions of socio-economic factors and political factors. Further, the literature has shown that socio-economic and political factors also shape the availability of health services and human resources in health institutions as well as access of people to these health services. *Therefore, it was tenable to examine if there are possible associations of socio-economic and political factors and access to health services and basic amenities.*

The Kashmir and Jammu regions have separate administrative divisions (Ladakh is part of Kashmir division) to implement welfare programs separately in their divisions- Kashmir and Jammu, but the state level policies are dealt with same political structure. There is a possibility of using welfare measures by political parties to mobilize people to their own advantage in Kashmir, as for long time a majority of people in Kashmir were boycotting elections, and mostly are seen against the establishment of India government. However, the political conflict has also been in some districts of Jammu region like Ponch, Rajauri and Doda. Therefore, may be difficult to relate the better availability of services and accessibility to services in Kashmir to the Kashmir conflict, and in most cases, the continuous strikes and protests, and limited mobility during night hours due to roads being blocked, would add to the problems in Kashmir. However, what seems a plausible explanation that Kashmir as a region has been dominant politically in the state, and may be one of the reasons for the disparities that exist in availability and accessibility to health services in J&K across regions. *Nevertheless, what is to be explored is to what extent and the processes that the political factors determine the disparities in establishing the health infrastructure and access of people to health services and other basic amenities, and would need to conduct a micro-level study.*

Therefore, from the data and discussion, one can make a hypothesis that *the disparities in the availability of health services and access to health services between districts and*

regions are a function of socio-economic determinants, geographical and political factors in J&K.

The observations of the data also raise some more questions, as below, that are to be explored, and therefore, there is a need to conduct a micro-level research into these questions.

1. *What is the contribution of each of these socio-economic factors to the inter-district and inter-regional disparities in the availability of health services and access of people to these health services?*
2. *To what extent the geographical factors contribute to the existing disparities across districts and regions in the availability of health services and access of people to these health services.*
3. *What is the role of political factors, in terms of protests and strikes in Kashmir, feeling of alienation in Kashmir, Jammu and Ladakh and the attempts of government to maintain regional balances, in determining the availability of health services and access of people to these health services?*

The data has also shown relatively higher burden of diseases – TB, diarrhea, and ARI -- in Kashmir, instead of relatively better socio-economic status and access to health services and better availability of health facilities leading to lower morbidity. This needs to be explored in a historical and political context. *An inter-regional and inter-district analysis of health status remains unexplored.*

This attempt is a preliminary analysis and inferences can only be made cautiously. There is a greater probability of running through the risk of spuriousness and ecological fallacy, as the people in Doda, Punch and Rajauri within Jammu region, which are also hilly areas but seem to have relatively less access to health services than within Kashmir. These districts are poor and have hilly topography, which may have influenced the level of development and settlement patterns that shape the location and accessibility of health services. In addition to this, there are many other factors like the geo-climatic and ecological factors, nature of economic activities, ownership of assets, different religious composition, political factors (nature of relations between regions), etc. which may affect the access of people to health services, in addition to the socio-economic factors. The analysis also suffers from

many other limitations: unavailability of data at regional or district level on many of the sensitive health indicators like IMR, U5MR, anemia, nutrition status, etc., which could have provided a picture of disparities in health status across the three regions. Further, the analysis included a narrow list of health services and basic amenities, which was again due to limited data availability; and the inability to find literature on health issues specific to Kashmir, Ladakh, and Jammu regions in public domain, which would have enriched the analysis and may have provided deep insights into the findings.

All these factors provide the rationale to conduct primary studies at the grassroots level to test the hypothesis that the disparities in the availability of health services and access to health services are a function of socio-economic determinants, geographical and political factors in J&K., at district level and below, answer the raised questions and consider other confounding variables. This is also important to see how far and to whom the available services are accessible to find out what contributes to the disparities in access to health services in these two regions and to the disparities in the availability of health facilities in these regions.

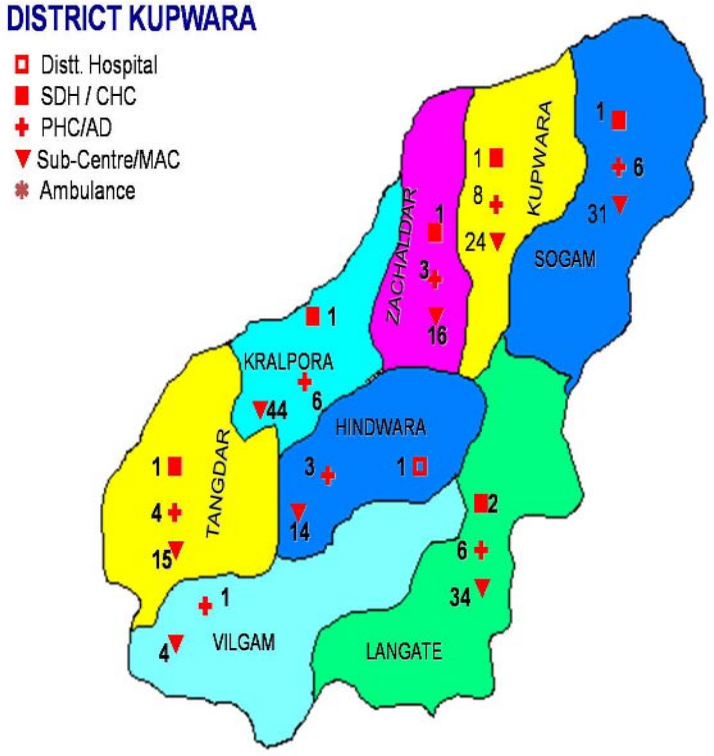
1.4.4. Inter-block disparities in Health services:

In J&K, each district is divided into medical blocks (broadly overlaps with community blocks). However, there are disparities within the district itself between these different blocks with some of the poor and may be politically weak blocks bearing the major burden of deficit in infrastructure of district and some of blocks, which are probably the politically strong and /or urban or semi-urban, enjoy the major facilities of the district. However, down to the district level there is hardly any investigation that records the disparities further. The district health action plans (DHAP) prepared under NRHM, nevertheless, provide some clues about the disparities within the districts in the health infrastructure and health institutions. Kupwara as a district provides an illustration of how the disparities exist within the district in sharing of the health facilities available in the district between the different areas of the district. The Kupwara district is divided into 9 medical blocks and there are a total of 1 District Hopsital (DH), 7 CHCs, 37 PHCs and 205 Sub-centres in Kupwara district. However, the DHAP shows that there some medical blocks, which have very less health infrastructure as compared to the district as a whole. For instance, *Zachaldara medical block* has only 1 CHC; 3 PHCs; 9 Medical officers; 1 PHC running for 24 hours; 16 SCs; 2 ANMs; 1 AYUSH dispensary; 43 AWCs, etc. While as the other

medical block, *Kupwara medical block*, has 1 referral hospital, 1 blood bank, 1 CHC; 8 PHCs; 23 MOs; 1 PHC running for 24 hours; 29 SCs; 31 ANMS; 205 AWCS, etc. The other medical block is of *Sogam medical block*, which appears much blessed by the health facilities has 1 specialty hospital; I referral hospital; 2 CHC (including 1 CHC of IPHS standards); 5 PHCs; 16 MOs; 1 MTP centre; 31 SCs and 30 ANMS; 335 AWCs, etc. The few specialists present in the district are also posted in either Kupwara or Sogam (District Administration Kupwara, 2007).

However, these medical blocks vary in terms of population with Kupwara, Sogam and Langate bigger than average size in population; therefore, any such analysis must consider the catchment area of medical block while drawing any inference. Nevertheless, the distribution of health facilities does not appear to be proportionate across different blocks.

Figure 1.3: Map showing Disparities in Availability of Health facilities in Kupwara District



Note – The different colours in map represent medical blocks. However, the information about Trehgam medical block is not available.

Source: Govt. of J&K, n.d

Table 1.10 shows the disparities across different blocks in Kupwara district on many indicators. For instance, the average population covered by each CHC at district level is 99914. However, the average population coverage by each CHC in Kupwara (120000), Sogam (129290) is much more than at district level. At the same time, medical blocks like Trehgam (55490) and Villigam (66213) do not have any CHC, while as Zachaldara had a CHC for only a population of 45928, lesser than Trehgam and Villigam and Langate (104850), and Langate is the only medical block with two CHCs for a population of 104850

(Kupwara and Sogam have more than this population but only one CHC) (District Administration Kupwara, 2007).

The average population covered by each PHC at district level is 19427.8 but the average population coverage by each PHC in Tanghdar (52360), Trehgam (27745), Sogam (25858) and Villigam (22071) is much more than average population covered by a PHC at district level. At the same time, the number of PHCs in Kralpora medical block are four covering an average population of only 14992.5, number of PHCs in Zacahaldara medical block are three covering an average population of 15309.3, and number of PHCs in Handwara medical block (where District Hospital is also located) are four covering an average population of 16325.0 (District Administration Kupwara, 2007).

Similarly, the average population covered by each sub-centre in the district is 3268.2. While in blocks like Handwara (5023.1), Kupwara (4137.9) and Sogam (4170.6) is much more than the average at district level, the blocks like Kralpora (2221.1) and Tanghdar (2181.7) is much lesser than the average at district level (District Administration Kupwara, 2007).

The average population covered by each ICDS centre is 565.9 at district level. However, in Langate the average population covered is as high as 3744.6 and in Kralpora it is 1276. While as in as low as 278.8 in Trehgam and 315.4 in Tanghdar (District Administration Kupwara, 2007).

There are also disparities in availability of medical staff. On an average, there is one medical officer available for 8853.2 populations at district level but in Trehgam one medical officer caters to an average of 18496.7 persons and 13242.6 persons in Villigam and is as low as 5103.1 persons in Zacahaldara, 5217.4 persons and 7480 persons in Tanghdar. Similarly, there are disparities in availability of ANMs in different blocks, with Langate, Trehgam and Kralpora in a better position than average district level, and Zachaldara, Handwara and Tanghdar is poor position (District Administration Kupwara, 2007). There are many vacancies in the staff at district level, however, the vacancies are much more in some blocks and less in certain blocks. The table 1.10 provides a glimpse of the vacancies of workforce in different blocks in the district.

The question arises, what are the possible reasons for these disparities that exist at the block level within Kupwara district in the availability of health facilities. One possible reason seems to be that some of the areas in Kupwara district are hilly and get snow locked for few months in winters. In such areas, the less availability of transport makes it much more difficult for people to access the health facilities, even if located at few kms away. Therefore, such areas would require more health facilities. However, the disparities do not seem to hold that logic. The blocks which include hilly areas are Tanghdar (all hilly, snow bound and border area), Kupwara and Zachaldara but the disparities don't show such trend. The favourable blocks seem to Handwara, Langate and Kralpora. Therefore, the reasons seem of to be political in nature. There is one other layer that needs to be explored in this disparity and that is at the tehsil and constituency level. There are three tehsils in the district – Tanghdar, Kupwara and Handwara, and the availability of health services seems to be better in Handwara than in other two tehsils for political reasons, and is analysed in the chapter- 3 in the socio-economic and political profile of district Kupwara.

Therefore, the regional disparities in health infrastructure and access to public health services, as reflected by DLHS has to be explored further down to block level and would have implications for the planning of health services in the district, region and state. Therefore, even if a region has better availability of health services, there may be districts and blocks, which would be at much disadvantaged position than any other part of state or region, and in macro-analyses at the state or regional level, such micro-level details get missed.

Table 1.10: Availability of Health Facilities across different Medical Blocks in Kupwara District												
S. No	***Name of Block***	***Count/ Av. Pop Coverage***	***Kupwara***	***Sogam***	***Kralpora***	***Trehgam***	***Langate***	***Zachaldara***	***Handwara***	***Villigam***	***Tanghdar***	***Total***
1	Population		120000	129290	59970	55490	104850	45928	65300	66213	52360	699401
2	CHCs	*Number*	1	1	1	0	2	1	1 (DH)	0	1	7
		Av. Pop. Coverage	120000.0	129290.0	59970.0	0.0	52425.0	45928.0	65300	0.0	52360	99914.4
3	PHCs	*Number*	8	5	4	2	6	3	4	3	1	36
		Av. Pop. Coverage	15000.0	25858.0	14992.5	27745.0	17475.0	15309.3	16325.0	22071.0	52360	19427.8
4	MOs	*Number*	23	16	10	3	16	9	NA	5	7	79
		Av. Pop. Coverage	5217.4	8080.6	5997.0	18496.7	6553.1	5103.1	0.0	13242.6	7480	8853.2
5	MTP Centres	*Number*	0	1	0	0	0	0	2	0	1	4
		Av. Pop. Coverage	0.0	129290.0	0.0	0.0	0.0	0.0	32650.0	0.0	52360	174850.3
6	Sub Health Centres	*Number*	29	31	27	17	35	16	13	22	24	214
		Av. Pop. Coverage	4137.9	4170.6	2221.1	3264.1	2995.7	2870.5	5023.1	3009.7	2181.7	3268.2
7	AYUSH Dispensaries	*Number*	0	3	4	0	0	1	1	0	4	13
		Av. Pop. Coverage	0.0	43096.7	14992.5	0.0	0.0	45928.0	65300.0	0.0	13090.0	53800.1
8	ICDS Centres	*Number*	205	335	47	199	28	43	95	118	166	1236
		Av. Pop. Coverage	585.4	385.9	1276.0	278.8	3744.6	1068.1	687.4	561.1	315.4	565.9
9	ANMs in Position	*Number*	31	30	23	18	35	2	12	15	7	173
		Av. Pop. Coverage	3871.0	4309.7	2607.4	3082.8	2995.7	22964.0	5441.7	4414.2	7480.0	4042.8
10	Workforce Vacancy	*Number*	44	5	25	10	65	33	87	32	48	349
Source: Calculations based on data from District Health Action Plan of Kupwara, (District Administration Kupwara, 2007)												

1.5. Issues for Research:

The macro data sets suggest that J&K provides a better picture on many of the health indicators as compared to India but lags behind many of the other Indian states. The prevalence of some of the health problems is also much lesser in J&K than India. The reasons for J&K to achieve relatively better health outcomes than India as a whole may because of the better socio-economic conditions of the people in the state, as the health status of population is largely determined by the socio-economic factors. The other aspect of having relatively better health status may be also because of the better access to public services, including livelihood, food, nutrition, social security, health services, hygiene, sanitation, etc. The 52nd round of NSSO survey in 1995-96 found that access to treatment by the persons who reported illness in the last 15 days was high to the level of almost 93.7 percent of ailing person in rural J&K. This level of access to treatment was much higher than in Kerala (883) and Tamil Nadu (776), the states known for better provisioning of public health services than rest of India (NSSO, 1998). The 60th round of NSSO in 2004-05 revealed that the level of access to treatment by the persons who reported illness in the last 15 days have gone down to almost 82 percent, but that is still as high as in India (NSSO, 2006). *Therefore, such higher levels of accessing treatment by the ailing persons in J&K need to be studied at the ground.*

The NSSO report further revealed that the levels of morbidity are lower amongst STs but the access to treatment among STs is much higher (100 percent) than other higher castes. It seems to be contradictory to huge literature, which has shown that STs have relatively poor living conditions and lower access to health services than other higher castes. The level of discrimination and exclusion based on caste in J&K is not of the level of India but it cannot be denied that the socio-economic conditions of STs are worse than the other higher castes in the state, as result of their least access to resources, employment, livelihood and other public services.

Therefore, what STs have reported that they have less levels of morbidity than the other higher castes may be due to either differential health consciousness, which is in turn shaped by the experiences of health services, or may be that they have reported only those illnesses in which they have sought treatment. The probability seems to more that they have reported only those illnesses in which they have sought treatment that is the reason why the report has shown 100 percent treatment for STs among ailing persons. Also, with many

disadvantaged groups, the experience of illness is so often that they internalise it as part of life and often do not report some illnesses, as they may see it normal. *It makes it imperative that such issues of reporting among the STs and their access to health service are to be examined and analysed at grass roots level, if it is a case of under-reporting of morbidity (reporting only those illnesses in which they have sought treatment).*

The NSSO reports, NFHS-3 data and planning commission study revealed that a majority of people access public health services in J&K, as compared to India. Although the average health expenditure in J&K for outpatient care is more than in India for both public and private sector, the calculations show that a majority of people in J&K have to incur lesser amounts than in India for treatment because they access public health services. The costs of public health services in J&K are much cheaper than the private health care in India. *The considerably higher levels of access to government health care in J&K than in India, where a major section depends on private health care, may also be reason for relatively better access to health services in J&K than in India, and has to be explored.*

But at the same time, a significant proportion of ailing persons have received treatment from private facilities, which are much more expensive than in India, and therefore, it may not be just the accessibility to government health services in J&K, which led to higher levels of access to treatment but also the relatively better socio-economic conditions of people in the state than India as a whole. However, *this has to be examined at the grassroots level, if it is better accessibility to public health services or better socio-economic conditions or an inter-play of both factors, that leads to higher levels of access to treatment in J&K.* At the same time, it is pertinent to understand why a significant portion of people access private health care.

The NFHS -3 data reveals that the levels of access to institutional delivery, ANC, vaccination, and treatment to children, who suffered diarrhoea and ARI, were better in J&K than in India. However, the data raised important questions about the quality of maternity and child health services and outreach of grassroots levels workers. The data also shows that a significant portion of women do not utilise the maternity and child health services. Some *proportion of women reporting that they have not utilised the maternity health services, could be for both reasons - there is no 'need felt' as well as not being able to access maternity health services, which includes the compromised quality of services,*

limited outreach of maternity health services, affordability as well as socio-cultural factors, and has to be explored.

More importantly, the access of women to maternity health services depends on status of women and their freedom to travel alone (or accompanied by other person) to health facility, which are always outside the village, and needs to explored in the socio-economic and political context of state.

Further, J&K has been a witness to more than two decades of ongoing conflict, which has affected the mobility of people as well as the socio-economic conditions of people and their access to livelihood. Though the conflict has affected all sections of population, the impact has been relatively more on women and lower socio-economic sections. As a result, the conflict has resulted into many structural constraints and has created many barriers that are likely to shape the access of people to health services. This may have resulted in growing inequities in access to health care along the lines of gender and class. *What needs to be explored are the processes of how the conflict has affected the socio-economic conditions and access to public services including health services in a more systematic and comprehensive way*?

Importantly, the NSSO report does not reflect the differential access to health care by the social groups and even reflects the better levels of access by STs, a finding contradictory to huge literature that shows ST and Scheduled caste are the disadvantaged social groups in access to public health services and in socio-economic conditions. The reports and the data also fail to bring the gender perspective in access to health services.

Although the J&K state is met with special treatment in India and the financial arrangements of state are different with Government of India as compared to other Indian states, the reports show that there is a severe shortage in infrastructure and human resources in public health sector. The shortages in infrastructure and human resources would be affecting the quality of services, and therefore on the access of people to health services. People who may have accessed a health facility near to home in presence of health providers may not be able to reach out to a health facility, located away from his home. The reports have also shown that percentage of women with any contact with grass roots level health workers is also very limited. *However, this remains to be explored, if the shortages*

in health infrastructure and staff and outreach of health workers affect the access of people to health services, and in what ways?

The data also suggests that the disparities exist between the Kashmir, Ladakh and Jammu regions with Kashmir having relatively better access to health services and other basic amenities. The data also suggests that there are disparities in the availability of health facilities and socio-economic conditions within the three regions across districts. At further disaggregated level, there are even disparities in the health facilities available in the district between the different areas of the district. Therefore, even if a region has better availability of health services, there may be districts and blocks within that region, which would be at a disadvantaged position than other parts of state or region, and in macro-analyses at the state or regional level, such micro-level details get missed. *It is therefore interesting that the high level of access reflected by NSSO needs to explored in this context of regional disparities and disparities within the districts at the gross root level.*

The other important concern seems to be the fact that there are no micro-level studies that have made investigation into the functioning of health services in the state at the grass roots level, which would have reflected the levels of accessibility and analysed the factors affecting the accessibility to health services. This provides a rationale, therefore, to undertake a micro-level study in the state to understand the access to health services and the processes which make it possible for such a higher proportion of people to access health services in the context of severe shortages of health infrastructure and human resources. The micro-level study will also explain the linkages of the factors that influence the access to health care in the state and the linkages between the better socio-economic conditions and access to health services among different social and economic classes of population.

As part of the M.Phil dissertation, a study was undertaken on the issues that have emerged through reviewing of literature on the availability of and accessibility to health services in J&K. The next chapter discusses the study design for the study that was undertaken.

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CHAPTER 2: STUDY DESIGN

'Access' is not a function of mere availability of health services, though the availability of health services is important and the primary requirement to ensure that all people have access to health services. The concept of 'Access' has been delineated by many scholars from mere availability of health services to use of health services. Most progressive definitions include the three important components- availability (physical proximity), social access and affordability. However, one of older and widely used has been demonstrated by Panchansky and Thomas (1981), who have identified five dimensions of access that influence the realisation of health care including availability, accessibility, accommodation, affordability and acceptability. *Availability refers to the adequacy of supply of health care infrastructure and human resources, and accessibility relates to the geographical location of health care providers and their users, whereby travel, cost and time are taken into account. While as accommodation refers to the organisational structures of health care services (e.g. appointment systems, hours of operation, walk-in facilities, telephone services), and the patient's ability to cope with these structures. Affordability refers to the financial ability of patients to use the available health care. Lastly, acceptability refers to the relationship between users' attitudes towards the providers and available health care and vice versa.* These five factors collectively determine the accessibility to health services. This study uses the same approach to investigate into the multi-dimensional phenomenon of access to health services by people in J&K.

Functional quality of the available facilities requires more ground level data, some of which is available in DLHS and Common Review Mission (CRM) reports of NRHM. Nevertheless, micro-level observations and analysis are necessary to understand and develop insights into the experiences of people with access to health services. By saying 'provisioning of health services' as one of the important components of this study and using secondary sources to understand issues with it, didn't mean that provisioning is separate from access or is less complex. This study conceptualizes access in terms of physical availability, social access and economic affordability, and the micro-level study included enquiring into the availability of health services at the grass roots level. However, '*provisioning of services'* is rather used in a very broad way to mean the availability of services within the state and at regional level and '*availability*' as a component of access

has been conceptualized to enquire into the availability of services at the local level where the study was conducted.

It was not logistically possible to spread the micro-level study through many areas of the state, though it was imperative considering the regional variations in topography of state. Therefore, it was decided to understand the inter-regional differences in health services, if any, using data from macro-level surveys, as was analyzed in the first chapter of this dissertation, and to develop insights into the experiences of people with health services through a village study to be conducted in Kashmir. The Kashmir region was chosen for conducting micro-level study for the only reason that the researcher belonged to Valley and it was feasible to find logistic support in Kashmir. With these presumptions and limitations, the study was designed along the following dimensions:

2.1. Research Questions:

The approach of the present study was structured around the following lines of inquiry, which were dealt rigorously in the course of the present research:

1. *What is the status of availability of health services in the state of J&K?*
2. *What are the regional disparities in the availability and accessibility to health services in the state?*
3. *Whether people face difficulties in accessing health services?*
4. *Whether there are disparities in access to health services along the line of gender and socio-economic class? If so, why and what are the factors that influence the differential access?*
5. *What are the others issues involved with access to health services?*

2.2. Methods of Data Collection:

2.2.1. Sources of data:

The study was conducted in two parts: (a) A review of literature and analysis of the data from official surveys and reports, and (b) Primary data collection in one village in Kashmir.

For the first part of the study – provisioning of health services in the state -- the researcher referred to the relevant available studies, data and reports including large-scale surveys such as Census, NSSO, NFHS, DLHS, Rural Health Statistics (RHS); NRHM reports and

data, and District Health Action Plans. The other referred reports include Economic Survey -2008-09, J&K Government ; Hunger in the Valley; Evaluation study of NRHM in seven states; District Economic Review of Kupwara; BPL Survey-2008, J&K Government; Socio-Economic Profile of J&K-2008; State Development Report, J&K; Evaluation Report of ICDS; State Domestic Product of J&K : 1999-00 to 2007-08; among others.

For the second part of the study, a micro-level household study was conducted in a village in Kashmir to gain a deeper understanding into morbidity and access to health care and services. The study conducted an enquiry into access to health services covering treatment of illness both inpatient and outpatient cure, maternal and child health services, and other preventive and curative aspects of public health system.

2.2.2. Study Area:

The micro-level study was undertaken in Kupwara district of J&K. Kupwara is one of the poor and backward districts of Kashmir (and the state), as reflected by its poor development indicators. The district is almost fully captured by Indian security forces, with many roads blocked by them, which was thought likely to affect the access to health services. The topography of the district is hilly, which makes it difficult to access health services even if they are located within a few kms distance, in absence of a proper transport system.

Within the district, the study was to be carried out in one village. However, it was thought in order to develop in-depth insights into the difficulties that people face while accessing the health services and the disparities in access to health services along the lines of class, caste and gender, in a socio-economic and political context, the village should meet some basic criteria, as follows:

(i) The village should have average population strength (500 to 1000), (ii) It should be composed of different castes including ST population so that they have probability of being covered under the study, (iii) The village should be located in a place neither far nor close to the block or district head quarter, and (iv) It should have hilly topography.

Kupwara district is divided into three tehsils- Handwara, Kupwara and Tanghdar, and nine medical blocks – Villigam, Zachaldara, Langate, Handwara, Trehgam, Kralpora, Sogam, Kupwara and Tanghdar. There are disparities in availability of health facilities across

tehsils and blocks. A block level analysis revealed that Zachaldara medical block presents an average picture of availabile facilities. Therefore, Zachaldara medical block was selected for the study. The terrain in certain parts of Zachaldara medical block is hilly. It is also one of the poor and backward areas of the district. Zachaldara is a part of Handwara tehsil, which is one of the towns/tehsils of the district but politically very strong and historically developed, and is entertaining the development of most of the district level services within the town for the political reasons.

Within the Zachaldara medical block, the village was selected only after understanding the socio-economic conditions, topography and availability of health institutions in the entire block. A health map was obtained from Block Extension Educator, which underlined all the health institutions of government in the medical block (see Appendix -C). An analysis was carried out to choose the village, which neither would be far nor too close to the major health institutions like PHC, CHC and District Hospital (DH), situated around the medical block. The topography of the medical block was divided into two regions- Lower Belt and Upper Belt[15]. However, the CHC and PHCs were mostly located in the Lower Belt. Therefore, it was assumed that the people in the Upper Belt would have to face many problems in accessing health services, which are mostly situated in the Lower Belt. The other consideration was to select a village where ST population would also be inhabited to be covered under the study to develop insights into their experiences with health services and if any disparity exists between them and other general castes in accessing health services. The researcher travelled to many villages in the block before selecting the village.

Neeligam village was found to be meeting the criteria for the study and was selected. Neeligam is located in the Upper Belt of the Zachaldara block. Neeligam village was neither the beginning nor the end of Upper Belt and was located almost centrally in the Upper Belt, with one hamlet inhabited by ST populations, and was composed of ten castes. The population of the village is around 875. These characteristics made it ideal for undertaking this study in that village. The socio-economic, demographic and political characteristics of the Neeligam village and of the whole district Kupwara are analyzed in the next chapter -3.

[15] The demarcation between the Lower Belt and Upper Belt was basically the topography of the block. The block had arbitrary a plain area and a hilly area. The point where the hilly area start is taken as the demarcation line between the Lower and Upper Belt.

2.2.3. Sample and Sampling:

Within the village, 50 households were selected by *systematic random sampling*. Initially, a group discussion was conducted for information about ecology, topography, castes, economy and sources of livelihood, and functioning of government schemes in the village.

After this, a baseline survey was conducted, using an interview schedule, covering all households to record their socio-economic status to ensure that sample drawn covers all the different socio-economic classes in the village. The interview schedule consisted of 10 questions related to indicators of socio-economic conditions of households. Each household was scored based on the observation, and the households were ranked based on a composite score. However, the scoring of one parameter related to status of children (whether they attend school, and if they are engaged in child labor) turned out to be so complex that people presented much diverse picture and it was difficult to find any pattern in giving scores. The researcher felt there was no clarity and was difficult to give it any quantifiable score and therefore, the parameter was not included in calculating the final composite score. The interview schedule is annexed as Annexure- A.

This provided insights into the living and working conditions but was becoming too reductionist for the complexity present in each parameter. A group discussion was, therefore, conducted with some of the key informants of the village, to discuss and verify whether the ranking of the households based on these indicators matches the perceived socio-economic differences of the households in the village by the locals. If not, whether any modifications are to be made based on the discussion with the key informants. In this discussion, the major findings of the survey were also discussed with the informants. The group constituted 15 people, with participation from many castes including Geelani, Gujjars, Khan, War, Reshi and Bhat.

The researcher asked the people in the discussion if the households vary in socio-economic conditions. If yes, on what basis can the village households be segregated into different socio-economic classes? Through discussions it was finally agreed that the village should be divided along castes with Ganaie and Gujjars at the bottom of indices and other castes at the top. Among other castes at the top, they argued that livelihood and land holdings are the important indicators to divide these castes into poor and rich households. They explained this with many examples and it would hold valid.

With further debate on this issue, all the people agreed that the Ganaie and Gujjars are the poorest in the village, but Khans on the other side have better socio-economic conditions and other castes like Bhat, Geelani, War, Reshi, etc. (as an individual caste they were smaller in number) would fit in the moderate socio-economic conditions. The survey had shown the same results with few households scattered through the indices on socio-economic conditions. The analysis of almost each indicator showed that Ganaie and Gujjars are the poor in the village, while Khan households were amongst those who had better socio-economic conditions. Taking scores from all indicators together, except for one Ganaie family that ranks in the middle part, all other Gujjars and Ganaie's were classified in the lower third part of ranking.

The discussion refined the assumptions and results of the socio-economic survey, and therefore, all the households were ranked based on a composite score they could get on nine parameters (out of 10 parameters one was not included in the final analysis). It was decided, not to draw any line to divide the households into three strata, as the line would have to be arbitrary[16]. However, the sample was selected using a systematic random sampling, and each third household was selected, until the 50 households were included. The final sample drawn was checked to see whether it reflected the range of socio-economic classes. It was found that the final sample drawn included households from Ganaie and Gujjars –poor castes, proportionate to their total numbers, and from other higher castes (rich as well as other poor households from higher castes). Therefore, both caste and class (in terms of living conditions) were represented in the sample.

2.2.4. Tools of Data Collection:

The data collected was quantitative as well as qualitative in nature. First, an interview schedule was used for baseline survey on socio-economic status (see Annexure –A) Second, an interview schedule was used for survey on health indicators (see Annexure –B). The second interview schedule included questions related to morbidity and mortality, maternal and child health, expenditure incurred on treatment, contact with grass roots level health workers, and access of people to health services. The schedule was divided into sections to ensure that there is flow in related questions and to ease the process of interviewing. Asking questions randomly on different issues may have led to

[16] In case of BPL survey, which uses similar kind of methodology, the line drawn to divide the households into BPL and APL is completely arbitrary and has varied across states. For the same reason, the methodology was severely criticized by the activists, policy makers and scholars.

misunderstanding and confusion in the interview process. Within each selected household, the details were to be recorded for all the members but only two adults of each household, one male and one female, were taken as respondents (in few cases, the male respondent was not available at home, and in a few cases, female respondents didn't participated in presence of their male members) .

Group Discussions were conducted with people including the panchayat and with women to gain insights into their socio-economic conditions, health issues, problems in access to health services, and their participation in the health services. As it was clear that Ganaie and Gujjars are the poor and backward classes and castes in the village but Gujjars were being discriminated much more than Ganaie for different reasons, therefore, the researcher decided to facilitate a separate focused group discussion with ST women, to understand their health issues and their experiences with health services. Since, it may not have been easy to understand the issues of STs in a common discussion at same time with Kashmiri women as well as ST women. Separate discussion provided many insights about how being a Gujjar affected the access to health services in J&K.

Other than the questions framed in the interview schedule, the researcher had facilitated the discussion in almost each household interviewed under this study on many diverse issues related to health and their access to health services. It was thought while designing the study that there may be many such issues particular to the area that would be important to discuss but may not be referred in the interview schedule. Therefore, the researcher would add such issues to the schedule, as the interview process would move on with increasing insights of the researcher into the issues of health and health services in the village. The researcher developed an *interview guide* during the fieldwork itself, in which as many questions were added as each new issue emerged. That interview guide provided flexibility to bring in the issues that were not envisaged while designing the study. The interview guide is annexed as Annexure –C.

2.2.5. Coding and Pre-test:

The interview schedules were pre-coded to the extent possible, before going to the field. After the second Interview schedule (on health services) was finalized, it was used directly in the field without conducting any pre-testing to gain insights into the reliability and validity of the data. However, it had been thought while designing the study that if the

researcher would feel, after 10 interviews are conducted, that data recorded was not reliable or any changes are to made in the interview schedule, the field work would be stopped and changes would be incorporated in the interview schedule. Also, corrections will be made in the recorded data already collected. However, as the researcher conducted interviews in the field, the data recorded was in consideration with the assumptions and research questions, and the data was reliable. Thus not required any changes in the interview schedule. Nevertheless, as the researcher felt, that some of the issues had emerged during the interview process and it was important to facilitate discussion around these issues with the households, an interview guide was developed; in which as many questions were added as each new issue emerged.

2.3. Data Analysis and Techniques:

The quantitative data collected was analyzed using statistical methods and techniques (with the help of SPSS). The analysis included drawing frequencies, percentages and cross-tabs. A content analysis was undertaken of the qualitative data collected through interviews and discussions with people.

2.4. Ethical Dilemmas and Protocol:

An attempt was made that interview schedule was very sensitive to the experiences and emotions of respondents. The interviews were conducted only after taking *informed verbal consent* of respondents. Respondents were assured privacy and all the information recorded was kept *confidential*. A consideration was given to the emotions and feelings of the respondents, and in cases, the women or any other respondent felt uncomfortable in sharing any information, the researcher would shift the focus of the interview to ensure that people are comfortable and assured privacy and confidentiality to them. Few questions were dropped from the schedule on realizing that it was creating discomfort amongst the respondents, e.g. inquiry about whether the women were presently pregnant.

Further, the name of the village in which the study was conducted has been changed in this dissertation for reasons of preserving some confidentiality. The name 'Neeligam' used in this study is pseudo name, and any resemblance with any other village in Kashmir, if any, is unintentional.

2.5. Processes of Data Collection and Methodological Observations:

One of the peculiarities of social research is that what is planned outside the field cannot be practically conducted in the same manner. The fieldwork always puts forth a number of challenges and the study design initially proposed could not be translated exactly as planned. It is also possible that the study design framed will not be much relevant to the study in the field. This all affects the desired level of reliability and validity of data. Therefore, the processes of data collection actually followed in the field are important to bring rigour in the research being undertaken. The following paras explain the processes of data collection under this study and some of the methodological observations.

1. As it was snowing in January and February in Kashmir, the fieldwork turned out to be very difficult to undertake. The researcher had to spend days together at his residence doing nothing and just hoping for a working day. The conditions in the field were very uncomfortable with freezing weather. The freezing of snow on the roads also led to inadequate transport services to the field, and the day would close early to catch the last bus back. This all cut down the number of hours spent in the field to almost half, which, otherwise, would have enriched the quality of research further. What helped researcher to complete this study in such uncomfortable conditions was his familiarity with the area, his living experience of keeping up in such cold weather, and his motivation to undertake this study.

   However, this brought a different element into the research, since it showed how and what people do during such winters to cope with the climate and access health and other services. It also enlightened the researcher about the limitations of medical staff during such time to be able to reach out to the people in delivering the health services. However, the researcher felt that winters could not be an alibi for the dysfunctioning of health system for the reasons that the winters in Kashmir are part of life and the government has the obligation to undertake such measures and develop infrastructure of required level.

2. It was thought while designing the study that there were many such issues particular to the area that would be important to discuss but may not be referred in the interview schedule. Therefore, the researcher would add such issues to the schedule, as the interview process would move on with increasing insights of the researcher into the

issues of health and health services in the village. The researcher developed an *interview guide* (see Annexure -C) during the fieldwork itself, in which as many questions were added as each new issue emerged. The researcher facilitated discussion in almost each household interviewed under this study on the issues related to health and their access to health services emerged in the field, which provided many insights into the access of people to health services. The interview guide provided flexibility to bring in the important issues, which were not envisaged while designing the study.

3. The researcher felt that, as he was enlightened with many such issues as he moved on during the interviewing of households that were not referred in the interview schedule and were important to discuss and bring in the present study. Therefore, he developed an *interview guide* during the fieldwork, in which as many questions were added as each new issue emerged. That interview guide provided flexibility to bring in the issues that were not envisaged while designing the study, and helped to develop deep insights into the experiences of people with health services.

4. The discussion notes were written immediately after the formal interview was completed with the household, in the same place. Earlier, the researcher had thought that he would write field notes in the evening after he would return from the village. However, as he felt in a few days, that there was overlap of thoughts and experiences that few households shared with on a same day, and due to some logistic problems at the base camp, he was not able to write the notes on each evening, and the next day, it would become very difficult to write down the experiences. In the first few days only, therefore, the researcher decided to write the discussion notes immediately after the interview is completed and before entering into the next household. This led to huge time taken by each interview and the overall process of interviews was delayed, but it ensured that quality data and experiences of people, which had come through discussion, are recorded clearly.

5. The researcher observed that women were better respondents than men in sharing the personal information and negative experiences with health services. The researcher remember the interviews with some of the women who shared their experiences in very detailed way, which was much helpful and provided deep insights into the health services. For instance, it was a woman who had reported the doctors keep talking over

their mobile phones while writing prescriptions for the patients. Another woman had shared that how the staff of CHC discouraged them that they should not avail the services of dispensary set up by MSF in nearby village, as that was affecting the sale of drugs in shops around CHC. Another woman compared the hospitals with slaughterhouses for not caring to patients while staff is always busy in calculating money and their arrears. It was women who explained why most of pregnant women are referred to State Maternity hospital at District Hospital, Kupwara. However, there were occasions, the researcher could feel, that the responses of the women were highly restricted whenever a man was sitting around in terms of illustrating their experiences with health services or even recounting expenses incurred on accessing health services. This may have also led to some under-reporting of illness or experiences with health services.

However, it is pertinent to note that on the broader issues of socio-economic conditions and political development, men were articulate, which is of course, due to their relatively greater exposure to media, development and politics, and confidence in this sphere. This also made it necessary to ensure talking to male members under this study. It was equally obligatory not to ask any male to leave the woman alone for the interview, in order to be sensitive to their culture that households may be uncomfortable for a stranger male investigator talking to their woman for a long time alone.

6. In a few households the researcher found no male was present for the interview and women were little hesitant to talk to the researcher in absence of a male member. In such cases, the researcher modestly left and enquired about the timings of male, so that he could come for the interview only when a male member was present. In a couple of cases, the researcher had to visit the households more than one time to conduct the interview.

7. The researcher took precautions to ensure that informants are interviewed as per their convenience and feasibility and even visited few households more than a single time to take interview. However, most of the informants gave adequate time, but in just a few households, the researcher felt that the informants were in little hurry and wanted to wrap up the interview quickly, probably due to their other engagements around the same time.

8. The interview schedule was very comprehensive to cover almost all aspects of health services, which resulted in a huge number of questions. It was assumed that not all the sections and questions would be applicable and asked to all households, which would result in not long interviews. For example, it was assumed that not in all households any women would have given birth in the last three years; not in all households there would have been a death in the last one year; not in all the households any member would have been hospitalized in the last one year; etc. Therefore, not all sections and questions were to be asked to all informants. This assumption holds valid for most of the interviews and limited interview to a manageable time limit of one to one and quarter hours. However, in a few households, who had especially any women who had given birth to one or more children in the last three years, led to lengthy interviews of one and half hour or more, that the researcher felt t would have been little uncomfortable to informants for giving so much time. To judge the comfort level of the respondent, in regards to both the duration as well as the content, was left to the discretion of the researcher. On observing any form of uneasiness experienced by the respondent the interview was shortened or discontinued. Barring a few cases, no such problem was experienced.

9. The researcher was able to speak fluent Kashmiri, however, he belonged to south Kashmir and the fieldwork was being undertaken in north Kashmir and there is a slight difference in slang being spoken through Kashmir, which made it slightly difficult on few occasions for both researcher and informants to understand each other. The researcher was aware of this and took all precautions to explain some words and issues, as many times as required to make informants understand what he meant, and similarly confirmed from informants the meaning of some words which he did not understand so that there is no misunderstanding. However, in the ST hamlet, some of the informants were not able to speak Kashmiri but would understand Kashmiri language with some interpretation. Therefore, the researcher took the help of local people to interpret and translate whenever necessary.

10. As was expected, the researcher observed that in many cases the informants would simply dismiss the question that they were not ill in the reference period and it was only when a set of probing questions would be put to the informant, information on many illnesses they would have suffered would come out (see Annexure –D). The reason

primarily was, which the researcher felt, was the fact that some of the people didn't consider minor ailments like head ache, cough, body ache, fever, viral infection, etc. as illness, probably for the reason that the regular prevalence of some of these illnesses had changed the perception of some of the people that they started considering it normal. There was also a feeling that for the illnesses for which treatment was not sought were not being considered as illness, and it was only after probing the informants would say that they had suffered from such illnesses. The researcher felt that this may be the reason that why the access to treatment in this study and other similar designed quantitative studies like NSSO, has turned out to be of higher level, for the illnesses which were not cured were not being recorded. The researcher felt that it would be only a qualitative design study, which could bring the issues of untreated morbidity among people in J&K. It was only after continuous probing about untreated morbidity that informants would recall that there are occasions that they are not able to seek health care but that was not reflected in the row of quantitative questions about their ability to access treatment for the illnesses, if any, in the reference period.

11. As the study was designed to investigate the access of health services along the lines of gender, caste and class, the actual operationalisation of these concepts in the field study found it very difficult to design the tools to bring out the disparities in access to health services along such parameters for the following reasons:

a) Class as such is very complex in nature. The Marxian perspective would have required to investigate into the nature of relationship between the people who own and control the means of production and the people who are being exploited and simply sell their labour in the market place; or to find out the nature of relationship between the employers and employees. However, it was not felt feasible to carry an extensive exercise to divide the field area into Marxian classes and then to investigate into disparities along the lines of class. As proxy to this, income, expenditure, or economic conditions are being widely used to investigate into disparities among different classes by the academicians, policy makers and large-scale surveys. The recent BPL methodologies in India to identify the poor to be benefited under the poverty alleviation programs have also relied on using the proxy criteria. For instance, the BPL 2001 and recent Saxena committee report on BPL identification used the indicators like land holdings, access to sanitation and drinking

water, type of house, ownership of consumer durables, means of livelihood, etc. to identify the people who are poor (Saxena, 2009). This study developed on the same tool and used some of these indicators, with addition of few more, to examine the different socio-economic conditions of people in the field area, and to divide the households into different sections based on their socio-economic conditions, to use it as proxy to class.

b) Caste in Kashmir is not very clear and demarcated. There is just 0.05 percent population who are Scheduled Castes in Kashmir. There are no such religious scriptures, which govern the conceptualization of caste in Kashmir society, as Muslims mostly inhabit it and follow Islam. Above all, there is no substantial research work on the conceptualization, existence and the way casteism operates in Kashmir. The existence and severity of casteism would also vary with composition of population in a particular village or area. Therefore, it was difficult to draw simple criteria to distinguish between different castes and to investigate into the disparities along the lines of caste. However, the researcher travelled through most part of the Zachaldara medical block and spoke to as many as could have been possible in a short span of time of one month and realized the composition of population in the villages in the block and pattern of possible caste differences. A discussion was conducted with the people in the selected village to find out if there was a perception of caste differences and caste hierarchy or any form of casteism, before actually conducting the study. This process led to conceptualization of caste for this study and demonstrated the existence of caste hierarchy and other forms of caste differences in the village, as are discussed in much detail in chapter -3.

c) Similarly, the researcher felt the disparities in access along the lines of gender were difficult to record for the reasons of strong influence of men while being present during the interviews. However, as mentioned earlier their presence was inevitable. In winters when most men, who are wage workers, do not find employment, and mostly are present in their houses. Nevertheless, some of the women felt and narrated that there was a gender disparity in access to health care in different forms and a few of them explained the reasons as perceived by them. The researcher felt that such analysis may not come through quantitative data and that might be the

reason why the data in this study and other quantitative studies like NSSO, do not reflect disparities in access to health services along the lines of gender in Kashmir.

2.6 Limitations of the Study:

It is not possible to design and conduct a foolproof study. The fieldwork always poses number of problems while conducting a study and it is possible that what has been thought and assumed while designing the study is not much relevant to the actual data collection. There are occasions that many challenges cannot be overcome due to logistic limitations. The researcher realised in the field that the present study have also suffered from a few limitations. However, an attempt is being made to make explicit the limitations of the study as perceived by the researcher to help the readers to make any conclusion or inference within the ambit of those limitations.

1. There are wide disparities in the socio-economic, ecological, and political conditions between the different regions of state – Jammu, Ladakh and Kashmir, therefore, undertaking a study in Kashmir, may limit the generalization of the study to the other two regions – Jammu and Ladakh, provided some measures to verify its validity in these two areas are conceptualized and undertaken.

2. As the study was conducted in only one village in Kashmir, and the village selected had hilly topography, with majority of the households falling under poverty line, the conditions of health services in the towns, cities, and the areas near to towns may be much better than what is reflected in this study. Therefore, the generalization of any inference to Kashmir have to be done with precautions, and considering the socio-economic and political context of the areas, in which this study was undertaken and the areas to which the generalizations are validated.

3. There were chances of under-reporting of morbidity as the methodology involved recorded the data only on self-reported basis, and no medical examination or any verification was undertaken. However, some probing questions were put to the informants during data collection to improve reliability and accuracy as possible. Nevertheless, as envisaged, there would be some under reporting but that should not affect the analysis of the data to understand the issues of access to health services and factors affecting the access in the state.

Secondly, there were chances of under-reporting of morbidity particularly by women due to the reason that a male investigator was undertaking this research and some women may have been hesitant to share information about their health concerns with a male investigator. This issue was genuine and in many studies of such nature, like one undertaken by NSSO on morbidity and treatment, the intermediaries are allowed to take interviews in such cases. However, in this study, an attempt was made to make the tools very sensitive, and in a few cases, where women showed some reluctance or hesitance in discussing the nature of problem, the investigator just recorded the illness without going into the nature of illness. The hesitance might have been also because of male members of the family being present while interviewing. Nevertheless, the researcher felt that considering the level of rapport he could develop with the respondents and the level of comfort of the respondents with which they shared their information, the under-reporting may not be of serious level that it would have affected this study, especially in understanding the issues of access to health services, which was the focus of this study.

4. The study design also included visiting the health facilities including sub-centres, CHC and District Hospital in Kupwara district that the village residents accessed. A discussion was to be conducted with officials and other providers at these different health institutions, and an assessment was to be made about the availability of facilities and infrastructure at health institutions. This also included visiting a dispensary run by MSF and meeting one local person who was regarded as a Peer (mendicant or fakir). However, due to the time constraints that emerged out of limited work output in the winter months and due to transport and other logistic inconveniences, visits to health facilities was not undertaken and no discussion were held with health providers. Although the researcher went to sub-centre couple of times, he always found it closed and could not meet the staff. The research felt that it was important to record the problems the health providers face in delivery of services as well as their experiences and thinking about availability of and accessibility to health services in the area.

2.7. Concepts and Definitions:

The concepts and definitions of the terms, which were used in this study and had implications for the study, are briefly discussed in this section[17]:

[17] All the definitions in this section have been adopted from NSSO report 441 on 'Morbidity and Treatment of Ailments' conducted in 1995-96, unless specified.

a) Access: The operational definition of 'Access' has been used from the framework developed by Panchansky and Thomas (1981), who have identified five dimensions of access that influence the realisation of health care including availability, accessibility, accommodation, affordability and acceptability, and are explained earlier in this chapter.

b) Household: A group of persons normally living together and taking food from a common kitchen constitutes a household. The word 'normally' means that temporary visitors are excluded but temporary stay-aways are included.

c) Ailment -- illness or injury: Ailment, i.e. illness or injury, is defined to be any deviation from the state of physical or mental well-being. Cases of visual, hearing, speech and locomotor disabilities are also treated as ailment. Injury covers all types of damages like cuts, wounds, haemorrhages, fractures and burns caused by an accident, including bites to any part of the body.

Cases of sterilisation, insertion of IUD, getting MTP, etc., under family planning programme, pregnancy and childbirth are not treated as ailment. But a spontaneous abortion, is treated as a deviation from the state of normal health and thus considered to be illness.

As mentioned earlier that for ascertaining whether an individual had suffered from any ailment during the reference period and whether she/he had received any medical treatment on that account, the following set of probing questions was put to the informant:

- During the reference period, did the member feel anything wrong relating to skin, head, eyes, ears, nose, throat, arms, hands, chest, heart, stomach, liver, kidney, legs, feet or any other organ of the body?
- Does the member suffer from any disease of a chronic nature relating to stomach, lungs, nervous system, circulation system, bones and joints, eye, ear, mouth or any other organ of the body?

- Does the member have any kind of hearing, visual, speech or locomotor disability?

- Did the member take, during the reference period, any medicine or medical advice for his/her own ailment or injury?

d) Spell of ailment: A continuous period of sickness owing to a specific ailment is treated as a spell of ailment. A spell is generally identified with a specific cause of ailment. If a person was reported to have suffered from two or more types of ailment during the reference period, it was recorded as two different cases of ailment. *However, for this study, a continuous period of sickness was treated as a spell of ailment, irrespective of whether a person suffered from one or more types of ailment.*

e) Hospitalisation: A person is regarded as having been hospitalised if he/she has availed of medical services as an indoor patient in any medical institution. However, hospitalisation of female members for child-birth was not considered to be hospitalisation for the survey.

f) Medical treatment: A person is considered to have received medical treatment if he/she consults a health provider anywhere (in OPD of a hospital, community health centre, private residence, etc.) and obtains medical advice for the ailment. Self-doctoring or acting on the advice of a non-medical person is not treated as medical treatment in NSSO survey. *However, for this study, taking treatment even if on the advice of a non-medical persons was to be considered as treatment, but there was no single person who reported that he/she acted on such advice or took treatment at his/her own within the reference period.*

g) Expenditure for medical treatment: Total expenditure incurred for medical treatment received during the reference period (15 days for non-hospitalised treatment and 365 days for hospitalised treatment) includes expenditure on items like bed charges (with charges for food included in it); medicines (including drips); materials for bandage, plaster, etc.; fees for the services of medical and paramedical personnel charges; for diagnostic tests, operations and therapies; charges of ambulance; costs of oxygen, blood; etc.

All other types of expenditure incurred for treatment, such as lodging charges of escort, attendant charges, cost of transport other than ambulance, and cost of personal medical appliances, are excluded from medical expenditure in NSSO methodology but are recorded in separate categories. *For this study, every cost that was incurred because of the ailment was recorded and mentioned in different categories.*

h) Reference period: The enquiry on morbidity was conducted with a reference period of 15 days. All spells of ailment suffered by each member of the sample household during the 15 days preceding the date of enquiry, whether or not the patient was hospitalised for treatment, were covered in the survey. For hospitalised treatment, however, information was collected for every event of hospitalisation of a member, whether living or deceased at the time of survey, during the 365 days preceding the date of enquiry. *Further, for the purposes of this study, for maternal and child health services, enquiry was conducted with a reference period of 3 years.*

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CHAPTER 3: SOCIO-ECONOMIC PROFILE OF KUPWARA DISTRICT AND NEELIGAM VILLAGE

3.1: Socio-Economic and Health Profile of Kupwara District:

Kupwara is one of the oldest districts of J&K, located to the extreme north of Kashmir, bordering Pakistan occupied Kashmir on one side, and known popularly as '*The Crown of Kashmir'*, for its position at the top of the map. It is one of the most beautiful areas in Kashmir, however, many of its beautiful valleys, meadows, pastures, landscapes, dense forests, rich wild life, etc. that make it significant for tourism, are not explored yet and there is hardly any tourism seen. As a border district, Kupwara has seen widespread presence of Indian security forces throughout the district, from mainland to hills, meadows, pastures and roads. The similar reasons have led to Kupwara always been in news for the violence, encounters, firings, infiltration, killings, torture and harassment of people and women by security forces. Due to the distance from Srinagar (90 kms), many of the serious conflict related events and people's sufferings don't come in news, and as a result, people in Kupwara over the time have internalised many of the sufferings they lived with through more than two decades of conflict. Besides, the people of this district have suffered through painful experiences of unnatural division of this district along the temporary L.O.C (line of control). The District Administration narrates that there are numerous examples whereby the LOC separates brothers from sisters, sons from mothers, wives from husbands and other kith and kin (District Administration Kupwara, n.d). This researcher had visited and travelled through Karnah tehsil and has witnessed few villages divided into two politically different villages along the L.O.C, one portion under the control of India and another portion under Pakistan.

Further, this researcher had visited Kupwara district for first time, six years ago, and found it not less than an Army camp, heavily occupied by Army (interchangeably used with India security forces) through all sides, and the presence of Army was so visible that after each mile or so, one would encounter Army in Kupwara. Many of the roads were blocked by Army and all passengers travelling through these occupied roads would have to parade through the road and show identity cards to Army, and there was no alternative to this. Even in other parts of Kashmir, which have been witnessing conflict through the same time, many people were scared of visiting Kupwara district. During the fieldwork for this study

in 2012, the researcher has felt that over the last six years, the political conditions have improved tremendously in Kupwara, as in rest of Kashmir.

However, not many people know that the district is one of the poor and backward districts of Kashmir. People in Kupwara suffer not only for conflict reasons but also for their access to basic needs of life including food, water, education, health services, etc. Kupwara is also a hilly district, at an average height of 5300 feet from sea level (District Administration Kupwara, n.d). As a result, many of its areas are cut off from the district headquarter for a significant part of year. The areas like Machil, Keran and Karnah (one of three tehsils of Kupwara) remain land locked (snow bound) for more than six months in a year. Besides, there are some other smaller areas like Kumkadi, Lashdat, Jumgund, Kethanwali and Budnambal, which remain cut off from District Headquarter for a considerable time (District Administration Kupwara, n.d). Therefore, many of the basic services are inaccessible to people living in these cut-off and landlocked areas. The following paras describe the socio-economic, demographic and other development related aspects of the district:

3.1.1. Social and Demographic Indicators:

Kupwara[18] as a district was carved out of Baramulla district (then Baramulla included present Baramulla, Bandipora and Kupwara districts) in 1979[19]. The district consists of three tehsils including Kupwara, Handwara and Karnah; eleven community blocks and nine medical blocks (District Administration Kupwara, n.d). The district has 13 education zones, 356 panchayats and 369 villages (District Administration Kupwara, 2009).

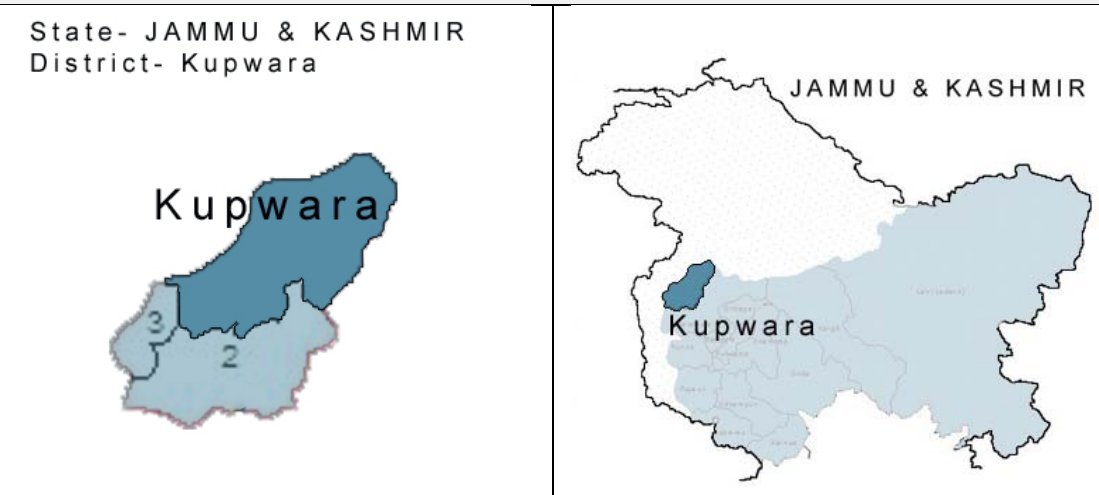
[18] There are some narratives about why this district is called as Kupwara, although, there seems to be no written documents about this. The District Administration puts it as, "It is said there was a hut, constructed by somebody in the nearby jungle. It was known as Kopar (hut in shambles) because accidents often took place there .Sometimes the animals rolled down and sometimes these were killed by the wild beasts. The habitation was named after the same Kopar. Some elders say that the famous saint, Zaiti Shah Wali called the habitation Ko-pore (people of bad reputation) because the children of this habitation used to throw stones on him when he passed through it. Others say the famous Saint Syed Mohammad Gabi, whose tomb is in the heart of Kupwara, called it Kuferwari (the place of non-believers). Later on he converted the people to Islam by his preachings, thus Kupwara is the modified and changed name of Ko-por or Kuferwari. However , it is mostly believed that there was a hut on the hill, in front of presently existing Higher Secondary School Kupwara known as koh-nar or the hut constructed in the jungle. The same hut has given it the name Kopore" (District Administration Kupwara, n.d).

[19] During its creation, Kupwara town was chosen as its district headquarter, for political reasons although a major part of district, which left Kupwara district divided into two politically demarcated areas – Handwara and Kupwara.

The total population of the district is 8,75,564 (RGI, 2011), which includes 0.01 percent of Scheduled caste population and 7.96 percent of Scheduled tribe population; with only 3.9 percent people living in urban areas (J&K has 25 percent population living in urban areas) (RGI, 2001b).

Among the three tehsils, Karnah is mostly inhabited by Gujjars and Paharis, while Handwara and Kupwara tehsils are predominantly inhabited by Kashmiris but many of the villages have mixed population of Kashmiris and STs, with STs localised in separate hamlets in most of the villages. Kupwara is more populous with a total population of 3,95,159, followed by Handwara with a total population of 2,12,463 and Karnah with 42,771 population. Among the eleven community blocks of this district, Kupwara block has the highest population of 1.22 Lakh, and the Rajwar block in Handwara tehsil, in which this study was undertaken, had a total of 0.69 lakh population (RGI, 2001 cited in District Administration Kupwara, 2008-09). The district is majorly inhabited by Muslims, with just two percent of Hindu population and 0.7 percent of other religions (RGI, 2001b). In terms of population, the district has fourth highest population in Kashmir, and fifth in J&K, after Jammu, Srinagar, Anantnag and Baramulla (RGI, 2011). The density of population was very high in Kupwara district of about 273 per square km, while it was only 100 in J&K, in 2001. The district accounts for 2 percent of the total area of J&K, and for 5 percent of total population (District Administration Kupwara, 2009).

Figure 3.1: Map of Kupwara District



Note -- 3 in the map denotes Karnah tehsil and 2 denoted Handwara tehsil

Note -- The highlighted area shows the Location of Kupwara district in J&K.

Source: RGI, 2001c

The decadal population growth in Kupwara is about 38.6 percent, much higher than the 28.3 percent in Kashmir and 29.4 percent in J&K (IIPS, 2010). The sex ratio of Kupwara is 843 in 2011, and has declined from 906 in 2001, as against 883 in 2011 for J&K which has declined from 892 in 2001 (RGI, 2011). This shows that the district Kupwara has seen much higher rate of declining sex ratio as compared to state. The child marriage rates of girls are higher in Kupwara at 9.3 percent, against 7.2 percent for J&K (IIPS, 2010). *The socio-demographic features of other districts of J&K can be referred in Appendix –B.*

3.1.2. Economic conditions of Kupwara:

As mentioned earlier, Kupwara is one of the backward and poor districts of Kashmir, and of J&K, with an average per capita income of 16360, against 23125 in Kashmir (including Ladakh) and 24398 in J&K (Govt. of J&K, 2008-09). Almost 31.82 percent of population is living below the poverty line (as per state poverty survey), against 21.37 percent in Kashmir and 21.63 percent in J&K (Govt. of J&K, 2008). *The economic features of other districts of J&K can be referred in Appendix –B.*

As a result of significantly high proportion of people living under poverty line in Kupwara as compared to Kashmir, and state, the human development indicators show a similar trend of Kupwara lagging behind on many indicators, as compared to Kashmir and J&K. The literacy rate in Kupwara have always been low as compared to Kashmir, and was about 43 percent (29 % for females) in Kupwara and about 48 in Kashmir (36 % for female) and 55.5 in J&K (43% for females), in 2001 (RGI, 2001b). However, in 2011, the Census results revealed much better performance for Kupwara, as the literacy rate of Kupwara stands at 66.9 percent and 68.7 percent for J&K (54.7 for women in Kupwara and 58.01 percent for J&K), which is not a major difference now (RGI, 2011). Table 3.1 summarises some of the socio-economic characteristics of Kupwara district, in comparison to Kashmir region and J&K as a whole.

Table 3.1 : Socio-Economic and Demographic Indicators of Kupwara District								
District/ Region	***Total Population***	***Population in Percent***	***People living in Urban Areas (%)***	***Scheduled caste Population (%)***	***ST Population (%)***	***Per Capita GDDI***	***Poverty Ratio***	***Literacy (%)***
1	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***
Kupwar	650393	6.41	3.9	0.01	7.96	16360	31.82	43.24
*Kashmir Region**	5476970	53.99	26.9	0.05	5.81	23125 *	21.37	48
J&K	1014370	100.00	24.8	7.6	10.90	24398	21.63	55.5
*Note -- *The data was not available for Kashmir region, and the value shown in this table is for Kashmir division which includes Leh and Kargil districts as well, and the actual value for Kashmir region would be little more than 23125, because the per capital income for Leh and Kargil together are the least in Kashmir division. ** Calculations based on data from RGI, 2001b; Govt. of J&K, 2009 and Govt. of J&K, 2008*								
Source: RGI, 2001b for columns 2 to 6, & 9; Govt. of J&K, 2009 for column 7; Govt. of J&K, 2008 for column 8								

The total area of the district is 2379 square kms, with forests spread across almost 1703 square kms, about 72 percent of its area. The district is rich in minerals, especially marble and lignite, however, due to the unfavourable political conditions in the district, such minerals are mostly unexplored and have not been able to create livelihood for people in the district.

The dense and widespread forest area in the district leaves a smaller portion of land available for agriculture. The total reporting area in the district is only 0.67 lakh hectares and out of which the net sown area in the district is only about 0.49 lac hectares (District Administration Kupwara, 2009). The main agricultural crops are paddy, maize, vegetables and pulses. A total of 17411 hectares (28% of net sown area) are under cultivation of paddy, 26643 hectares (almost 54 percent) under maize, 4704 hectares (19 %) under pulses and vegetables (District Administration, 2009). A larger portion of land is under maize for the reason that a major share of sown area is rain fed and depends heavily on rainfall. The cultivated land is mostly single cropped land as the area sown more than once does not exceed more than a percent of total sown area (District Administration Kupwara, 2009).

Other than agriculture, horticulture occupies a significant portion of land in the district. As the district is hilly, it is suitable for fruit cultivation, and almost 60000 hectares of land are under orchards (mostly apple) in the district (almost 4 times more than paddy). Kupwara is

one of the main districts for walnut production, and produces almost 5110 metric tons of walnut each year (District Administration Kupwara, 2001-02). Apple accounts for almost 80 percent of total fruit produced in the district, and walnut, almond, peer and apricot account for almost 20 percent of total fruit produced (District Administration Kupwara, 2009).

Due to widespread presence of pastures, there is a huge potential for rearing of animals and sheep, and many people are engaged in such activities. However, as a result of security forces occupying most of its highland pastures through the district, the access to these pastures and forests has drastically reduced. The district accounts for more than 5% of the state's total livestock population (District Administration Kupwara, 2009).

The landholdings are very small in the district, with an average land holding size of about 0.44 hectares, against of 0.83 hectares of the state, with almost 96 percent of landholdings are less than 2 hectares (District Administration Kupwara, 2009).

The district's main work force is 1.23 lakh persons, i.e. almost 18.9% of the total population of the district. This includes 0.49 lakh cultivators and 0.13 lakh agricultural labourers (District Administration Kupwara, 2009).

There are some of the small-scale industrial units in the district of about 83 in number, like, food, textile, wood, etc, but they only provide employment to a small number of people of workers, about 255 persons (District Administration Kupwara, 2009). There is also some handicraft and sericulture work being done in the district, but not at par with other districts of Kashmir.

3.1.3. Health Outcomes and Public Health Services:

The prevalence of tuberculosis was much higher in Kupwara at 869 against a minimal of 234 in J&K (prevalence is per 1 lakh population). However, prevalence of malaria was much lower in Kupwara at 19 against 108 in J&K. Nevertheless, the prevalence of blindness is much higher in Kupwara. For instance, the prevalence of complete and partial blindness in Kupwara was 43 and 1664 per lakh population respectively, as against 248 and 799 respectively in J&K. Similarly, the percentage of children who suffered from diarrhoea were 16.5 percent in Kupwara, while it was almost similar in Kashmir (15.6%) and lower

(12.3 %) for J&K. The percentage of children who suffered from ARI were 33.4 percent in Kupwara, while it was much lower of only 17.6 percent in Kashmir and 11.7 percent in J&K (IIPS, 2010).

The Kupwara District has a network of health services: one District Hospital located in Handwara, 7 Sub-District Hospitals (CHCs), 1 T.B. Center, 2 Leprosy Units, 29 P.H.Cs, 2 Subsidiary Health Centers, 24 Allopathic/Ayurvedic Dispensaries, 154 Family Welfare Centers, 46 Medical Aid Centers and 1 District Mobile Ophthalmic unit, which gives a total bed strength to the District of about 306. The total doctors and paramedical staff availability is 135 and 464 respectively (District Administration Kupwara, 2009). This comes on to an average of one health institution for population of 3279.3**,** one doctor for population of 6485.7, one paramedical staff for population of 1887 and one bed for population of 2861.3, as can be seen from the *Table 3.2*

Table 3.2: Average Population covered by Health Institutions in Kupwara District

Health Institutions	***Number***	***Av. Pop. Covered***
District Hospital	1	875564
SDH/CHC	7	125080.6
PHC	29	30191.9
T.B. Center	1	875564
Leprosy Unit	2	437782
Subsidiary Health Center	2	437782
Allopathic/Ayurvedic Dispensaries	24	36481.8
Family Welfare Clinic	154	5685.5
Medical Aid Center	46	19034
District Mobile Ophthalmic Unit	1	875564
Total Health Institutions	267	3279.3
Doctors	135	6485.7
Paramedical Staff	464	1887.0
Total Bed Strength	306	2861.3

Source: District Administration Kupwara, 2009

The DLHS-3 data shows a little poor availability of health facilities in Kupwara district as compared to Kashmir but almost a similar picture as in J&K as a whole. The percentage of villages with a sub-centre was 43.8, against 46.3 percent in Kashmir and 47.6 percent in J&K. Similarly, the percentage of villages with a PHC was 20.8 percent, against 16.8 percent in Kashmir and 12.4 percent in J&K. The percentage of villages with a doctor was 8.3 %, against 9.8 % in Kashmir and 6.5 % in J&K. Similar picture is reflected with the availability of grassroots workers. The percentage of villages

with ASHA and AWWs in Kupwara was 66.7 percent and 95.8 percent, against 74.6 and 97.0 percent in Kashmir and 72.9 percent and 93.7 percent in J&K respectively. The constitution of VHSCs in Kupwara has been more than the state on an average, with 10.4 percent of villages having VHSC, as against of 10.9 percent in Kashmir and 7.3 percent in J&K. The DLHS-3 data also shows that in general, Kupwara has more availability of any government facilities. For instance, the percentage of villages with any government facility in Kupwara was 66.7%, against 60.4% in Kashmir and 62.2% in J&K, as can be seen in table 3.3.

Table 3.3 : Availability of Health facilities* in Kupwara District

District/ Regions	***Sub-centre***	***PHCs***	***Any Government Facility****	***Doctor***	***ASHA***	***AWW***	***JSY Beneficiary***	***VHSC***
Kupwara	43.8	20.8	66.7	8.3	66.7	95.8	31.3	10.4
Kashmir Region(1)	46.3	16.8	60.4	9.8	74.6	97.0	27.3	10.9
J&K	47.6	12.4	62.2	6.5	72.9	93.7	28.5	7.3

*Notes--*Facilities as reported by village pradhan/any other panchayat member/teacher/gram sevak/aganwadi worker; ** Includes Sub-Centre, Primary Health Centre (including Block PHC), Community Health Centre or referral hospital, government hospital, and government dispensary within the village.*

***(1)** Calculations based on data from DLHS-3, 2007-08*

Source: IIPS, 2010

This is despite the fact that villages, in general, are bigger in size in Kupwara than Kashmir region and J&K as a state. Therefore, a higher proportion of villages should have reported availability of health facilities at village level in Kupwara than in Kashmir region as well in J&K collectively. The proportion of smaller villages (less than 500 persons) is only 23.2 in Kupwara, as against 25.1 % in Kashmir and 33.9 % in J&K. Further, the proportion of bigger villages (1000 to 4999 persons) is 46.13 % in Kupwara, as against 45 % in Kashmir and 37.9 % in J&K (RGI, 2001b).

Further, the access of people to maternal and child health services in Kupwara reflects a lower performance as compared to Kashmir or J&K, as can be seen from the *Table 3.4*. The percentage of women in the age group of 15 to 49 who received any ANC during pregnancy were 81 percent and the percentage of women in this group who received full ANC were 33.8 percent in Kupwara, against 90.9 and 35.5 percent respectively in Kashmir

and 84.3 percent and 29.1 percent respectively in J&K. The percentage of women who received ANC services from government facilities were lesser in Kupwara (72.2%) than Kashmir (73.5%) and J&K (79.2), and a much higher percentage of 33.9 percent received ANC from private facilities in Kupwara, against 31 percent in Kashmir and 22.7 percent in J&K (IIPS, 2010).

The private health facilities available in Kupwara are mostly small private clinics attended by a doctor(s) (mostly working with government but run private clinics in the mornings, evenings and on holidays). Besides, there are few clinics, which conduct deliveries as well.

The percentage of women who gave birth in institutions is relatively more for Kupwara than J&K but lesser than Kashmir, as 56 percent had reported that they had institutional delivery in Kupwara as against 54.9 percent in state and 69 percent in Kashmir region. Further, with child health services, a lesser percentage of children have received vaccination in Kupwara as compared to Kashmir and J&K. For instance, there were only 54 percent of children, in the age of 12 to 35 months, who have received full vaccination in Kupwara, against a higher percentage of 65 percent in Kashmir and 62 percent for J&K. Similarly, there were 7.3 percent of children who had not received any dose of vaccination in Kupwara, against 2.4 percent in Kashmir and 4.6 percent in state (IIPS, 2010).

The percentage of children who could seek treatment for diarrhoea was only 54.2 percent in Kupwara, while as it was 72 percent in Kashmir and 68.7 percent in J&K. For ARI, the percentage of children who could seek treatment was also lesser in Kupwara (84 percent) than Kashmir (86.7 percent) and J&K (84.1 percent) (IIPS, 2010). Table 3.4 summarises the access to maternity and child health services in Kupwara in comparison to Kashmir region and state as a whole.

Table 3.4: Access to Antenatal Care in Kupwara District							
Districts/ Regions	***Any ANC***	***Full ANC***	***Full Vaccination***	***None Vaccination***	***Institutional Delivery***	***Children Sought Treatment***	***Children Treated for ARI***
Kupwara	81	33.8	54	7.3	56	54.2	84
Kashmir Region*	90.9	35.5	65.0	2.4	69.0	72.0	86.7
J&K	84.3	29.1	62.2	4.6	54.9	68.7	84.1
** Calculations based on data from DLHS-3, 2007-08*							
Source: IIPS, 2010							

On an average, there is one sub-centre for a population of 3211 in Kupwara, while as it is 4334 for Kashmir[20] and 3499 for J&K. Similarly, there is one PHC and CHC for a population of 19,474 and 76,852 respectively in Kupwara; while, as the counter figures for Kashmir are 32,903 and 94,838, and for J&K are 25802 and 89659. The better coverage of government health facilities in Kupwara may also be because of the fact that an average population density is very high in Kupwara district of about 273 per square km, while as it was only 100 in J&K, in 2001. Further, as explained earlier, that the village in general are bigger in size in Kupwara than Kashmir region and J&K (IIPS, 2010).

The lesser access to maternal and child health services in Kupwara can be for other reasons than just not better availability of health services, as '*access' is not just a function of availability of health institutions, but is determined by an interplay of other factors such as social, cultural, economic, geographical and quality of services.* Kupwara is one of the poor and backward districts in Kashmir and state, and therefore, the affordability of people to seek health care in Kupwara may not be at par with other economically better districts of state, therefore, it affects the access of people to health services in Kupwara. Similarly, the relatively more difficult terrain geography of Kupwara district than other districts of Kashmir, and many of its areas are land locked (snow locked in winters) for a significant portion of year, would heavily affect the access of some sections of people to health services, especially those who are localised to mountainous hamlets of villages. The wide presence of security forces (due to which people are fearful to move) in Kupwara than other

[20] The average coverage of a sub-centre in Baramulla has been reported to be 42650, which seems to be a data error, and the value has been assumed to be around 4265 for this table, otherwise if considered the original value of Baramulla, the average population coverage by Sub-centre will be 8259 in Kashmir and 6011 in J&K.

districts may also limit the access of people to health services. Thirdly, the availability of medical staff seems to be comparatively lesser in Kupwara than in Kashmir and J&K, which would be affecting the quality and outreach of services very negatively. For instance, the percentage of villages with ASHA in Kupwara is lesser than in Kashmir region (66.7 % in Kupwara and 74.6 % in Kashmir). Further, the percentage of villages having sub-centre is 43.8 percent in Kupwara, while as the counter figures are 46.3 percent in Kashmir and 47.6 percent in J&K. The percentage of sub-centres with ANM/FHW available is 42.9 percent in Kupwara, while as it is 55.1 percent in Kashmir and 68.8 percent in J&K. The less availability of sub-centres, ASHA and ANMs in Kupwara than Kashmir region and J&K may be the reason for relatively poor performance of Kupwara than Kashmir and J&K.

Further, out of the 19 PHCs in Kupwara there were only 10 (52.6 percent) PHCs with medical officer, 5 (26.23 percent) PHCs with lady medical officer, one (5.3 percent) PHC with AYUSH medical officer and 17 (89.5 percent) PHCs with pharmacist in Kupwara district. While as out of 222 PHCs in J&K there are 115 (51.8 percent) PHCs with medical officer, 87 (39.2 percent) PHCs with lady medical officer, 76 (34.2 percent) PHC with AYUSH medical officer and 211 (95.0 percent) PHCs with pharmacist[21]. The CHCs in Kupwara show a much worse situation as compared to state in terms of availability of specialists. Out of five CHCs in Kupwara, only 1 had a Gynaecologist, 2 had Anaesthetists but none had a Paediatrician or a Health Manager, while as in the state overall out of 73 CHCs, 33 had Gynaecologists, 14 had Paediatricians, 40 had Anaesthetists and 7 had Health Managers (IIPS, 2010).

The availability of special health facilities in CHCs in Kupwara also shows a dismal picture. Out of 5 CHCs in Kupwara, 2 had an operation theatre (43 out of 73 CHCs in J&K), all the five are designated First Referral Units (52 out of 73 CHCs in J&K); four had new born care services (35 out of 73 CHCs in J&K); three had facilities to manage low birth weight babies (24 out of 73 CHCs in J&K); but not a single one had blood storage facility (8 out of 73 CHCs in J&K). However, it is important to raise the issue that in absence of specialists like Gynaecologists, Paediatricians and Anaesthetist, many of such special health facilities cannot be helpful to people (DLHS-3, 2007-08).

[21] Similarly, there were only 54.24 percent of PHCs with Medical officer 41.53 of percent of PHCs with lady Medical officer, 23.73 percent of PHC with AYUSH Medical officer and 94.92 percent of PHCs with pharmacist in Kashmir (IIPS, 2010).

3.1.4. Access to other Basic Amenities:

For other public health services, the data shows a mixed picture (see table 3.5). There are almost 92.3 percent houses electrified, against 93.4 percent in Kashmir and 91.4 percent in J&K (IIPS, 2010), however, as per government records there are almost 99 percent of villages electrified (District Administration Kupwara, 2009). There are only 12.4 percent households using LPG for cooking, against 25.3 in Kashmir and 22.8 percent in J&K. The DLHS-3 had revealed that only 64.5 percent households had access to drinking water, against 78.9 percent in Kashmir and 75.1 percent in J&K (IIPS, 2010). However, the district administration of Kupwara notes that almost 98 percent of the villages in the district have access to potable drinking water (District Administration Kupwara, 2009). Further, the DLHS-3 reveals that 39.6 percent households have Pakka houses[22], against 43.5 percent in J&K; and 93.7 percent have toilet facility, against 91.4 percent in Kashmir and 60.2 in J&K. The proportion of households who had BPL card were 66.7 percent, against 44.43 percent in Kashmir and 38.4 percent in J&K (IIPS, 2010). This shows that the distribution of BPL cards in the district is almost two times more than the BPL ratio of the district as revealed by a BPL survey of the state, which categorised only 31.82 percent of population as living under poverty line in Kupwara.

Table 3.5 : Access to Basic Amenities in Kupwara, Kashmir and J&K

District/ Region	*Electricity*	*Drinking Water (1)*	*LPG*	*Toilet Facility (2)*	*Pakka House*	*BPL Card*	*Sample Households*
Kupwara	92.3	64.5	12.4	93.7	39.6	66.7	1297
*Kashmir Region**	93.4	78.9	25.3	91.4	49.6	44.43	9783
J&K	91.4	75.1	22.8	60.2	43.5	38.4	17858

Notes--1: Includes piped water, public tap/sand pipe, hand pump, tube well/bore well;

2: improved source of sanitation, or flush not to sewer/septic/pit/twin pit, or pit without slab or dry toilet.

** Calculation based on data from DLHS-3, 2007-08.*

Source: IIPS, 2010

[22] This seem to be underestimated in the context that many of villages, this author had travelled in Rajwar block, had a significant proportion of houses constructed of wood exclusively (as revealed in the village study also), and they should have been considered a Pakka houses, which may increase the proportion of Pakka houses in the district significantly than what is revealed by DLHS-3 survey (2007-08).

3.1.5. Political Factors affecting Public Health Services:

Other than on the *'access to health services'* political factors affect the spatial arrangements of health services in the district and in the state. This is true of Kupwara district as well. During its creation, Kupwara town was chosen as its district-headquarter rather than Handwara, which was a major and very popular town and the old tehsil headquarter as well. Going by popularity and administrative functions by then, Handwara should have been chosen as a district-headquarter. The present popular Sopore and Baramulla towns were part of Handwara tehsil (then called as Uttar Machipora). However, as narrated by many local people in Handwara area, the then MLA from Handwara, Mr Gani Lone, who was married in Handwara, did his college from Handwara and even was contesting from Handwara constituency but actually belonged to Kupwara, was the main person who influenced the decision of choosing Kupwara as the district headquarter. He belonged to a different party than the then ruling National Conference (NC) party, but was very influential and a strong opponent for National Conference from North Kashmir (was earlier Minister as well before NC came in power). His decision of choosing Kupwara seemed to be very logical and wise for Kupwara tehsil is very huge in its area and even at present includes population almost two times as compared to Handwara tehsil. However, the decision has had significant implications on the intra-district politics between Handwara and Kupwara. Handwara, even just as a tehsil, retains huge power and influence on the development pattern of the district. The vote bank in Handwara is dependent on the development of Handwara as against Kupwara. After the district was created the National Conference won the constituency seat of Handwara, a benefit of the anger among people towards the then MLA who led the creation of Kupwara as district head quarter, and retained the assembly seat consistently until now, except in the last election they lost the seat to People's Democratic Party (PDP). One of the reasons for the PDP losing elections in the recent elections has been that people felt that Handwara has not developed at par with Kupwara in their tenure. The NC MLA's consistent success in Handwara has been for the reasons primarily that he stands and has ensured that many of the public facilities are established in Handwara. For illustration, the district hospital is located in Handwara. There is an extra Additional Deputy Commissioner in Kupwara district who sits in Handwara (Kupwara is only district in Kashmir who has two Additional Deputy Commissioners, one for District headquarter and another for Handwara). The district Police Line is located in Handwara. The Chief Judicial Magistrate sits in Handwara. The Chief Medical Officer is located in Kupwara but the Chief Medical Superintendent sits in Handwara. This was also

observed by the Third Common Review Mission, which states that, "*Location of facilities is not properly planned and rational. District hospital in Kupwara is not located at the district headquarters but in Handwara block. A number of health facilities are clustered within a limited geographical area close to Handwara DH*[23]*"* [emphasis added] (NRHM, n.d, p. 8).

The influence of political factors seems to be obvious in development planning and in location of many public health services in Kupwara district. However, as the household study was done in Rajwar block, part of Handwara tehsil, the accessibility to health services seems to have been much better than it would be in Kupwara tehsil. As mentioned earlier, that there are many areas, which remain land locked (snow bound in winters), are part of Kupwara tehsil, and the population of Kupwara tehsil is almost double than Handwara tehsil (395159 in Kupwara and 212463 in Handwara), therefore, from epidemiological point of view the public health services should have been more in areas of Kupwara than around Handwara. However, the data shows that the availability of health facilities is skewed towards Handwara tehsil.

Table 3.6 shows the disparities across the three tehsils in Kupwara district on many indicators. For Tanghdar tehsil it would not be feasible to make comparisons with either of other two tehsils because Tandhdar is a completely hilly area and remains cut off for almost six months from the district. However, other two tehsils can be compared and the comparisons shows there are disparities in availability of health facilities between the other two tehsils of district – Handwara and Kupwara. For instance, the average population covered by each CHC at district level is 99914. However, the average population coverage by each CHC in Kupwara tehsil is 121583.3, while as the average population coverage by each CHC in Handwara tehsil is 70572.8.

The average population covered by each PHC at district level is 19427.8 but the average population coverage by each PHC in Handwara (17643.2) is much less than average population covered by a PHC in Kupwara (19197.4). However, the data shows that the medical officers are relatively more in Kupwara tehsil (52) than in Handwara (30), which seemed to be for the reason that the information for Handwara medical block (district is divided into nine medical blocks and three tehsils) is not available (*which has a one district*

[23] SDH Langate is at 4 kms, PHC Chowgal is at 5 kms, PHC Natnosa is at 5 kms, PHC Vadipora is at 4 kms (NRHM, n.d) and SDH, Zachaldara is at 7 kms from District Hospital Handwara (field observations).

hospital, four PHCs and two MTP centres). If that were accounted in, the medical officers would certainly be more for Handwara tehsil.

Out of the four MTP centers, two are in Handwara tehhsil and only one in Kupwara tehsil. Further, the average population covered by each sub-centre in the district is 3268.2. While in Kupwara the average population covered by sub-center is 3507.2, the figures for Handwara tehsil are 3282.5.

However, what seem to be better available in Kupwara tehsil than Handwara are ICDS centres, AYUSH dispensaries and ANMs in position, as can be seen in *Table 3.6.*

Therefore, the data shows that Handwara has relatively more availability of health facilities than Kupwara, even if Kupwara included some of the land locked (snow bound in winters) areas like Machil and Keran, and has more hilly terrain than Handwara tehsil.

Table 3.6: Availability of Health Facilities across different Tehsils in Kupwara District									
S. No	***Indicators***	***Kupwara***	***Average Population Covered****	***Handwara***	***Average Population Covered****	***Tanghdar***	***Average Population Covered****	***District in total***	***Average Population Covered****
1	Population	364750		282291		52360		699401	
2	CHCs ***	3	121583.3	4	70572.8	1	52360	7	99914.4
3	PHCs	19	19197.4	16	17643.2	1	52360	36	19427.8
4	Mos	52	7014.4	30**	9409.7	7	7480	79	8853.2
5	MTP Centres	1	364750.0	2	141145.5	1	52360	4	174850.3
6	Sub Health Centres	104	3507.2	86	3282.5	24	2181.6	214	3268.2
7	No. of AYUSH Dispensaries	7	52107.1	2	141145.5	4	315.4	13	53800.1
8	No. of Anganwari Centres	786	464.1	284	994.0	166	52360	1236	565.9
9	No. of ANMs in Position	102	3576.0	64	4410.8	7	13090	173	4042.8
10	Workforce Vacancy	189		150				10	

*Notes --***Handwara includes District Hospital as well*

** *The data is not available for Handwara medical block, which has a one district hospital, four PHCs and two MTP centres.*

**Calculations based on data from District Health Action Plan of Kupwara (District Administration, Kupwara, 2007)*

Source: District Administration Kupwara, 2007

3.2. Socio-Economic Profile of Neeligam Village:

Neeligam village has a hilly topography with one hamlet, Neeligam Nagni, inhabited by Gujjar population, completely cut off from road and located at a 40 minutes walking distance from the main village. People have settled in this village a few centuries ago. However, the settlement pattern was distinct for its caste stratification. Hamlets are called with the caste names as Ganaie Mohalla, Khan Mohalla, Bhat Mohalla, etc. (Mohalla is hamlet, and Ganaie, Khan and Bhat are the castes). Neeligam was constituted of 146 households and the total population of the village was 875 with 466 males and 409 females including 412 children[24]. However, the village level study, conducted as part of the dissertation, recorded only 131 households for the boundaries were not clearly demarcated between the two neighbouring villages, with ten castes- Ganaie, Wani, Khan, War, Geelani, Reshi, Baba, Mir, Bhat and Gujjars (further divided into three castes). Out of 131 households recorded in this study, the majority were Khan in number with 52 households and the Gujjars were second with their total of 22 households. The other castes were small in numbers -- Ganaie with 14, Bhat with 13, Reshi with 8, Geelani with 6, Baba with 6,War with 5, Wani with 4 and Mir with just 1 household. All were Muslims.

Neeligam is part of Rajwar community development (CD) block and falls in Zachaldara medical block and is located at a distance of almost 12 kms away from Handwara, a tehsil and nearest town. However, the 12 km distance on many occasions turns out to be a large distance, due to various political and geographical reasons, that is difficult to cover for reaching Handwara. Rajwar block (overlaps with Medical block, Zachaldara)[25], a border area, is close to forest range (some villages are in forest only) and has seen huge presence of Indian security forces across the block. The widespread presence of security forces has had significant impact on mobility of the people, their socio-economic conditions, access to means of livelihood, and access to services. The wide presence of Army can be understood by the fact that there are presently 12 Army camps, in addition to two police posts in Rajwar Education Zone[26], while the zone has only 16 panchayats, which meant that on an average there is almost one security forces camp for each panchayat. This was excluding the eight Army camps, which have been removed from the area in the last few years, one

[24] The figures are based on the mapping of the village that was conducted as part of the village study.
[25] The Kupwara district is divided into 11 blocks and 9 medical blocks. Although a major portion of community blocks and medcial blocks overlaps, but in some cases like Zachaldara medical block, the area under community block extends beyond the catchment area of Zachaldara medical block.
[26] There is some overlapping between the block and zone, but on an average the block is bigger in size than education zone (block is community block and zone is planning and administrative unit for education).

with huge protests from people after the killing of four youth in a play field, which has brought some relief to people.

The presence of security forces has reduced in the area with eight security force camps being displaced from the area and the conflict situation has seen some improvements over the years as in rest of Kashmir. However, the presence of other 12 security forces camps (plus two police posts) in the area makes a case to understand how it would have affected the accessibility of people to livelihood and other services including health services. There are two Army camps on the way from Handwara town to Neeligam village; one is located just after Handwara and another about midway at Zachaldara village. One gets a feel that one is passing through an Army camp while passing on the road, with all their antennas on a person passing by. The first camp is known as Rajwar Tigers Army Camp, and is meant to screen and check each activity happening in the Rajwar area. Therefore, they have put two gates on the main road, one at starting and another at end of this camp. The gate is not less than an old cruel and imperialist King's gate, which cannot be crossed until one is summoned by, or belongs to King's Army/administration. The gate was closed around 6.00 to 7.00 pm, which ultimately cuts off most part of Rajwar block (and the entire Zachaldara medical block) from the tehsil and district headquarters. People in the Rajwar area spoke of the political situation improving and earlier they would have to de-board the vehicles and parade through the road until the Army camp ends and then allowed to board the vehicle again. Almost each vehicle would be searched and each person would have to show their identity card each time they pass by, otherwise they were likely to be imprisoned inside the camp and asked as many questions as Army would like to and even interrogated some times. After the gate was closed not a single vehicle even if a serious patient is being carried to the district hospital Handwara, is allowed to pass through the road. So, in this portion of Rajwar block either the illness had to come to a person during the day time or he/she should be lucky enough to survive the pain through the night. Unfortunately, neither illnesses come with Army's approval nor all the people are lucky to survive the pain of illness during the 12 hours of the dark night. This explains why it is being often said that in Kashmir night turns life dead. People also spoke of other areas in this district, which are cut off from the district headquarter by blocking the roads from evening through night. The researcher's personal experience is of Lolab Valley (one of the constituencies of Kupwara district). The Army had put a huge gate at its entry and displayed timings of opening of gate from morning 6 am to 7 pm. This researcher's first impression of Kupwara district

during his first visit in 2005 was of a place, which was not less than an Army camp, with Army heavily occupied its roads and landscapes from all corners. This researcher, although belongs to South Kashmir and has experienced the conflict situation in Kashmir during his 23 years of life in Kashmir, was even horrified when he first visited Kupwara as an intern, with the wide presence of Army in the district and almost each road he passed by was occupied by Army. Not only the blocking of the roads affects directly the access to health care but has its huge impact on the means and access to livelihood and mobility of people especially women. This researcher has spent many days travelling through the villages of Rajwar block and was told in almost each village he visited that they heavily depend on Handwara town for their work as casual labourers and market purposes.

In Zachaldara village, the Army camp had occupied a Government Higher secondary school, part of it was vacated a few years back. However, major part is still under army occupation. So, there is a Higher Secondary School, with students taking education in one side and Army on other side of premises. This not only puts the lives of so many children in threat by sharing the premises with Army, it has had a huge impact on the education of girls coming to that higher secondary school, which was among the only two secondary schools available in Rajwar education zone. Some of the passengers travelling together in a local vehicle told this researcher that some Army personnel would intentionally come out of their Army camp and would stand on the roadside at the time when girls move out of school to their homes.

On the other hand, there are other camps lying in the forest, which has largely limited the access of people of not only Neeligam but most villages of Rajwar to forests, once a major source of their livelihood. This researcher's own experience of travelling to Waderballa village demonstrated the controlled access of people to forest area. Firstly, the vehicles are not allowed to go to the village and are stopped at 1 km before the village. All those wanting to enter the village are required to prove their identity, which is noted by the officials and while returning they have to show their face to Army.

Besides the political reasons, the geography of Neeligam and many other villages of Rajwar have also limited the access of people to livelihood, health care and market. In the people's perception, the Rajwar block is divided into two belts –lower belt, which is little plain area, and another is upper belt, which is hilly and many areas especially hamlets

inhabited by Gujjars are still not connected by roads. The roads connecting many villages are not all weather roads, and once they get drenched with rain or snow, then it becomes difficult and risky for vehicles to drive on the drenched road and the winter season of snowing intermittently spreads across three and half months of winter from December to March. Although there are machines, which clean the snow from roads but cities, towns, national highways and main other roads are given priority. The roads connecting to villages are the last to be served, which are mostly cleared manually but takes days, and roads to small villages are most often not cleared at all. So, during this time, the accessible areas become inaccessible and people with illness are not able to seek health care. The researcher was told by some people during his visit to Waderballa village that through winter it becomes impossible to take pregnant women to hospitals, which are very far off and have to pass quite a few Army camps in between, for giving birth to a child. This was also the problem with many hamlets, especially, which were located far off and close to forests and mostly inhabited by Gujjars.

Neeligam has a majority of people living below the poverty line. Almost 76 percent are officially recognised as poor and only 16 percent had APL ration cards, while as 7.6 households had no cards at all. The main sources of livelihood were irrigated and un-irrigated land and apple orchards; employment with government; small business; artisanship; transport sector; and mostly casual labour. In almost all villages of Rajwar most of the families owned land but the productivity of land varied from Lower Rajwar Belt to Upper Rajwar Belt. In the Lower Belt, there was availability of water to lafor farming, so its productivity was high, as compared to Upper Belt, which depends on rainwater for its cultivation. People in Neeligam were much depressed with the productivity of their land. All households had land from small to large land holdings but a major part was un-irrigated land. The main crop is paddy for irrigated land, which is cultivated only once in a year during summer and maize for un-irrigated land. In the focused group discussion with people, almost all people showed dissatisfaction with land. People reported that the rains have become unpredictable and there is no sufficient water available for irrigation. They further pointed out that the productivity of their land is much lesser (2.5 quintals of paddy per Kanal), as compared to land in lower Rajwar belt (3 to 4 quintals of paddy per Kanal). The researcher attempted to calculate the returns of land in Neeligam and it seemed that there was a negative income from land for last few years because of crop failure or less returns. However, what seemed to be paying huge dividends

were apple orchards. In the discussion with people, it was revealed that one Kanal of apple orchards, if fully blossomed, could pay up to 50 to 70 thousand of rupees annually as a profit. Although there was huge potential to cultivate apple in both irrigated and un-irrigated land, not all the families have orchards and even those, which had, had orchards for limited cultivable area. While this was surprising, the people explained why they are not cultivating apple on their whole land. Firstly, it takes up to 10 ten years for apple trees to grow and give good yield and therefore for these 10 years there would be no produce, so all families can't afford to have no yield from land for a decade. Secondly, it needs a good investment for planting trees, and then each year for fertilisers, pesticides and for making water available using kerosene run motors. What was even surprising that people told in the discussion that they were getting an average of Rs 5 to 6 thousand for apple produce from one Kanal of land? They explained that most poor people cannot afford the pesticides/fertilisers and to get a water pump/motor on rent and, therefore, they sell their produce at the beginning itself. Besides, even if they can manage to invest on the apple cultivation until it is ripen, it needs a huge and unaffordable investment for its packing and transport to Jammu or Delhi. The other important factor is that there is risk of crop destruction due to hailstones or heavy rain during flowering season or later, and they cannot afford for such risks in absence of any governmental crop insurance scheme. All these factors make the poor orchard owners vulnerable to exploitation and many businesspersons –local and outsiders- buy their crop in its initial stage and make lot of money. In later part of fieldwork on access to health services, many poor people reported that they borrow money from fruit businesspersons, in return of their annual produce, to get treatment for illness. Despite all this exploitation, orchards still pay much more than irrigated and un-irrigated land.

In Neeligam village, although all the households had land, but the land holdings were very less among the Gujjars and Ganiae (Gujjars are STs and Ganaie are backward and poor castes in the village). They together constituted almost one third of households in the village (36 out of 131 households). Not even a single Gujjar and Ganaie household had orchards; and just one Gujjar household had irrigated land. The village was also stratified into different socio-economic classes on many parameters other than land.

The researcher conducted a survey of all the households using 10 indicators[27] of socio-economic conditions to rank households based on the score each household would get. The interview schedule also included enquiring about type of ration cards they have been provided by government. At the end of interview, the researcher also rated the household into poorest, poor, middle class and upper class based on his observation (other than scoring). The observation was random but mostly based on type and maintenance of house, material used in construction of house, land holdings, and source of livelihood. The survey results revealed that the maximum score that a family could get was 48 and the lowest was 3. Within this range of 3 to 48 score, almost all Gujjar and Ganaie household fell into the lowest range in scoring from 3 to 16 points, except one Ganaie household who was in the middle range. Besides, all of them had either AAY or BPL ration card, which shows that they had also been officially declared as living below poverty line[28]. Their scores very equally low on other socio –economic indicators. The findings of this survey on different socio-economic indicators are analysed below.

Among 131 households, a majority of them of almost 59 percent had Pakka houses, 25 percent had Semi Pakka, 15 percent had Katcha house and just one household had no house. The majority having a pakka or semi-pakka (a larger part was made of wood) house seems to be contradictory with a majority of households in the village as living under official poverty line. However, as the village is very close to forests, wood has been available to them, especially in the peak conflict time in 1990s when there was not much watch from government functionaries on the jungle. Therefore, even if the families were poor but had the physical capacity to cut trees from forests, they have been able to make a Pakka house. One family with no house was because of the reason that just before the survey was started, the Army had put the entire Ganaie Mohalla on fire in an encounter, which led to seven houses (housed nine families) being completely damaged.

Over 40 percent had no irrigated land. However, 30 percent had less than 2 Kanals of irrigated land, 15 percent had irrigated land in the range of 2 to 4 Kanals, 11 percent had in

[27] However, the scoring of one parameter related to status of children (whether they attend school, and if they are engaged in child labor) turned out to be so complex that people presented much diverse picture and it was difficult to find any pattern in giving scores. The researcher felt there was no clarity and was difficult to give it any quantifiable score and therefore, the parameter was not included in calculating the final composite score.

[28] It is agreed that there are significant exclusion and inclusion errors in the official identification of people living below the poverty line but as these groups are the powerless and voice less in the village, there being within the BPL category corroborates to the findings that these two castes are poor.

the range of 4 to 8 Kanals and 1.5 percent (2 households) owned irrigated land more than 12 Kanals. However, the situation was not as bleak with un-irrigated land. Only 6 percent of households had no un-irrigated land. 34 percent households had less than 4 Kanals; 22 percent had un-irrigated land in the range of 4 to 8 Kanals, 24 percent had in the range of 8 to 16 Kanals; 7 percent had in the range of 16 to 24; and 6 percent owned land more than 24 Kanals. On the other hand, only 27 percent of the households owned high paying apple orchards, while as 7.6 percent had orchard for less than 2 Kanals, 8.4 percent had orchard for 2 to 4 Kanals, another 3.1 percent had for 4 to 6 Kanals, and 3.1 percent had for 6 to 8 Kanals, 3.1 percent had for 8 to 10 Kanals and 1.5 percent (2 HHs) had for more than 10 Kanals. Table 3.7 shows the land holdings of the people in Neeligam village.

Table 3.7: Ownership of Land in Neeligam Village

Irrigated Land Holdings			**Un-irrigated Land Holdings**			**Orchard Land Holdings**		
Holdings (Kanals)	***Frequency***	***Percent***	***Holdings (Kanals)***	***Frequency***	***Percent***	***Holdings (Kanals)***	***Frequency***	***Percent***
Nil	56	42.7	Nil	8	6.1	Nil	96	73.3
Less than 2	39	29.8	Less than 4	45	34.4	Less than 2	10	7.6
2 to 4	20	15.3	4 to 8	29	22.1	2 to 4	11	8.4
			8 to 16	32	24.4	4 to 6	4	3.1
4 to 8	14	10.7	16 to 24	9	6.9	6 to 8	4	3.1
12 above	2	1.5	24 above	8	6.1	8 to 10	4	3.1
						10 above	2	1.5
Total	131	100	Total	131	100	Total	131	100

A majority of households had some form of latrine with only 4.6 percent households without latrines and had to go for open defecation. 14.5 percent households reported that they use pit latrines shared by a group of people other than their own family members. A majority of 70 percent reported that they use pit latrines, which are shared by their own family members only, and another 13 percent of households had flush system in their houses. Further, for over one third of households (38.2 %), the major source of drinking water was piped water/tube well, which was to be fetched from longer distance; for 23.7 percent the major source of drinking water was piped water/tube well, which was available

inside their own yard; for 10.7 percent households, the major source of drinking water was piped water/tube well, which was available inside the house itself; and for 27.5 percent of households, the major source of water was river/stream, which was flowing on the bottom side of the village.

For a majority of households of 70.2 percent wood was used as fuel for cooking purposes; for 2.3 percent dung cake was cooking fuel, for 0.8 (one HH) Kerosene was cooking fuel, and for 26.7 percent households, LPG was used but not all the times. Table 3.8 presents the data on type of sanitation, sources of water and type of fuel used by households in Neeligam village.

Table 3.8 : Type of Sanitation, Source of Water and Type of Fuel used in Neeligam Village

Type of Sanitation	***Percent***	***Source of Water***	***Percent***	***Fuel Used***	***Percent***
Open defecation	4.6	Stream/river/spring	27.5	Dung Cake	2.3
Group Pit latrines	14.5	Piped water/tube well to be fetch from longer distance	38.2	Wood	70.2
Pit latrine (only used by this household)	67.9	Piped water/tube well inside the yard	23.7	Kerosene	0.8
Flush	13.0	Piped water/tube well inside the house	10.7	LPG	26.7
Total	100	Total	100	Total	100

An enquiry was also made if the households own any of the four consumer durables, a computer, washing machine, refrigerator or colour television. Only 3 percent (4 households) had all the four items, another 2.3 percent (3 households) owned any three of these items, 4.6 percent (6 households) owned only two items, 14.5 percent (19 households) owned one of the four items, and a majority of 75.6 percent reported not possessing any of the four items. Further, an enquiry was made if the households owned tractor or equivalent, car, scooter or equivalent, which were assets of richness. However, only four households owned a tractor or its equivalent (which was transport vehicle in all cases) with one household possessing two vehicles. Not a single household had a car and only two households had a scooter/motor bike.

Considering that the education attainments are a function of socio-economic conditions, an enquiry was made into the highest literate in the households. It was found among 17.6 percent households there was not a single person who had achieved any level of education; among 3.8 percent households there was a person who had primary level of education; among 28.2 percent households there was a person who had achieved upper primary level of education; among 22.1 percent there was a person who has been able to pass secondary level; among 16 percent there was a person who had been able to complete higher secondary; among 6.9 percent households, there was a person with graduate; and among only 5.3 percent there was a person with post-graduation level of education, as can be seen from the *table 3.9.*

Table 3.9: Education Attainments and Source of Livelihood in Neeligam Village

Highest Education Attainments	***Frequency***	***Percent***	***Livelihood Sources***	***Frequency***	***Percent***
Illiterate	23	17.6	Living on Alms/ Begging/Charity	2	1.5
Up to primary/passed 5th	5	3.8	Casual labour	63	48.1
Up to middle/ passed 8th	37	28.2	Artisan/ Small Business	21	16.0
Completed secondary	29	22.1	Low salaried	14	10.7
Completed Higher Secondary	21	16.0	Middle Salaried/ Medium Business	19	14.5
Graduate/Professional Degree	9	6.9	High Salaried/ High Business	3	2.3
Post Graduate/ Professional Degree	7	5.3	Multiple occupations	6	6.9
Total	131	100	Total	131	100

Two households of the village were living on alms/begging. 16 percent households rely on artisanship or small business; 10.7 percent had a person engaged in any low salaried employment (equivalent to 4^{th} class in government); 14.5 percent relied on middle income salaries or medium level business; only 2.3 percent (3 HHs) had high level business or high salaried person; a majority of 48.1 percent relied on being casual labour; and 7 percent had multiple sources of livelihood. This was in addition to having cultivable land and engaging in agriculture themselves, as can be seen from the *table 3.9.*

Adding all the scores together, all the households lay in the range of 3 to 48 points. However, it was very difficult logically to draw any line in this scoring to divide the households into groups with poor, moderate and better socio-economic conditions. What the BPL census 2002, had done that in all states they drew the line depending on the quota for BPL, which was allocated by Planning Commission. The line drawn was very arbitrary. For instance, if a state would have been allotted 1 lakh BPL ration cards, they would draw line at a mark which would separate the lowest 1 lakh households in the entire set of households of state. The markers would be irrespective of the range of scores. Therefore, it was very difficult to reach to any consensus on any score to make a marker of dividing the entire households into three groups of poor, moderate and better. However, the scoring reflected that the households at the top had better socio-economic conditions than those in the middle of scoring, which in turn better socio-economic conditions than those at the bottom.

An attempt was made to draw an arbitrary line at 18 and 33 to divide the households into poor, intermediate and better off (18 and 33 was assumed considering that the range of scores lie in between 3 to 48 and the total groups to be created was three, therefore, it may be better to divide the entire score range into three groups at equal intervals). This lead to the results that a majority of 67.2 percent would have poor socio-economic conditions, 29.8 had intermediate and only 3.1 (4 HHs) had better socio-economic conditions.

On the other hand, as mentioned earlier, 76 percent are officially recognised as poor and only 16 percent had APL ration cards, while as 7.6 households had no cards at all. The official list of poor people has its own limitation but it does point out that a majority of this village were poor.

A FGD was conducted in Neeligam after the data on socio-economic conditions was analysed. The group constituted 15 people, with participation from Geelani, Gujjars, Khan, War, Reshi and Bhat castes. The discussion was related to the socio-economic conditions and caste relations in village. The previous discussion that had been conducted was for gaining an understanding of the villages, its amenities and reach of government schemes

In the FGD, the initial question posed by the researcher was about an appropriate method to categorise the households into different socio-economic classes. The participants came out

with different opinions. For example, one teacher said that all those who send their children to private schools are rich, those who send their children to government schools are in middle range and those who are not able to send their children to school are the poorest. However, this was not agreed by all and many examples were cited to argue against it. Finally, they agreed that firstly divide the village along castes with Ganaie and Gujjars at the bottom of indices and other castes at the top. Among other castes at the top, they argued that source of livelihood and land holdings are the indicators to divide these castes into poor and rich households[29]. They explained this with many examples to show how it would hold valid.

All the people agreed that the Ganaie and Gujjars are the poorest in the village, and Khans on the other side have better socio-economic conditions and other castes like Bhat, Geelani, War, Reshi, etc. (who were very less in numbers as individual castes) would fit in the intermediate socio-economic conditions. The survey had shown the same results with few households scattered through the indices on socio-economic conditions. The Ganaie traditionally have been shepherds of the village, and therefore, have not been able to attain high education status, which was also obvious even in the present times that not a single person from Ganaie was a graduate. In the social gatherings like marriage where the neighbours and relatives contribute by offering their service, the Ganaie were most often assigned work considered menial such as cleaning of plates. Even though over the period, occupations and socio-economic relations between Ganaie and other castes have changed, the present occupational structure still shows a similar hierarchical trend. There were three barbers in the village and all were from the Ganaie caste. The people who make the Kangri (fire pot) in the village were also Ganaie. Similarly, the Gujjars are the backward classes in the villages. Gujjars have different ethnicity from Kashmiris, so the socio-economic relations between them and other castes were not of similar nature as of Ganaie and other castes. The Gujjars, in almost all villages of Rajwar block, live in separate hamlets and not within the main village. Their main occupations are livestock breeding and agriculture. However, the landholdings were only un-irrigated with not a single household out of 22 had orchards or irrigated land in Neeligam. There was not a single person holding a job, and not a single person who had completed graduation. Their hamlet was physically

[29] Although the researcher had reservations with putting Rehbar-e-Teachers (they are provided only 1500 Rs per month for 5 years until they are regularised) into a class much better than those who are casual labourers, they explained how such people are much better than casual labourers for the reasons that their incomes are secure and regular and enjoy influence that they are helped and can borrow anything anytime, which a casual labour could never have that privilege.

inaccessible with no road connecting them to main village. It was also obvious that they are socially excluded and discriminated as being Gujjars. In the discussion it was reported that the Gujjars undertake seasonal migration for almost four months during summer to a nearby forest landscape called Bangus (very famous for its beauty and now developing a tourist site), to feed their livestock. The Gujjars also said that they harvest good milk during this period and they are able to sell milk products. However, this seasonal migration results into their children dropping out of schools, and as a result, they are not able to attain higher educational levels. The Gujjars were highly dissatisfied with their agriculture, which was giving almost no returns, with rain being insufficient for their cultivation now.

The analysis of almost each indicator showed that Ganaie and Gujjars are the poorest in the village. For instance, just one Gujjar household out of 22 had irrigated land; not even a single Ganaie and Gujjar households had any land under apple cultivation, which was relatively high paying asset, as compared to irrigated or un-irrigated land, as can be seen from the *table 3.10.*

Table 3.10: Landholdings by different Castes in Neeligam Village

Irrigated Land Holdings (Kanals)

Caste	***Nil holdings***	***Less than 2***	***2 to 4***	***4 to 8***	***12 above***	***Total***
Khan	16	16	9	10	1	52
Ganaie/Gujjar	29	5	1	1	0	36
Other Castes	11	18	10	3	1	43
Total	56	39	20	14	2	131

Un-irrigated Land Holdings (Kanals)

Caste	***Nil holdings***	***Less than 4***	***4 to 8***	***8 to 16***	***16 to 24***	***24 above***	***Total***
Khan	6	11	12	15	4	4	52
Ganaie/Gujjar	2	12	10	10	2	0	36
Other Castes	0	22	7	7	3	4	43
Total	8	45	29	32	9	8	131

Orchard Land Holdings (Kanals)

Caste	***Nil Holdings***	***Less than 2***	***2 to 4***	***4 to 6***	***6 to 8***	***8 to 10***	***10 above***	***Total***
Khan	25	8	8	3	3	4	1	52
Ganaie/Gujjar	36	0	0	0	0	0	0	36
Other Castes	35	2	3	1	1	0	1	43
Total	96	10	11	4	4	4	2	131

Further, among the 17 households, who had flush type of sanitation in their houses, not a single was from Gujjars and Ganaie families. Among the 14 households in the village who had piped water lines into their house not even a single was from Ganaie or Gujjar families. Similarly, among the 35 households who used LPG as cooking fuel, not even a single was Ganaie or Gujjar family, as can be seen from the *table 3.11*.

Table 3.11: Access to Basic Amenities by different Castes in Neeligam Village

Sanitation

Caste	***Open defecation***	***Group Pit latrines***	***Pit latrine (only used by this household)***	***Flush***	***Total***
Khan	0	5	35	12	52
Ganaie/Gujjar	3	2	31	0	36
Other Castes	3	12	23	5	43
Total	6	19	89	17	131

Type of Fuel

Caste	***Dung Cake***	***Wood***	***Kerosene***	***LPG***	***Total***
Khan	0	28	1	23	52
Ganaie/Gujjar	1	35	0	0	36
Other Castes	2	29	0	12	43
Total	3	92	1	35	131

Source of Water

Caste	***Stream/ river/ spring***	***Piped water/ tube well to be fetch from longer distance***	***Piped water/ tube well inside the yard***	***Piped water/ tube well inside the house***	***Total***
Khan	3	31	8	10	52
Ganaie/Gujjar	16	11	9	0	36
Other Castes	17	8	14	4	43
Total	36	50	31	14	131

The data also shows that not even a single Ganaie or Gujjar family owned any of the four consumer durables like colour television, washing machine, computer and refrigerator. Similarly, among the six households which had vehicles or scooter/bike (wealthy assets), not even a single was from Ganaie or Gujjar background. Not even a single person from Ganaie and Gujjars was able to attain graduation or post graduation, while as nine people were graduates and seven were postgraduates from Khan and other castes. Besides, not a single Gujjar person was holding a government or private job, but only three Ganaie

persons had jobs (one low salaried and two middle salaried). These findings of the survey show, as agreed by people in the FGD in Neeligam, that Gujjars and Ganaie are the poor in the village. These findings were corroborated by the government categorisation of households into BPL and AAY that not a single family from Ganaie and Gujjars have been categorised as APL. Taking scores from all indicators together, all the Gujjars and Ganaie get classified out in the lower third part of ranking, except one Ganaie family, which figures out in middle part of ranking.

The socio-economic survey has revealed that Khan households were among those who had better socio-economic conditions. For instance, among the 16 households who had the highest irrigated landholdings of more than 4 Kanals, 11 were Khan and 3 were from other castes. Among 35 households who owned apple orchards, 27 were Khan and 8 were from other castes. Further, among the 17 households, who had flush type of sanitation in their houses, 12 were Khan and 5 from other castes. Among the 14 households in the village who had piped water lines into their house, 10 were Khan and 4 were other castes. Similarly, among the 35 households who used LPG as cooking fuel, 23 were Khan and other 12 were from other castes. Among 32 households who owned any of the four consumer durables like colour television, washing machine, computer and refrigerator, 23 were Khan and 9 were from other castes. Similarly, among the six households, which had vehicles or scooter/bike (wealthy assets), all the six were Khan.

Further, among the 16 graduates and postgraduates, 7 were Khan and 9 were from other castes. Among the 45 households, who had a person(s) engaged in any low, middle or high salaried job or in middle or high business, or multiple occupations, 25 were Khan, and 16 were from other castes, as can be seen from the *table 3.12*. Therefore, these findings of the survey show, as agreed by people in the FGD in Neeligam, that the Khan are the better-off ones in Neeligam, followed by other castes.

Table 3.12: Education Attainments and Source of Livelihood by different Castes in Neeligam Village

Education Attainments

Caste	*Illiterate*	*Up to primary/ passed 5th*	*Up to middle /passed 8th*	*Completed secondary*	*Completed Higher Secondary*	*Graduate/ Professional degree*	*Post Graduate/ Professional degree*	*Total*
Khan	6	2	9	14	14	3	4	52
Ganaie/Gujjar	8	1	16	6	5	0	0	36
Other Castes	9	2	12	9	2	6	3	43
Total	23	5	37	29	21	9	7	131

Source of Livelihood

Caste	*Living on Alms/ Begging /Charity*	*Casual labour*	*Artisan/ Small Business*	*Low salaried*	*Middle Salaried/ Medium Business*	*High Salaried/ High Business*	*Multiple Occupations*	*Total*
Khan	0	19	8	8	11	2	4	52
Ganaie /Gujjar	0	27	5	2	2	0	0	36
Other Castes	2	17	8	4	6	1	5	43
Total	2	63	21	14	19	3	9	131

However, the findings of the government categorisation of households into BPL and AAY show that among the 21 households who have been categories into APL, 12 are Khan and 9 from other castes. Similarly, it also shows among 52 Khan households, 11 are in AAY category and 26 in BPL category and 3 had no cards; and out of 43 households from other castes, 8 are in AAY and 23 in BPL cards with 3 households no cards. Similarly, taking collective scores from all indicators together, a majority of 33 Khan households were in the middle or upper third part of ranking, and 19 households fall into the lower third part of ranking. In the same way, 17 households from other castes figure in the middle third part of ranking, while as a majority of 26 households figured in the lower third part of ranking. These findings taken together shows that the rule that Khan are better off in the village didn't apply across all Khan households. Although Khan were among the better-off ones in the villages but not all Khan were economically better off. Similarly for other castes, there were different economic categories within each caste.

What was good about the social relations between different castes was their participation in social gatherings. In the discussion, it came out that for wedding ceremonies people across castes are invited to participate and eat together in a big plate called Trami in Kashmiri (four people eat together in one Trami). This is a Kashmiri tradition, which finds its roots in the Islamic teaching of egalitarianism and brotherhood. However, what was astonishing was that there were no inter-caste marriages happening. The researcher asked the people in the discussion if any inter-caste marriages has taken place in their village, and all of them smiled and said 'No'. They explained that there would be no marriage between Gujjars and all other castes, and between Ganaie and all other castes, and between Geelani and all other castes. In a way, based on this there were four caste groups, one was Gujjars – a separate ethnic group, another was Ganaie – lower caste, another was Geelani and Baba – upper caste, and a bigger group included Khan, War, Bhat, Wani, Reshi and Mir. When asked why, one person said that even if they want to have marriage of their son with the Gujjar family, the Gujjar family will never be ready for this for the reason that the Gujjars understand that they are not treated equally by Kashmiris and are strongly discriminated by Kashmiris. So, it may be very problematic for their daughter to live in a Kashmiri family. When asked if there has been any one case of marriage against these norms and the researcher was told in the history of this village there had been only one marriage between Geelani and other caste, in which a son of Geelani family and daughter of Khan family eloped at their will for the reason they belonged to the two castes. All of their relatives had to struggle a lot for this. What was the problem with the marriage between Khan or any other caste and Geelani is that Geelani belongs to a caste group called Peer, who claim to be superior castes and traditionally did not undergo marriage with any other caste in Kashmir, and treated all other castes as Zamindars (farmers). Though many of the intellectual Kashmiris deny any caste stratification in Kashmir and justify that traditionally the inter-caste marriage between Peer and other castes didn't happen but in present times there are many examples of inter-caste marriages, so this is more a class issue than a caste issue. But this thesis doesn't apply to Neeligam where the Khan are having better socio-economic conditions and are more powerful than the Geelani but still the inter-caste marriage don't happen easily or with general social acceptance.

Interestingly, this caste stratification was also the basis for being powerful or powerless in the village, and even in the panchayat politics of the village. In the discussion, people agreed that the Khans are most powerful and articulate group in the village, with Ganaie

and Gujjar being powerless and voiceless. This was reflected in the recent panchayat elections in the village. Among the ward members, one is Gujjar, as per the provisions of the Panchayat Act there must be one ST representative, but there was none from the Ganaie. When asked this why there is no one from Ganaie (though the researcher was aware of the fact that they are only 14 families in village of 131 families and each one can't be a panchayat representative), the people in the village said they don't have adequate majority in the village, which would mean there is a strong belongingness to these caste groups that people from other castes would not have voted a Ganaie person to power. Besides this, it also came out in the discussion that one Ganaie person had submitted application to contest for the ward member position, but just before the elections, he withdrew his candidature. Whether it had some caste link or there were other political pressures remains unexplored.

The survey on the socio-economic conditions of all households in Neeligam village and FGD with people in Neeligam, lead to the understanding that just caste cannot be taken as an entire criteria to divide the village into different socio-economic groups, and it warranted to use multiple criteria together, which can catch such complexity in the village. As among the Khan households, though majority of them have better socio-economic conditions, there were few who were poor, and this was true for other castes as well. As a result, using the collective score of households based on 9 indicators to rank households into different socio-economic groups, would be more desirable than just relying on any one criterion. Therefore, the final ranking of the households on the collective score they could get on the 9 indicators and the arbitrary division of households into three socio-economic groups, underlined the basis for this study of understanding the disparities and issues with access of people to health services among different socio-economic groups. However, what is important to mention that these 9 indicators are not foolproof, and have many limitations especially the relative weight-age that each indicator and each possible answer was given.

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CHAPTER 4: ACCESS TO HEALTH SERVICES IN NEELIGAM VILLAGE OF KUPWARA DISTRICT

Access is not mere function of availability of services but interplay of many other complex factors including social, cultural, economic, physical/geographical and acceptability factors. Therefore, to understand, access of people to health services and issues related to it, the study has to incorporate all these aspects to be able to explore the complexity of their interaction. This study, which attempted to explore and understand the issues of access in the context of Kashmir, has examined access from a multi-dimensional perspective and considered five important dimensions of access that influence the realisation of health care including availability, accessibility, accommodation, affordability and acceptability. This study also attempted to understand the people's perception of illness, felt needs to seek health care and difficulties in accessing health care. These aspects have been examined through a combination of quantitative methods and narratives about experiences of people. This chapter describes and analyses the findings of the village study conducted through a household survey.

The study was conducted in Neeligam village in Kupwara District. The research design of this study has been described in detail in *Chapter 2* of this dissertation. Within the village, 50 households, selected by *systematic random sampling*, were interviewed to collect information about all family members, which gave a total of 341 individual units. However, not all of them were respondents for each aspect of study. For instance, the information about maternal and child health services was recorded only from women and children, and not all respondents. Therefore, the effective sample for each aspect of study varied and the actual numbers are defined in each relevant separate section of this chapter.

4.1. Socio-Economic Conditions of Households

In addition to the information on the socio-economic and political aspects of the entire village Neeligam which has been delineated in *Chapter 3*, this study recorded detailed information about socio-economic conditions of the 50 selected households to understand and present a thorough picture of the village population through the selected households. The findings of which are described below to contextualise the findings of the study.

4.1.1 Religion, Age, Gender, Education and Marriage:

All of the households were Muslims. Almost 60 percent families were nuclear households, and 20 percent each were nuclear-extended and joint households.

Out of 341 persons covered in the study, 52.2 percent were male and 47.8 percent were female. Further, a majority of 58.7 percent were unmarried (or never married), 38.1 percent were currently married, 2.9 percent were widowed and 0.3 (just one person) was separated. Further, as can be seen from the table 4.1, a large section (26.7 %) was in the age group of 15 to 25 years; 22 percent were in 5 to 15 years; 13.2 percent were in 25 to 35 years; 9.1 percent were under 5 years; and 6.7 percent were 65 or above years.

Table 4.1: Age Groups of Household Members

Age Groups	*Frequency*	*Percent*
Under 5	31	9.1
5 to 15	75	22.0
15 to 25	91	26.7
25 to 35	45	13.2
35 to 45	29	8.5
45 to 55	25	7.3
55 to 65	22	6.5
65 & Above	23	6.7
Total	341	100

A large section (28.2 %) had no formal education at all, 18.5 percent were educated only up to primary but not passed primary; only 2.9 percent had passed higher secondary and 2.6 percent had completed graduation and few of them had also completed post graduation or passed another degree. 8.5 percent persons were underage (under 5) and were not enrolled in schools at the time of survey (see Table 4.2).

Table 4.2: Education Attainments of Household Members

Education Level	*Frequency*	*Percent*
Uneducated	96	28.2
Below Primary	63	18.5
Primary	42	12.3
Middle	65	19.1
High School	27	7.9
Higher Secondary	10	2.9
Graduation or above	9	2.6
Under-age/Not Applicable	29	8.5
Total	341	100

However, the education attainments were not equal across all the castes and economic classes. Among the 27 people who had passed high school, not a single one belonged to either Ganaie or Gujjar family; among the 10 people who had passed the higher secondary

level, just a single person belonged to Ganaie and not a single one to Gujjar family; and among the nine graduates or postgraduates, not a single one was from Ganaie or Gujjars. Similarly, there were disparities along the line of gender but only in higher education. Among the nine graduates or postgraduates, only one was female; among the 27 people who had passed high school level, 13 were females; and among the 10 people who had passed higher secondary level, six were females.

Table 4.3 gives the information about the occupations of the household members. 33.4 percent were presently studying (that doesn't mean they were not doing anything or were not helping in household work), followed by 27.6 percent were engaged in household work as their primary occupation; 11.7 percent were casual labourers; 4.4 percent had small business or were artisans; 3.5 percent were working as government employees; and 1.8 percent were engaged in business/contractors and as private employees (low salaried) each. As people in villages carry multiple tasks, there were many engaged/ or doing other types of work depending on season and timings, however, this study focused on recording primary occupation. Secondly, the agricultural work, as most of households owned some portion of irrigated or un-irrigated land, was mostly seen as in addition to primary occupation, and as part time.

Table 4.3: Occupation of Household Members

Occupation	Frequency	Percent
Studying	114	33.4
Household Work	94	27.6
Casual Labour	40	11.7
Under-age	30	8.8
Small Business	15	4.4
Inability to do anything	14	4.1
Government Employees	12	3.5
Business/Contractors	6	1.8
Private employees	6	1.8
Agriculture work	4	1.2
Others	6	1.8
Total	341	100.0

4.1.2 Caste:

There were ten castes- Ganaie, Wani, Khan, War, Geelani, Reshi, Baba, Mir, Bhat and Gujjars (further divided into three castes) in the village, however, this study covered households among nine castes (the tenth caste had only one household and by random

sampling didn't get selected). Among the selected 50 households, 21 were Khan, 15 were other castes and 14 were Gujjars and Ganaie[30].

4.1.3. Other Socio-Economic Conditions:

a) Housing: As mentioned earlier in Chapter 3 that most of the households in the village had pakka houses for the reason that many houses were made of wood, which has been easily accessible to them due to the close proximity of the village to forests. Among the 50 households where the study was conducted, 20 percent (10 out of 50) were living in katcha houses, a majority of 66 percent (33 out of 50) owned pakka houses, 3 percent (6 out of 50) lived in semi-pakka and urban type pakka (very concrete) each, and only one household didn't have a house (his house was burnt by Army, along with other 6 houses, in an encounter with militants)[31].

Among the people who reported having any type of house, almost 96 percent (48 out of 49) owned the house they lived in, except one family which was living in relatives houses, and had lost their house to fire during an encounter in the village by Army.

b) Electricity and Fuel: A majority of households of about 80 percent (40 out of 50) used wood as their main fuel for cooking and 10 percent used dung cakes and LPG each, as fuel for cooking. All the people who used LPG were Khan. Further, most of the households of about 98 percent had electricity connections.

c) Water and Sanitation: For 34 percent (17 out of 50 households), the main source of water for their family members was surface water (stream flowing through that village), followed by 40 percent households (20 out of 50) who had access to piped/tap water, 12 percent (6 out of 50) used water from dug well and spring (natural but open outlet) each, and one household used water from a tube well.

[30] The individual castes included 21 Khan, 6 Bhat, 3 Reshi, 2 Geelani, 2 War, 1 Baba, 1 Wani, 7 each of Ganaie and Gujjars.

[31] In Kashmir, if militants are hiding in any house and Army/security forces come to know and they raid the place, mostly their strategy have been to put the entire hamlet/group of houses on fire, so that the militants come out and would not have any place to hide in the neighboring areas. These incidents have happened across Kashmir so often that every Kashmiri may recall being witness to any such incident or hearing about such incidents very frequently. The houses that would be burnt by Army during any such encounter would not also be entitled to any insurance, if they had acquired a policy.

There was a public pipeline through the village, and also through the Gujjar hamlet, however, as the village had hilly terrain, the water was not flowing to some parts of the village, and was not available at all the times. There was a pipeline through the Gujjar hamlet but there was no water flowing through.

There was a disparity along the line of caste with access to pipe/tap water. Among the 20 households who used pipe/tap water, 15 were Khans, only two belonged to the Ganaie caste and no one was from the Gujjars.

However, for cooking and hand washing purposes, a majority of households of 46 percent (23 out of 50) reported using pipe/tap water, 28 percent used surface water only, 12 percent used dug-well, 10 percent used spring and 4 percent used tube well. The relatively higher proportion of households reporting using pipe/tap water for cooking and hand washing than they reported using for general purposes was for the reason that some of these would walk to fetch pipe/tap water from long distance to be used for cooking and hand washing purposes.

For a majority of them (almost 64 percent), the source of water was located outside their own building/yard. A majority of households of about 66 percent (33 out of 50) treated their water to make it safer, and among them a very large majority of 93.9 percent (31 out of 33) boiled water before using it for drinking, and two households had water filters.

An enquiry was also made into the type of toilet facility they use, and a majority of 82 percent (41 out of 50) reported using pit latrine, 16 percent (8 out of 50) used flush latrine and one household reported going for open defecation. Among those who had flush type of toilet facility, 7 were Khan and one belonged to other castes, and not a single was from lower class castes – Ganaie and Gujjars. For a majority of households of almost 90 percent the toilet facility was located in house or within their own yard, but few households of about 8 percent (4 out of 50), shared toilet facility with other few households.

d) Land Holdings: On an average, the landholdings in Kashmir are very small but most of the people do own some land. Further, the hilly terrain in the area of study reduced the available agriculture land. Among the 50 households, a majority of 96 percent owned some agricultural land, as can be seen from the table 4.4.

However, the landholdings varied. A majority of 28 percent (14 out of 50) owned 4 to 8 Kanals (8 Kanals are equal to one acre), followed by 22 percent who owned 1 to 4 Kanals, 16 percent owned 8 to 12 Kanals, 10 percent owned 12 to 16 Kanals, 6 percent owned 16 to 20 Kanals and 14 percent owned land more than 20 Kanals.

Table 4.4: Ownership of Land

Kanals	*Frequency*	*Percent*
4 to 8	14	28.0
1 to 4	11	22.0
8 to 12	8	16.0
12 to 16	5	10.0
16 to 20	3	6.0
0	2	4.0
20 to 24	2	4.0
24 to 28	2	4.0
28 to 32	2	4.0
52 to 56	1	2.0
Total	50	100.0

The irrigated landholdings were much lesser. Forty eight percent owned only 1 to 4 Kanals, 26 percent didn't own any irrigated land, 22 percent owned 4 to 8 Kanals, and only 4 percent (2 households) owned land more than 12 Kanals (see table 4.5).

Table 4.5: Ownership of Irrigated Land

Kanals	*Frequency*	*Percent*
1 to 4	24	48.0
0	13	26.0
4 to 8	11	22.0
12 to 16	1	2.0
28 to 32	1	2.0
Total	50	100.0

e) Livestock ownership: As the landscapes, meadows and rich pastures provide scope for livestock rearing in Kupwara district and in this village, many of the households did own some livestock across different castes. Almost 64 percent of households had one or more cows/bulls/buffaloes and varied from one to 15 numbers, 20 percent had one or more goats/sheep and varied from one to 10 numbers, 68 percent had chicken/ducks and varied from one to 10 numbers, and only one household did own a horse. However, the livestock was relatively owned more by Gujjars, as livestock is one of their main sources of livelihood. Nevertheless, some of the people from this community told the researcher during the survey they are witnessing transformation in their primary occupations and are becoming more dependent on casual labour. Few of them said that livestock rearing was providing them self-reliability and if needed could have sold their livestock anytime but now due to changing occupation they have become dependent on others and if needed money abruptly have to borrow from employers.

f) Other Household Durables: An enquiry was also made into other household durables and the results are shown in table 4.6. As can be seen from the table that all households owned one or more mattresses, more than half owned a pressure cooker, only 14 percent owned a chair, only 6 percent owned a cot or bed, 12 percent owned table, 28 percent owned electric fan, 74 percent owned a watch/clock, 48 percent owned a radio/transistor, 6 percent owned a black and white TV, 32 percent owned Colour TV, 12 percent owned sewing machine, 90 percent owned a mobile phone, 10 percent owned a bicycle, 8 percent owned a car, and among items. It can be seen that most of the households have reported not owning many of such assets/household items.

Table 4.6: Ownership of Household Durables

Item	*Frequency*	*Percent*
Mattress	50	100
Pressure Cooker	26	52
Chair	7	14
Cot/Bed	3	6
Table	6	12
Electric Fan	14	28
Watch/Clock	37	74
Radio/Transistor	24	48
A black and white TV	3	6
Colour TV	16	32
Sewing machine	6	12
Mobile telephone	45	90
Any other type of telephone	2	4
Refrigerator	3	6
Water pump	2	4
Computer	1	2
Bicycle	5	10
Motorcycle/Scooter	1	2
Car	4	8
Tractor	1	2
Animal-drawn cart	0	0
Thresher	0	100

g) Access to Public Distribution System (PDS): Almost 96 percent of families (out of 50) had any type of ration card. 50 percent (25 out of 50) had BPL cards, 28 percent (14 out of 50) had AAY cards, a lesser percentage of 18 percent (9 out of 50) had APL cards, and two households didn't had any card, for they had separated from families recently and had applied for issuing of ration cards, which takes months to years of time.

The households were also asked if they buy any ration from the PDS in the last three months prior to survey, and almost 96 percent (48 out of 50) reported 'Yes'. Among them 91.7 percent (44 out of 48) reported buying rice from PDS shop thrice, just two families reported buying rice twice and once each in the last three months. However, only 50 percent of them (24 out of 48)

reported buying wheat once in the last three times. This is for the reason that there is very high demand for rice in the market as most population consumes rice, and wheat is mostly used for making 'chappatis' and consumed as snacks with tea. Therefore, with a high demand for rice among people, PDS shops supply mostly rice to people as their monthly entitlements and wheat is supplied only occasionally.

It give an impression that the PDS system in Kashmir is working much better than in other parts of India, where the PDS system is targeted and supplied ration to only BPL and AAY card holders. The public distribution system in Kashmir is to a large extent able to meet the regular food demand of the people and also help them cope with fluctuations in the annual food grains production in the state. The '*Hunger in the Valley'* report mentioned that the PDS in Kashmir is a very important system in making food grains accessible to people at all times, given the mountainous terrain of the state and the fact that the state has a 40% deficit in food production. The report finds that one of the reasons for the success of the PDS in the state of Jammu and Kashmir seems to be fact that the ration shops are controlled by the state government with the PDS shops (nodal distribution centers) being run by government directly, rather than by private dealers, as seen in most parts of the country. The employees running the shops get a regular salary from the government and do not depend on the commission from sale of the food grains; and therefore have lesser incentives to cheat and to sell the grains in the black market. The other feature of the PDS in Kashmir that seems to be contributing to its better functioning is that although there is a difference in the prices at which different categories of people get grains from the PDS, almost all people in the village seem to be using the PDS system for buying food grains. This makes the scheme near universal in its coverage, unlike other states where the offtake by APL cardholders is very low, and therefore, there is a greater pressure on the scheme to function properly. In J&K the offtake of food grains by APL category was almost 80 percent for 2007-08 and 99 percent for 2008-09 (MoCAPD, 2009 cited in Dar, 2009).

4. 2. Socio-economic Class:

This study wanted to explore the disparities in access to health services along the lines of socio-economic class. However, the important question arises how to determine the socio-economic class of a particular family. There are many indicators, which reflect the socio-economic conditions like land holdings, occupation of family members, education attainments, type of house, and access to water, sanitation, fuel, etc. The government has

already divided the households into AAY, BPL and APL, and most of the households in the village Neeligam did hold a ration card. Therefore, this classification can also be taken as proxy of socio-economic class. Further, caste can also be used as an important indicator of socio-economic conditions.

However, possessing or dispossessing any of these socio-economic parameters, may not determine his/her socio-economic conditions, as the socio-economic conditions of a household are determined by several factors, including land holdings, occupations, and education attainments collectively. Therefore, a person may be poor if he owns more than an average land holding in the village, a person may be poor even if he belongs to one of the most powerful and economically sound castes in the village, and so on. Hence, one has to rely on combination of indicators to determine the economic class of a household. The initial survey on determining socio-economic conditions used nine indicators, to determine the socio-economic class of all households in the village. The question then raised was where to draw the lines to categorise households into poor, middle and upper socio-economic classes, for this study.

'*Caste'* is an important indicator and is being used as a proxy for class in many of the social science studies. However, in the context of Kashmir caste stratification is not very systematic and clear, and taking just caste to categorise households into different classes, would have resulted ambiguity. As people perceived in the village, and showed by the socio-economic survey in the village, Ganaie and Gujjars were the poorest in the village, and Khan were the powerfull and relatively rich in the village. But Khan was not a homogenous group, and included a significant proportion of people who were poor.

In 2007, the BPL survey ranked the households on 13 indicators (described in Chapter-3) and across different states of India, they used different markers to divide the households in a state into AAY, BPL and APL. In Kashmir, they had put marker at 7 and 13, which would mean households who could get a composite score below or equal to 7 would be categorized as AAY household, and those who could get any score in between 7 to 13 (including 13) would be categorised into BPL category, and all those who got above 13 score were categorized into APL category. This categorisation of households into AAY, BPL and APL was not based on any scientific or objective criteria, rather on the quota of subsidized food grains that was provided to the state. That was the reason this marker of

dividing households into AAY, BPL and APL categories varied across states. Further, there is enough research evidence of high levels of exclusion and inclusion errors in classification of households into these categories due to political influence. Therefore, it also does not make sense to make comparisons of the households based on their possession of type of ration card, or to draw any inference from the markers that state government has used to divide households into AAY, BPL and APL categories, because the quota of subsidy and not using any objective criteria determined the markers. If the same markers can be used to divide the 50 households into three categories, the results show that out of 50 households, two would fall into AAY category, 20 would be BPL and 28 would be APL.

Therefore, it seems any marker to divide the households into different socio-economic classes would be arbitrary. However, what is also clear is that more categories may lead to more methodological problems, and it seems to make sense to divide the households into poor and intermediate socio-economic class, rather than pushing upper class into the classification. That would imply that if one wants to use the state government markers – 7 and 13, it would be better to stick to only 13, and divide the households into two categories- poor, with scores less than or equal to 13 and another –middle/moderate, with scores more than 13.

Alternatively, one would stick to dividing the households based on the composite score in the initial survey using markers at equal intervals, like from 3 to 18, 18 to 33 and 33 to 48 (3 to 48 was the range of scores). Therefore, based on the score these 50 households got on the initial nine indicators used for entire village, 34 households would fall into the lower category having relatively poor socio-economic conditions and 15 households would fall into the middle category having relatively modest socio-economic conditions and only one would fall into the upper category having relatively better socio-economic conditions[32] (because there were only four households in the entire village who could get a score more than 33). However, in that case as there has been only one households who was selected from the upper category of 33 to 38, therefore, it can be merged with the middle category for any categorisation. This would lead to having two categories of poor/lower and intermediate/middle socio-economic class.

[32] This division was made arbitrarily considering the range of composite score the households could get on nine indicators, which lied in between 3 to 48, therefore, dividing into equal three classes, like 3 to 18, 18 to 33 and 33 to 48.

In any case, this seems to be desirable to divide the households into two categories only – poor and middle, and restrict from classifying households into upper class, as in its strict sense, it would have been difficult to categorise any household in the village into an upper class, considering the socio-economic conditions of the families in the village. However, it was obvious that there were poor and middle class living in that village. Therefore, it would be desirable to divide the households into two categories of lower and middle socio-economic class[33] for any relevance to access to health services in this study.

This would lead to a result that 34 households would be classified as lower socio-economic class and 16 as middle socio-economic class. An attempt was also made to analyse the disparities in access to health services along the lines of government recognised APL and BPL rations. As mentioned earlier that just considering '*caste'* for looking into disparities in access to health services was not desirable but it could have been one of the important criteria, and an attempt was made in this study to consider how caste may affect the access to health services. *Table 4.7* shows intersect between caste and socio-economic class and ration card.

Table 4.7: Socio-Economic Class and Ration Cards by Castes

Caste	***Number/ %age***	***Middle Class***	***Lower Class***	***APL***	***BPL***	***None***	***Total***
Gujjars/ Ganaie	Count	0	93	8	85	0	93
	% age	0	100	8.6	91.4	0	100
Khan	Count	71	78	44	97	8	149
	% age	47.7	52.3	29.5	65.1	5.4	100
Other Castes	Count	45	54	14	85	0	99
	% age	45.5	54.5	14.1	85.9	0	100
Total	Count	116	225	66	267	8	341
	% age	34.0	66.0	19.4	78.3	2.3	100

As can be seen from the table... that not a single Gujjar/Ganaie falls in middle class category and only 8.6 percent of them have been classified officially as APL. While almost 48 percent of Khans fall into middle class category and 29.5 percent of them have been

[33] The term class here is not being used in its strict sense; rather it reflects socio-economic conditions and is used as proxy for class. Please refer to chapter 2 on methodology for further discussion.

classified as APL. With other castes, 45.5 percent fall in middle class category but only 14 percent have been classified as APL.

The study investigated into different aspects of health services including inpatient and outpatient services, maternal and child health services and other aspects of public health services including access to ICDS and MDMS, and these different aspects of public health services are analysed as different sections of this chapter.

4.3. Availability of Public Health Services:

Around the village, there were many health facilities available for health care including a Sub-centre in the village itself, RNTCP centre in the neighbouring village but same panchayat, an allopathic dispensary in another neighbouring village at a few kms distance where a doctor used to attend clinic regularly, a Sub-district hospital at 5 kms distance, a PHC at 8 kms distance and a District hospital at 12 kms distance. The state level hospitals including GMC, State Child Hospital, State Maternity Hospital and another super speciality hospital SKIMS were located in Srinagar at almost 100 kms distant. There was a dispensary being run in a neighbouring panchayat by MSF, where medical assistants used to attend clinic twice a week. Also a medical chemist used to open his shop in this village in the evenings, but was available on call throughout day and night. In the whole Zacahaldara medical block with a population of 45928, there were one SDH (equal to CHC) hospital, two PHCs, five Medical Aid centres, eleven Sub-centres and one each allopathic and unani dispensaries.

The spatial arrangements of these health facilities can be well illustrated in a health institution map of the whole medical bock (see Appendix –C). The spatial arrangement of health services highlights the variations from a standard norm and expected referral chain of primary, secondary and tertiary levels of care. The Sub-district hospital was located at 5 Kms distance, closer than a PHC, and a district hospital was located at 12 kms distance. Although the district-headquarter is Kupwara town, the district hospital is located in Handwara tehsil town, due to political factors explained in the earlier chapter-3. The availability of services is an important component to ensure accessibility to health services, there are many other aspects of affordability, quality of services, logistical arrangements and social and cultural factors, which would collectively determine the access of people to

health services. These issues and aspects have been researched in this study from people's perception and are analysed in the next sections.

4. 4 Prevalence of Illness:

To investigate whether people have access to health services, the first pertinent question to raise was the prevalence of illness among the people and 'how many' and 'who' were the people among the households covered under this study who were ill within a reference period, so that they can be enquired about their access to health services and what were the issues related to their access to health services. Therefore, the respondents were asked about each family member if they were hospitalised in the last one year and / or if they were ill in the last 15 days prior to survey. This reference period was considered by its wide usage in the NSSO survey on morbidity. As mentioned in the earlier chapter on methodology, that there were chances of under-reporting of morbidity as the data related to illness was recorded only on self-reported basis, and no medical examination or any verification was undertaken. Secondly, there were chances of under-reporting of morbidity by the women, in particular, due to other reasons; including male investigator undertaking this research and some women may have been hesitant to share any information, which would have been important for this study. However, the researcher felt that considering the level of rapport he could develop with the respondents and the comfort of the respondents with which they shared their information, the under-reporting may not be of a serious level that it would have affected this study, especially in understanding the issues of access to health services, which was its focus. The women were given assurance that the information provided by them will be kept strictly confidential and if they are not comfortable to talk about some of their health problems, they can just mention that they had suffered from some health problem and if they were able to seek treatment, without giving the details about the nature of the ailment.

Table 4.8: Prevalence of Hospitalisation in last one year

Hospitalised	*Frequency*	*Percent*
No	316	92.7
Yes	25	7.3
Total	341	100.0

Table 4.9: Prevalence of Illness during last 15 days

Ailing	*Frequency*	*Percent*
No	202	59.2
Yes	138	40.5
Don't Know	1	.3
Total	341	100.0

It was found that in the last year proceeding to survey, almost 7.3 percent of people in the sample had been hospitalised one or more times. Eight of them had been hospitalised more than once, and two of them thrice.

In the last 15 days preceding to survey, a higher percentage of 40.5 percent reported being ill. Among those who were ill in the last 15 days, almost 57 percent (79 out of 138) were also ill a day before survey.

However, neither the hospitalisation nor the illness in the 15 days was equally distributed among all the people, sexes, all castes, and all socio-economic classes. For instance, among 163 females, 48.5 percent (out of 178 individuals) reported being unwell in the last 15 days, while as it was only 33.1 percent among males.

However, with hospitalisation, there was no significant difference along the lines of gender. There was no major difference in incidence of hospitalisation among the lower and middle socio-economic classes, as 6.7 percent out of 225 persons from lower socio-economic classes reported being hospitalised, against 8.6 percent out of 116 persons from middle socio-economic classes. Among the caste groups, the incidence of hospitalisation seems to be little more among other- castes followed by Khan than Ganaie and Gujjars, as 3.2 percent out of 93 individuals from Ganaie/Gujjars reported being hospitalised, while as it was 6.7 percent out of 149 for Khan castes and 12.2 percent out of 99 individuals among other castes.

Among the different occupation groups, the incidence of hospitalisation has been little more among those who were engaged in household work (mostly women), casual labour and who were old and not able to anything.

The illness was little more (but not a major difference) among the lower socio-economic classes with 41.3 percent (out of 225) reported being ill in the last 15 days proceeding to survey, while as 38.8 percent out of 116 persons in the middle socio-economic classes reported being ill in the same period. However, the disparities are little more significant along the lines of caste, as 48.4 percent of reported being ill (out of 93 persons) as compared to 39.6 percent among Khan (out of 149 persons) and 34.3 percent among other castes (out of 99 persons). Again the illness was relatively more among those who were

engaged in household work (mostly women), casual labour and who were old and not able to do anything.

The findings of the NSSO report 507 which revealed that the number of persons reporting any ailment (acute and chronic) during the last 15 days prior to survey in rural J&K were 70 per 1000 persons (7 percent) with a small gender gradient of 69 in females and 70 in males. The report has also revealed that among the ST population, the number of persons reporting any ailment (acute and chronic) during the last 15 days prior to survey in rural J&K were only 69 per 1000 persons (6.9 percent), which was very less as compared to Scheduled caste population, which stood at 79 (7.9 percent), and other higher castes, which stood at 86 (8.6 percent) (NSSO, 2006). However, these findings are contradictory to the findings of this study, which showed that almost 40.5 percent reported being ill in the last 15 days preceding to survey, with gender gradient that 48.5 percent females reported being unwell in the last 15 days, while as it was only 33.1 percent among males. The village study also showed that the disparities are little more significant along the lines of caste, as 48.4 percent reported being ill (out of 93 persons) as compared to 39.6 percent among Khan (out of 149 persons) and 34.3 percent among other castes (out of 99 persons).

This higher level of reporting of illness in the village study as compared to what has been reported in the NSSO study could have two reasons. Firstly, that some part of the village study was carried in the winter months in Kashmir, which are very cold as compared to summer months, and the incidence of some illness like cold, cough and body ache increases. Secondly, that there may be issues with the reporting itself in NSSO methodology. During the first few interviews in this study, the researcher realised that when people are asked if they have been ill in the last 15 days, they tend to recall only those illnesses for which they had sought treatment, and there is tendency not to recall the types of minor illnesses, which are being normalised as part of their life, and don't seek health care for such diseases, due to many reasons. It also seems that some people consider illness only when they had sought health care. The researcher recounts many examples when people first explained the illness when they had sought health care and could recall other minor illness when they did not seek health care only after probing. This is also important to understand that the perception of what would be called and considered as Illness varies among the communities and among the people from different socio-economic classes and regions, depending on their experiences with illness, health services and other

cultural factors. As a result, the perception of investigator and the respondents in village may mismatch and if the investigator cannot understand their perceptions of illness and then explains them considering their perception, and his own perception, there are greater chances of under-reporting of data. There are also chances that women under-report for the reasons of male investigator asking and recording the questions, or being asked in front of male family members. Therefore, if not probed and explained what illness means for this study there is a higher probability of underreporting.

Thirdly, it really matters whether the person who has suffered illness and has sought treatment is available at the time of interview. In many cases, especially when adults are not available at home, and during agricultural season and summer, not many adults can be found in homes, the information recorded from young people in the families looses many things. In many cases, not even all the adults would know the illnesses and treatment sought, especially about women, because in societies like Kashmir, women related health issues are not discussed in families, so some of the family members may not knew about their women suffering from any disease. Sometimes the young adults and other earning members who go outside their village for work on daily basis, may not always know about the illnesses in their family. Therefore, the kind of respondent interviewed has huge influence on the quality of information recorded. In this study, as major part was conducted through the winter months, most of the household members were available at home, and many times, the respondent would get up and ask other family members about the information he/she did not know. This might also be the reason that the prevalence if illness reported in this study is higher than the NSSO findings.

4.5. Access to Inpatient Care:

There were almost 7.3 percent of people (25 individual cases) within the households covered under this study who had been hospitalised one or more times. Eight of them had been hospitalised more than once, and two of them thrice, which adds up to 37 individual episodes. An enquiry was made into issues that these people experience while accessing inpatient care in health facilities. The below section analyse the issues they faced and the narratives of their experiences, which could not have been quantified but reveal more what the numbers could mean.

4.5.1. Type of Hospital:

All the people who reported being hospitalised in the last year preceding to survey were asked, what type of hospital did they seek inpatient care. In majority of cases except three, patients were admitted in public hospitals at different locations from their nearest CHC through DH to state level hospitals in Srinagar. As can be seen from the *table 4.10* About 56.8 percent (21 out of 37) patients had been admitted to either CHC or DH, in seven episodes patients were admitted at state level hospitals in Srinagar, in three cases patients were admitted in private health facilities but all in Srinagar, one patient was admitted in public hospital (Child Hospital) in neighbouring district. In five cases, information was not available because the patient was not available at home and the respondent did not know the details of his/her hospitalisation. All the three patients who were admitted belonged to either Khan or other higher castes.

Table 4.10: Source of Treatment for Hospitalised Cases

Type of Hospital	Frequency	Percent
CHC/DH	21	56.8
State Hospitals	7	18.9
Private Hospitals	3	8.1
Others	1	2.7
Don't know	5	13.5
Total	37	100

Among the three persons who reported accessing private health facility, one reported that at the District hospital there was no facility for MRI, and were asked to go to Srinagar and get an MRI done, so they chose then to admit the patient in a private hospital in Srinagar.

4.5.2. Nature of Ailments:

Information was also recorded about the nature of diseases they suffered through, it was difficult for both the respondents and the investigator to record the nature of ailments in technical terms. However, an attempt was made to get an idea of the nature of disease that could have been. It seems, as can be seen from the *table 4.11*, that the nature of illnesses have been diverse.

However, there were few patients who reported that they suffered more than a single ailment. Nevertheless, the second ailment was majorly related to the main ailment they reported. For instance, the patient who reported had cough, also suffered through head ache; the patient who reported had body ache, also suffered through fever; the two patients who reported had a stone in Kidney, also witnessed passing blood in urine; and the person

who reported was malnourished, was also weak.

4.5.3. Duration of Hospitalisation:

For 10 out of 37, it has taken a single day to stay in hospital, for another 12 patients it has taken 2 to 4 days, for another 3 patients, it has taken 6 to 7 days, and for 7 seven patients it has taken more than 10 days (up to a maximum of 20 days) to stay in hospital for treatment.

4.5.4. Access to Treatment before and after Hospitalisation:

An enquiry was also made if the patients had availed any treatment before hospitalisation. A majority of 73 percent reported availing treatment before being admitted in a health facility. Among those who reported availing any treatment before hospitalisation, a majority (19 out 28) availed treatment from public hospitals, mostly from CHC and DH, and in two cases from state level hospitals in Srinagar. However, a few had gone to private health facilities and few others had availed health services from local healer, MSF dispensary or done self-medication.

Table 4.11: Nature of Ailment for Hospitalised Cases

Ailment	***Frequency***	***Percent***
Heart related	7	18.9
Cough	3	8.1
Stone in Kidney	2	5.4
Physical Injury/ Fracture	4	10.8
High Blood Pressure	2	5.4
Diarrhoea	1	2.7
Chest Inflammation	1	2.7
Shivering	1	2.7
Joint related	1	2.7
Cyst in Belly	1	2.7
Blood in Urine	1	2.7
Malnourished	1	2.7
Body Ache	1	2.7
Head Related	1	2.7
Coma after Birth	1	2.7
Ear Problem	1	2.7
Gastric Problem/ Stomach Related/Ulcer	3	8.1
DK	5	13.5
Total	37	100.0

Among them who had availed treatment, 9 patients availed it up to a week, 11 patients availed treatment for more than a week up to a month, six had availed it for more than a month up to a year and two availed it for more than a year.

Among those hospitalised patients, there were almost 76 percent (28 out of 37) who continued treatment even after hospitalisation, only 3 patients reported not continuing

treatment after hospitalisation, and for 6 patients information was not available (see Table 4.12). All of them who continued treatment, had sought treatment from same source when they had been hospitalised.

Table 4.12: Access to Treatment after Hospitalisation

Treatment	Frequency	Percent
Yes	28	75.7
No	5	13.5
Don't Know/ Not Available	4	10.8
Total	37	100.0

4.5.5. Satisfaction with Health Services:

Although the utilisation of inpatient services was high from public facilities, the satisfaction among many families was very low. The high utilisation of public health facilities might be because of the reason that the inpatient care is very costly at private facilities. Further, this is important to mention that the private health care available in Handwara tehsil or Kupwara town is mostly outpatient care and not inpatient care that might be the reason for high utilisation of public facilities for inpatient care in this village. Since, taking a patient to Srinagar would need incurring much more money than if would have been admitted in a private facility in Handwara or Kupwara, and people find it difficult to arrange logistics for caretakers in Srinagar during the time of hospitalisation.

The dissatisfaction among some of the families was for many reasons including being referred from district hospital to state level hospital; not feeling relief; not being cared properly at government health facilities; long waiting hours; perception of not being examined properly; among others. One of the respondent recalled, "*The doctors have made it a business, otherwise if provided medicines, one should get relief*". Along the same lines, another person narrated, "*During rush, they don't examine properly and while examining they would be talking over phone to somebody. Medicines prescribed would not be much helpful, and even the medical shops give substitute medicine*". He recalled one incident when the medical shop gave him substitute syrup and he showed to doctor who said it is not that medicine he has prescribed but it will work. The patient felt that this should not have been strategy that it would work, rather they should care about patients.

Some people also felt that until the people do not cry for health services in the hospitals they are hardly looked after. This was narrated by a person as, "*Until people cry and make noise, they don't care about patients*". Another recalled that the staff and doctors were hardly caring about the children at State child hospital and said that, "*I was fighting with*

them throughout the time we were there. I had to approach the Superintendent each time...Even if people would die they don't bother". There was also dissatisfaction among the people about the costs being incurred on the health care, and some of them said that the medicines are to be purchased. Another said, "*Even the shopkeepers charge very heavily. I had to buy one cup of tea and one roti for Rs 15*".

Another important aspect was that the people who had sought health care from state hospitals were satisfied with their health services but were equally dissatisfied with the services at the district hospital. One person narrated that they are not satisfied with the District hospital at all but are very much satisfied with services at the SMHS, "*The doctors at SMHS were very cooperative. They stood there until we got cured. There was one doctor who would see our patient almost 3 to 5 times in a day*". There was another person who said that they are not satisfied with DH, "*Doctors at DH had assured that they will conduct the surgery at their own but at last they didn't do it. Finally we had to go to SKIMS*". However, she said that at SKIMS they felt satisfied. On the same pattern, another person narrated, *"I am not satisfied with DH health services. They put plaster and asked that I can walk and move without even doing an X-ray. When I started moving, I was not able to walk and felt pain. After that I went to DH again and the X-ray showed there was no improvement over the time, and then I had to go to State hospital for treatment*".

It is important that how people perceived differences in the quality of care between the DH and state health hospitals, and showed satisfaction with the services provided at state hospitals. It is often narrated by the medicos that people are never satisfied whatever they will do. However, the narratives of same people who were dissatisfied with the services at the district hospital but showed much satisfaction with the health providers at the state hospitals, points to the fact the quality of services and relief shape the perception of the people.

The people who were dissatisfied with the health services were asked what else could be done to make health services better. They explained certain issues that have to be taken care of, which reflected their experiences with health services. For instance, one said, that the waiting time should be reduced and the patients who are seriously ill should be given immediate attention. Secondly, they pointed that the health providers should care about patients. Thirdly, the doctors posted at the district hospital should be intelligent and

experienced. Probably, this person might have been pointing to the fact that if better experienced and intelligent doctors are posted at district level hospitals the referral to state level hospitals would be reduced. Another person expected when there are facilities available at DH to make proper diagnosis, why they were referred to state level hospital for health care. There was also an expectation that if doctors can't treat a patient, he/she should be told that the doctor doesn't have a capacity but they do it only when the illness reaches to its peak and then refer patients to state hospitals.

There was also a demand about regulating private medical shops. One person said, "*Private shops sell medicine at costly rates. What one could get for Rs 100 in Handwara will be sold in Zachaldara for Rs 300*". Similarly, people also demanded that government must ensure that the poor are provided medicines free. However, they felt that doctors have a vested interest in government not providing medicines. One person narrated, "*Because they get commission, they want us to buy medicines from market, which is also duplicate. This is just business for them*" (*duplicate term was used to mean a very inferior quality or of different company*).

4.5.6. Affordability to Inpatient care:

The inpatient care is very expensive even in public hospitals, and involves both the direct and indirect costs. The direct costs include expenditures made on consultation, surgery, medicines, diagnostic tests, ward/bed charges, transport/ambulance charges and food charges for patients. Other than these diverse costs, people have to spend money on the travelling, lodging and food for escorts who accompany a patient in the hospital until he/she is discharged from hospital. Further, the patient as well as the escorts loose their work and wages, or have to bear other losses, especially if they are engaged in the unorganised sector.

This is one of the important aspects of access to understand the extent of expenditure made by the people who need hospitalisation. The macro-data from NSSO survey shows that on an average total expenditure incurred by the households per hospitalised case during last 365 days was Rs. 5666 in rural J&K, lesser than in rural India where the counter figure was Rs. 6225. In addition to this, there was an average loss of household income of about Rs 1,377 in rural J&K (636 for India) per hospitalised case. The medical expenditure

(excluding other expenditure) was much lesser, Rs. 4,463 in rural J&K and in Rs. 3,238 in rural India, in government health facilities than in other non-government services, mostly private, where an average of Rs. 10,145 in rural J&K (Rs. 7,408 for rural India) have to be incurred per hospitalised case. (NSSO, 2006).

An attempt was also made in this study to make estimates about the costs incurred by the people on the inpatient care and detailed information was recorded on many aspects. However, there were problems in collecting precise information about the different types of expenditures as not many respondents would remember the costs, in detailed way, incurred by them in the last year. In some cases the hospitalisation would have ended up to a year earlier, and was difficult for anyone to remember these details. Further, there were cases, that the costs were incurred by particular family member and others may not have an exact idea.

People were asked did they spend money on consultation, surgery, medicines and diagnostic tests. As can be seen from the *table 4.13* that in most cases the consultation has been provided free for most patients who had been admitted in public hospitals. A majority of the people reported spending money on the medicines. A good percentage of people had spent money on diagnostic tests, and few were charged partially for their tests.

Table 4.13: Details of Medical Services Received on Payment by Hospitalised Cases

Medical Service	Frequency	Percent
Consultation		
On payment	4	10.8
Free	29	78.4
Don't Know/ Not Available	4	10.8
Total	37	100
Surgery		
On payment	2	5.4
Not received	30	81.1
Don't Know/ Not Available	5	13.5
Total	37	100
Medicine		
On payment	27	73.0
Partly Free	3	8.1
Don't Know/ Not Available	7	18.9
Total	37	100.0
X-ray/ECG/EEG/Scan		
On payment	13	35.1
Partly Free	5	13.5
Not received	12	32.4
Don't Know/ Not Available	7	18.9
Total	37	100
Other Diagnostic Tests		
On payment	9	24.3
Partly Free	2	5.4
Free	1	2.7
Not received	17	45.9
Don't Know/ Not Available	8	21.6
Total	37	100

There were four major heads of expenditures that people had made: medicines, tests, ambulance/travel and loss of household income/wages.

As most people reported buying medicines even if they were hospitalised in public hospitals, people were asked what is the amount that they spend on medicines. The estimates varied a lot across people from up to Rs 100 to 30000. In 43 percent cases, adequate information was not available, average expenditure could not be estimated. However, as the *table 4.14* shows, for some of the families, the costs have gone up to Rs. 30000. Such huge expenditures may result in other household problems like distress sale of assets, borrowing money from employers; children dropping out from schools.

Table 4.14: Expenses Incurred on Medicines by Hospitalised Cases

Expenses in Rs	***Frequency***	***Percent***
100 to 500	5	13.5
1000 to 3000	4	10.8
3000 to 6000	3	8.1
30000	1	2.7
500 to 1000	4	10.8
6000 to 12000	3	8.1
Upto 100	1	2.7
Dont Know	16	43.2
Total	37	100.0

Similarly, the diagnostic tests have required good amount of money and varied from Rs 50 to Rs 6000 per hospitalisation case. For 5 patients, the diagnostic tests have cost more than Rs 1000, and for few up to Rs 6000.

The travel costs are equally high, as in most cases, the patient had to hire a private vehicle to reach hospital. In fact not all the referred emergency cases are provided ambulance and even if ambulance is provided they charge heavily. The travel costs have varied from Rs 30 to Rs 4000 in a few cases (see table 4.15).

Table 4.15: Expenses Incurred on Travel by Hospitalised Cases

Expenses in Rs	***Frequency***	***Percent***
Up to 50	4	10.8
50	10	27.0
100 to 200	5	13.5
200 to 500	3	8.1
500 to 1000	4	10.8
1000 to 2000	2	5.4
2000 to 4000	3	8.1
Dont Know	6	16.2
Total	37	100.0

Similarly, as mentioned earlier, many households loose some part of their household income, either of the patient him/herself or of other members. Some of the people reported losing money more than Rs 1000 to Rs 6000.

Other than these major costs, the people had to spend money on the food and transport of the family members who escorted the patient and stayed in the hospital during this time. In 13 patients, the expenditure has been up to Rs 50, but in 5 cases, the expenditure has been between Rs 100 to Rs 300, and in another 6 cases, the expenditure has shot up to between Rs 1000 to 5000.

The information on few heads of costs was not available for many patients. However, if the recorded costs are added the average costs per hospitalisation for 30 hospitalised cases (for 7 cases, there was lot of deficit in information), are much higher of almost Rs. 5729.

4.5.7. Source of Finance:

It was an important question to raise and investigate how these families managed such a huge expenditure on hospitalisation, considering that 21 out of 37 hospitalisation cases belonged to lower socio-economic classes; and 33 out of 37 belonged to officially recognised BPL/AAY category; and a majority belonged to lower occupation groups like 8 were casual labours, 16 were doing household work, three others were studying, one was old, three had small shops/or were artisans. Infact, such a high expenditure may be difficult even for a middle class family to manage from their own savings.

All the families were asked this question how did they manage the expenses on hospitalisation, and many distressing stories were narrated. There were families who reported that they had some savings and managed expenses at their own. However, in majority of cases, people had borrowed money from relatives and friends, and from their employer or a fruit trader, considering their own socio-economic status in the village and social networks. As the expenditure had gone up, some families did not cope with it up on their own and had to borrow money later. This was narrated by many families. One respondent puts it as, "*When Shafi was ill, we managed expenditure from own savings but when Saida was ill, we borrowed Rs 500 from a relative*". Another said, "*Some expenses were managed from own own savings but a larger proportion was borrowed from neighbours and relatives. There are still Rs 5000 to be paid back*". There were families

who have not been able to pay back that borrowed money until the survey, which made them further vulnerable to debt or may not being able to access health services, if a new health problem sets in among any family member during this time.

Not all the poor people are lent money because there may be no assurance of money from them soon. However, the socio-economically well off people may have financially sound relatives and friends who lend them money because there is assurance they will return money immediately. As a result, many poor families had borrowed money from employer or fruit traders in return for labour or annual apple produce, as the condition may be. This was narrated by some of the families. One respondent narrated that, "*We had some savings and managed expenses for initial hospitalisations but my father had to borrow money from his employer for next episodes*". This was the family belonging to lower socio-economic class, who had a BPL card, It had to manage expenditure for five hospitalisation cases in a year (one member was hospitalised three times in a year and another two times). Therefore, with such a high expenditure on hospitalisation, it is very difficult for a BPL family to manage the expenses and so becomes vulnerable to debt.

One respondent narrated, "*We had to borrow money from orchard traders to whom we sell our apple produce...*" Another said, "*We borrowed money from our employer but are not able to repay the debt fully until now. Rs 3500 are yet to be paid*". Now, borrowing money from a trader in return for an annual apple produce or from an employer in return of labour have other severe implications on the family. It may restrict their choice of changing employer over the period they don't pay back the money, or in case of apple the rates may be compromised.

The implications of high expenditure incurred on hospitalisation do not end with just borrowing money from relatives, friends or employer. Rather it penetrates into other aspects of family and sometimes has severe consequences. Some of the families reported selling assets to cope up high expenditure. One respondent reported, "*We had borrowed some money from a friend but had to manage the high expenses from sale of domestic animals*". Another adds, "*We borrow money from our relatives at the time of illness but for the treatment of Yasmeena we did borrow money from one relative but had to sell few trees to repay the debt*". Another narrated, "*We borrowed money from relatives and also sold a cow as a distress sale to get treatment*". Another said, "*We sold a cow as a distress sale*

for Rs 10000 only". One another family narrated, "*We had to sell a cow, a bull and a goat for Rs 20,000*".

There were a few families who, though managed immediate expenses, later had to sell assets to repay the debt. On the same lines, one person reported, "*We sold trees to repay the borrowed money*". Another added, "*We sold a half Kanal of irrigated land for Rs 40000 in emergency and returned some borrowings. We didn't get proper rates for land*".

One family, in the Gujjar hamlet, explained that they could not borrow money. "*From whom*?". Their neighbours and relatives are poor, and this compels to sell their assets to be able to afford to pay for the high expenditures. She says, "*No one here would have few thousands available*". This family had to sell their only cow to get treatment and said, *"Last time they had sold cow for Rs 10,000 to get treatment. We had only one cow and now I have got a cow from my bother"*

4.5.8. Social Protection Measures:

It seems that against such catastrophic expenditures there are no social protection measures accessible to people in this village that could have helped the poor sections to cope with high expenditures or distress situation that has resulted because of hospitalisation. Not even a single family reported any reimbursement they availed against medical expenditures, across all occupations. It seems that the government scheme, "RSBY" does not work at all in this area. Further, the employers do not seem to extend any health service or reimbursement to people.

4.5.9. Discussion:

What was important to understand, with such a high expenditure on hospitalisation, the middle class are not also able to afford and most of them had borrowed money. In poor families even if they borrowed money they had sold their assets to repay their debt, which in turn makes them more vulnerable to poverty. *Therefore, the concept of affordability has to be looked relative to level of health expenditures*. And what we may call middle socio-economic class or APL family, may not be able to afford health care if the costs are high, but if the costs would have been low even the poor families could have been able to afford health care. It seems that to make inpatient health care accessible to all socio-economic classes, the health care costs have to be reduced, otherwise at any point of time and at any

costs there would be some sections of people who would be excluded or pushed to further poverty. As the costs will lower, more sections of society can afford health care, irrespective of their socio-economic conditions.

4.6. Access to Outpatient Care:

There were 40.5 percent (138 out of 341) of people who had reported being ill in the last 15 days proceeding to survey. Among those who were ill in the last 15 days, almost 57 percent (79 out of 138) were also ill a day before survey. The disease burden was not equally shared among sexes, all caste groups, and all socio-economic classes. Among 163 females, 48.5 percent (out of 178 individuals) reported being unwell in the last 15 days, while as it was only 33.1 percent among males out of 178. The illness was little more (but not a major difference) among the lower socio-economic classes with 41.3 percent (out of 225) reported being ill in the last 15 days proceeding to survey, while as 38.8 percent out of 116 persons in the middle socio-economic classes reported being ill in the same period. However, the disparities are little more significant along the lines of caste, as 48.4 percent reported being ill (out of 93 persons) as compared to 39.6 percent among Khan (out of 149 persons) and 34.3 percent among other castes (out of 99 persons). Again the illness was relatively more among those who were engaged in household work (mostly women), casual labour and who were old and not able to anything.

Table 4.16: Period of Illness during last 15 days

Days	***Frequency***	***Percent***
1 to 2	17	12.3
3 to 4	18	13.0
5 to 6	23	16.7
7 to 8	15	10.9
9 to 10	5	3.6
15	53	38.4
Don't Know	7	5.1
Total	138	100.0

4.6.1. Period of Illness: An enquiry was made into the number of days a patient has been ill within the reference period of last 15 days, and total ailing days, as can be seen in the *table 4.16*. A majority of patients of about 38 percent have been ill for all the 15 days within the reference period of last 15 days preceding to survey, followed by almost 17 percent who reported of being ill for about 5 to 6 days. Further, 13 percent said that they were ill for 3 to 4 days and 12 percent were ill for 1 to 2 days. The data also point out that the period of illness within the reference period has been relatively more among females, lower socio-economic classes and BPL categories, as can be seen from the table 4.17, below.

Table 4.17: Period of Illness during last 15 days by Sex, Socio-Economic Class and Ration Card											
Days		***Sex***			***Socio-Economic Class***			***Ration Card (from Govt)***			
		F	M	Total	L	M	Total	APL	BPL	None	Total
1 to 2	Count	12.0	5.0	17	11	6	17	2	14	1	17
	%	70.6	29.4	100	64.71	35.29	100	11.8	82.4	5.9	100
3 to 4	Count	6.0	12.0	18	10	8	18	7	8	3	18
	%	33.3	66.7	100	55.56	44.44	100	38.9	44.4	16.7	100
5 to 6	Count	14.0	9.0	23	14	9	23	1	22	0	23
	%	60.9	39.1	100	60.87	39.13	100	4.3	95.7	0.0	100
7 to 8	Count	11.0	4.0	15	11	4	15	3	12	0	15
	%	73.3	26.7	100	73.33	26.67	100	20.0	80.0	0.0	100
9 to 10	Count	3.0	2.0	5	3	2	5	0	5	0	5
	%	60.0	40.0	100	60	40	100	0.0	100	0.0	100
15	Count	29.0	24.0	53	42	11	53	7	46	0	53
	%	54.7	45.3	100	79.25	20.75	100	13.2	86.8	0.0	100
Don’t Know	Count	4.0	3.0	7	2	5	7	0	7	0	7
	%	57.1	42.9	100	28.57	71.43	100	0.0	100	0.0	100
Total		79.0	59.0	138	93	45	138	20	114	4	138

The total period of illness could have been more than what was reported within the reference period because for some time the illness had started before the reference period and continued for some days within the reference period. When asked about the total duration of illness, 24 percent had been ill each for 1 to 4 days and 5 to 8 days. Almost seven percent were ill for 8 to 16 days, 16 days to 1 month and 1 to 4 months each. There were also almost 23 percent of patients who have been ill for more than a year up to 12 years now (see table 4.18).

Table 4.18: Total Period of Illness for Non-Hospitalised Cases

Period	***Frequency***	***Percent***
1 to 4 days	33	23.9
5 to 8 days	33	23.9
8 to 16 days	10	7.2
16 days to 1 month	10	7.2
1 to 4 months	10	7.2
4 to 8 months	1	.7
1 to 3 years	15	10.9
4 to 8 years	13	9.4
9 to 12 years	4	2.9
Don't Know	9	6.5
Total	138	100.0

These people have been suffering from long term chronic diseases that included hypertension, diabetes, breathlessness, disc prolapse, nerve related problems, heart related problems, and stone in different parts of the body. In addition they also included other minor illnesses like body ache, joint ache, fever and head ache. This can be seen from the *table 4.19*. This points to the fact that due to everyday frequent occurrence of some of these minor diseases, people internalise them and see them as part of their normal life, therefore, the is tendency of under-reporting in such cases, if not probed.

Table 4.19: Total Period of Illness for Non-Hospitalised by Nature of Ailment											
	1 to 4 days	***5 to 8 days***	***8 to 16 days***	***16 days to 1 month***	***1 to 4 month***	***4 to 8 month***	***1 to 3 year***	***4 to 8 year***	***9 to 12 year***	***Don't Know***	***Total***
Stomach Ache	3	0	0	0	2	0	0	1	0	0	6
Leg/joint Ache	1	2	0	0	2	0	5	3	0	0	13
Head Ache	0	8	1	1	1	0	1	3	1	0	16
Fever	9	4	2	0	0	0	0	0	0	1	16
Cough	12	13	3	4	1	0	1	1	0	3	38
Cold	13	15	1	0	0	0	0	0	0	0	29
Body Ache	7	2	3	1	0	1	2	1	0	1	18
Back Ache	0	0	0	0	2	0	4	1	0	0	7
Fracture/Injury	1	0	0	0	2	1	0	1	0	0	5
Diarrhoea	2	0	1	0	0	0	0	0	0	0	3
Scabies	2	2	0	0	0	0	0	0	0	0	4
Stone	0	1	0	0	0	0	1	0	0	0	2
others	2	1	2	3	2	0	6	5	3	0	24
Ear related problem	0	0	1	1	0	0	0	1	0	0	3
Personal problem *(Not shared)*	0	0	0	0	1	0	0	0	1	1	3
Hypertension	0	1	0	1	0	0	2	4	0	0	8
Heart related	0	1	0	0	0	0	1	0	0	0	2
Don't Know	0	0	0	0	0	0	0	0	0	4	4
Total	52	50	14	11	13	2	23	21	5	10	201

4.6.2. Nature of Ailment:

An enquiry was also made into the nature if illness the patients suffered through in the last 15 days prior to survey. A majority of patients of about 19 percent had suffered from cough; 14 percent suffered from cold; 9 percent suffered from body ache; 8 percent each from head ache and fever; 6.5 percent suffered from leg/joint ache, among others problems, as can be seen from the *table 4.20*.

Table 4.20: : Nature of Ailments during last 15 days

Ailments	***Frequency***	***Percent of Responses***	***Percent of Cases***
Stomach Ache	6	3.0%	4.3%
Leg/joint Ache	13	6.5%	9.4%
Head Ache	16	8.0%	11.6%
Fever	16	8.0%	11.6%
Cough	38	18.9%	27.5%
Cold	29	14.4%	21.0%
Body Ache	18	9.0%	13.0%
Back Ache	7	3.5%	5.1%
Fracture/Injury	5	2.5%	3.6%
Diarrhoea	3	1.5%	2.2%
Scabies	4	2.0%	2.9%
Stone	2	1.0%	1.4%
Ear related problem	3	1.5%	2.2%
Personal problem	3	1.5%	2.2%
Hypertension	8	4.0%	5.8%
Heart related	2	1.0%	1.4%
Others (1)	24	11.9%	17.4%
Don't Know	4	2.0%	2.9%
Total	201	100.0%	145.7%

Note: Although the number of people who were ill were only 138, the number of diseases are more as some of them reported suffering from more than one illness at a time

1. Others include being undernourished, unconsciousness, thyroid, mouth ulcers, inflammation of chest, Hip Ache, Disc in Leg & Neck, Diabetes, Dental Pain, Blood with Stools, Back related, Arm Ache, Nerve Problem in Legs, weakness, Neck Ache, Nose Blocking, Migraine, violent behaviour , eye Sight Problem

4.6.3.Present Status of Ailment: People were also asked about the present status of ailment, did they feel relieved of the ailment, and a little more than half of them reported that they were ill and didn't relieve until the time of survey (see table 4.21)..

4.6.4. Access to treatment:

All those people who had reported being ill in the last 15 days prior to survey were asked if they had received treatment anywhere (including treatment by self-medication, from RMP, local healers). It

was reported by a majority of almost 83 percent patients that they did seek treatment for their illnesses. However, a significant portion of 15 percent patients reported not being able to receive any treatment for their illness (see table 4.22).

Table 4.21: Present Status of Persons Ailing during the last 15 days

Status	*Frequency*	*Percent*
Continuing	70	50.7
Ended	63	45.7
Don't Know	5	3.6
Total	138	100.0

The NSSO report 507 has also revealed similar results that percentage of spells of ailment treated (non-institutional) during 15 days were 82 percent for rural J&K and 94 percent for urban J&K.

What is striking from the data is that there were no significant differences in access to treatment along the lines of gender and socio-economic class. However, it shows that there are some disparities in access to treatment among the APL and BPL categories. Among APL patients, only 5 percent (one out of 20) reported not being able to seek treatment, where as among BPL patients, almost 17 percent (19 out of 114) reported not being able to seek treatment. This points to the disparities that may exist between the rich and poor.

Table 4.22: Access to Treatment by Ailing Persons during the last 15 days

Treatment Availed	*Frequency*	*Percent*
Yes	114	82.6
No	21	15.2
Don't Know	3	2.2
Total	138	100.0

As mentioned earlier that the socio-economic conditions in Kashmir are on an average better as only 4.5 percent were poor as per Planning Commission in 2004-05, as against 28 percent in India (Saxena, 2009). Therefore, a large section of population may be able to access treatment. However, the disparities could exist in other forms like in terms of source of treatment (which may reflect quality of care), continuity of treatment, able to rest during illness, access to nutrition, and among other issues.

4.6.5. Source of Treatment:

An enquiry was made about the sources of health care for the people in the village. All those respondents who reported accessing treatment were asked from where they received the treatment. A majority of almost 60 percent of them reported that they did receive treatment from public hospitals (mostly CHC and DH), followed by 18 percent who

reported receiving treatment from a medical chemist in the village, 14 percent received treatment from private hospitals/doctors and 7 percent reported receiving treatment from other sources (which included MSF dispensary in 4 cases) (see table 4.23). It is surprising even though a majority of illnesses that people suffered were minor illness – cough, cold, body ache, headache and diarrhoea- that could have been treated at a functional Sub-centre /or a dispensary, but only one patient reported receiving treatment at a Sub-centre. This can be taken to mean that the Sub-centre does not function at all in the village, at least as the first point of treatment seeking for minor ailments. The NSSO report 507 reveals that out of those who reported receiving treatment, 52 percent reported receiving treatment from government health facilities and 48 percent from private institutions in rural J&K, which is similar to our data.

Table 4.23: Source of Treatment for Ailing Persons during the last 15 days

Source of Treatment	***Frequency***	***Percent***
Public Hospital	68	59.6
Sub-centre	1	.9
Private Hospital/Doctor	16	14.0
RMP	21	18.4
Others	7	6.1
Don't Know	1	.9
Total	114	100.0

There are disparities in source of treatment across different socio-economic classes, though the disparities are not sharp. For instance, almost 54 percent (19 out of 35) from middle socio-economic classes reported receiving treatment from public hospitals, as against 62 percent (49 out of 79) from lower socio-economic classes reported receiving treatment from public hospitals. 20 percent from middle socio-economic class (7 out of 35) had sought treatment from private hospital/doctors, as against 11 percent (9 out of 79) from lower socio-economic class. Further, 14 percent (5 out of 35) of middle socio-economic class had sought treatment from local chemist, as against 20 percent (16 out of 79) from lower socio-economic class. This is further added to the fact that 25 percent (10 out of 40) of Gujjars/Ganaie (poorest castes) had sought treatment from the local chemist, as against 14 percent (7 out of 50) from Khan castes (powerful and rich castes) and 17 percent (4 out of 24) from other middle castes.

Along the lines of APL and BPL categories, the disparities are much sharper. Almost 32 percent (6 out of 19) from APL category reported receiving treatment from public hospitals, as against 65 percent (60 out of 92) from BPL category reported receiving

treatment from public hospitals. Whereas 30 percent from APL category (6 out of 19) had sought treatment from private hospital/doctors, as against 11 percent (10 out of 92) from the BPL category.

4.6.6. Reasons for not using Public facilities for Health Care:

An attempt was made to understand why did some people used private and other health services. The main reasons what people reported included dissatisfaction with doctors working in public hospitals, perception that same doctors examine better in their private clinics, logistic related issues like non-availability of transport and its costs, non-availability of medical staff in the late hours, non-availability of money on time, expensive treatments like doctors write more prescriptions for their own commissions, and among other issues. One of the respondents illustrated his perception about the doctors as, '*The doctors are kings and write prescriptions for Rs 500 to 1000 even for minor ailments. They hardly care and are looters*". He further added, "*Recently I took my grand child to a Paediatrician who hardly bothered to examine him seriously but prescribed medicines for Rs 350. The next day, as the child did not feel relief, I took him to a Unani medicine shop and he was relieved at the shop only. RMPs prescribe very less medicines*". Some of the quotations, which explain the multiple reasons of why people choose not to go to public hospitals, are put in the box below:

Perception of People about the Public Health Services
"The person at Sub-Centre does not come regularly".
"The mother had gone to DH earlier but didn't get relieved and later went to private hospital clinic at Sopore"
"The doctors do not examine patients at government hospitals and we are compelled to go to their private clinics".
"The dispensary is far and it was late that centre would not have been open".
"The best doctors don't see patients in OPD but only see referred cases that take a lot of time to reach to them".
"The public facilities are far and have to put cost on transport".
"Shafi felt pain in late evening, so we took him to the nearest RMP to get some medicines".
"I had taken treatment from state hospital, SMHS, but I could not go there this time and my brother asked me to come to Baramulla. Going to SMHS takes a couple of days for travel, getting appointment and doing tests, but at Baramulla this very quickly done"

"I don't have money to go to Govt hospital"
"I don't get relieved of suffering when I get treatment from Govt Hospital"
"He was not feeling relieved".
"Dispensary don't have medicines available"
"At government hospitals they don't care, so we think it is better to go private health care where one can benefit"
"At CHC, we have to buy medicines in any case"
" I was told that private doctor is very good and comes to Handwara once a week"
"She said that some people had suggested her that the private doctor was good to consult"
" Safeena was going to PHC, Wadipora but she didn't feel relieved and then went to a private doctor at Srinagar"
"Only because they don't take interest at government hospitals"
"He examines patients with interest and properly because he gets money for it"

Further, some people did not perceive differences between the private or public health care. It was not more than a difference of Rs 50 to 100, which is paid as consultation fee to doctors at their private clinics. Some of them felt that in both cases people have to purchase medicines – a major expenditure, from the market and the doctors are the same in both government and private hospitals. Same doctors attend private clinics in the mornings and evening and in the day attend the government hospitals. So, just the difference is that people to have to pay consultation fee, but they perceive much difference in quality of care and waiting time. One person explained this as, *"Because the private doctors examine properly and it doesn't take much to consult a private doctor"*. Some of them feel that it takes long time to avail the treatment at government hospitals, however, at private clinics; they are able to save much of their time. Therefore, that has an implication on their financial aspects. For instance, a person who attends a government hospital looses a full wage day (almost Rs 200 to 250), and he/she can earn wages if he attends private clinic in the morning or evening. Further, many of the respondents felt that the same doctors examine properly in their private clinics and even some felt they do not prescribe unnecessary medicines, because they get incentives through consultation fee. However, as in case of public hospitals, they write extensive prescriptions for they are paid commission from the market on the medicines purchased by people. One person narrated a story that last year the woman (patient) was taken to DH and consulted a lady doctor. "*We were made to do many tests for Rs 5500. But she didn't get relief. Later her husband was told to take*

her to another lady doctor at her private clinic and she prescribed medicines for Rs 300 only and then she got relieved. Since we go to this private clinic only".

This raises an important question about the satisfaction of people from public health facilities, even when people felt that in terms of facilities the government institutions are much better equipped. So, it was important to ask people *did they feel satisfied with the health services and health providers in the public health facilities*, and their answers are analysed below.

Is it just that because of the rush at government hospitals the doctors don't examine properly or is it an intentional act to develop perceptions among the people that private care is a better option for them, after all the doctors are same at both places, and running private clinics goes towards their favour ? This question is still unanswered, however, there are some clues from the narratives of people how private care providers are creating dependency among people that they have to consult private clinics only, and that is suitable for them. This is being analysed later in the maternal and child health services section.

The next question to be asked is, why did people go to the local medical chemist (referred as RMP) in their village, even when there was a Sub-centre in the village, and a medical assistant was employed there, and the other health facilities were at an easy distance as compared to other areas of Kashmir? A few people with different reasons explained this. The important ones included accessibility in terms of close proximity, availability during late hours, inexpensive and treatment given on credit.

Some said that the RMP was accessible easily in the village; therefore, it was much better to consult him without wasting time to visit the longer distanced public facilities. Some even preferred RMPs for minor illnesses and felt that he is competent for that. For instance, one person said, "*Their patient went to an RMP and didn't seek treatment in any hospital as she was suffering from a minor illness. Headache is a common problem for her*". Another added, "*The RMP is good in treating minor ailments. In case there is major illness that can't be tackled by him we go to the CHC/DH*". Some felt that RMP is close and does not involve transport charges to reach him. Others said, "*If our patient will fall ill in the late evening, we have to hire a vehicle to go to the hospital. That is why we go to RMP for immediate health care*" .

The RMP also enjoyed the trust of people. One person said, "*He is very good, otherwise, many would have died here*". Another adds, "*He is very experienced, even if he examines patients with closed eyes, the patient gets cured*".

The most important reason was related to affordability of people to seek health services. As the Sub-centre was completely dysfunctional, the people have to go down almost 5 kms to reach CHC, but the transport facility is available only till 4 to 5 p.m in the evening. Therefore, to reach the hospital after 5 p.m people had to hire a private car, which added almost Rs 250 to their cost, so they prefer to buy medicines from the RMP only, at least to save that Rs 250. That might be the reason why the RMP opens his shop in this village only after 5 in the evening, and this was explained to this researcher by a youth in front of his shop when he enquired from him why the RMP was always closed in the day. Further, as mentioned earlier, that most of the people have to borrow money to buy costly medicines and RMP is only person who provides medicines even to poor people on credit, and the private medical shop don't give them that option. So, if people don't have money available for them, which is in most cases, they tend to consult the RMP. This plays a crucial role especially for the households where men are out for work and can return only in the evening, therefore, there is no money available at home in the day. It has been seen that the money is always controlled by men only, and women don't have access to the money in their homes. So, the RMP who is the only one who gives them medicines on credit, is resorted to. Some women explained to this researcher that there are times when they do not have money available, it is only men who can borrow money from others, and we have to wait until their return. Importantly, people felt that the RMP is very patient and waits for money for long time. Thirdly, some people also said that the RMP is available on call even during night hours. If any person falls ill anytime in the night, and he is called, he has always ensured that he would come. Now, this becomes important factor in the political situation of Kashmir, where people are scared of moving out after the late hours, and as explained in earlier chapter that the security forces block the road at two places during night hours and didn't allow people to travel through, even in cases of emergency. In such cases, a person coming home with medicines has much more meaning for people who otherwise would have suffered badly due to lack of care.

4.6.7. Reasons for not Accessing Health Care:

This study also tried to look into the reasons for people not being able to access health services when they were ill. Almost 15 percent (21 out of 138) had reported not availed any treatment. The issues that came included that in few cases there was no need felt by people, some adapted traditional local practices and most importantly was affordability to seek health care.

Some people reported that they did not feel the need to seek health care. Some of them illustrated that these illness are part of their life and therefore are seen as normal, they can't keep relying on medicines each day. One person, who said, 'This is a regular event with me', best narrated this. *"I am a labourer and after a hard work for the day, I feel body ache, and I can't afford to go to seek treatment regularly"*. Another person articulated the same as he puts it, *"We didn't feel the need for getting medicines and the patient got cured on their own. We know that the he will get cure from this illness in couple of days"*. *A*nother person sees cough as normal and felt that one cannot start going to take treatment for such things.

It is important to mention that health problems depend much on the experiences of people with health problems and institutional services and would vary among people depending on their culture and socio-economic factors, and upon the access to health services.

Many of them had actually tried local practices, though not called treatment within NSSO methodology, however, irrespective of its benefits and need, it does point to the health consciousness and behaviour of the people. One person said, "*We washed their feet with warm salted water for the cold and they did feel some relief from cold*". Many other people explained that they try local remedies and if a patient is not improved in couple of days, then we take the patient to seek treatment. This raises the important question on not considering adopting local remedies for illness as treatment, as in NSSO methodology.

An important question arises if they wanted to seek treatment why did not they try to access medical treatment. This is because some of them felt that there was no need of seeking treatment and they have experiences that in some of the illness local remedies do help. Further, for some of them, there were broader issues of not being able to afford health services. A majority of people said that they did not had the money to buy the medicines.

There was a perception among the people that if they go to hospital to seek health care they would be asked to buy medicines at high rates, and as they cannot afford, they decide not to go to hospital. This is important, as mentioned earlier that type and quality of health services, would influence the health behaviour of people and on their access to health services, this is how the perception of costly health services among people of this village have affected their access to health services. In one household, the researcher discovered that among the few patients in the family, their mother has not sought health care. When asked, her elder son and head of household said, "*Mother had denied"*. On further probing, the respondent said that he felt that his mother had thought of the expense and lack of money. Many others said they did not seek health care for not having money. One person said, *"I don't have money to seek treatment, even going to a government health facilities would require money to buy medicines. They don't provide medicines"*. *Another person said, "I didn't seek treatment due to unavailability of money as I am a very poor person. I am afraid that it may cost huge amounts of money for treatment"*. He further added, *"I just bow my head to God and pray for better health, as I can't manage money to go to doctor"*. *F*or this person reaching to God was easier than to see a Doctor. There was another person who discontinued her treatment even if she had felt relief for not being able to afford health care, and one of their family members said, "*She had gone and was relieved but is not going now because we don't have money to visit the doctor*". Few others said they had no money to buy medicines. One parent said his child is suffering from haemorrhoids (blood in stools) and his child has told them recently a month ago. However, the parent said the child would required a surgery and he doesn't have money to take him to a doctor, therefore, he was planning to take him in the next month when he can manage some money for treatment

However, the issues were not just limited to affordability but also about the time taken to reach health facilities and to return. In some families, the household work had to be managed otherwise would have allowed people to move out and spend a day to avail health care. The researcher happened to visit one of the poorest families on a day when one of their women had fallen down into a drain and got injured, but they did not rush her to hospital. On asking the reasons, her husband said, "*We had no ration available at home and we had put paddy for drying up in the sun that is why I was waiting and had thought once I will pack paddy, I will take my wife to the CHC. I had no problem in sending her alone but she will not agree to travel alone to CHC*".

Also, the experience that medicines help only when taken and do not cure, would also affect the health behaviour of people if they want to seek health care. Some people reported this that they do not get cure by taking medicines there is only timely relief.

In a way, the inaccessibility to health services becomes interplay of many aspects that collectively affect the ability of people to seek health care. One person, who best illustrated this, said, *"Firstly, I didn't had anyone to accompany me to hospital to take care of me while in hospital. My wife is from Calcutta and cannot be much helpful in hospitals here. Who will take care of two children at home? Secondly, I did not have money to afford the treatment. One is aware of the fact that it costs huge money to get treatment"*. He further said, *"I would have managed to get a person to accompany me if the health care would have been absolutely free"*.

4.6.8. Satisfaction with Health Service System:

The quality of services and satisfaction of people from health facilities is an important aspect and influences the health behaviour of people and the utilisation of particular types of health services – public, private and RMP. So, it was important to ask people, *did they feel satisfied with the health services and health providers in the public health facilities* ? Although many people did recognise that in terms of facilities the government institutions are much better equipped, the reaction of being satisfied was mixed.

There were some people who said that health providers are cooperative at the CHC and DH. There were people who showed much satisfaction with the services being provided at a dispensary in the neighbouring panchayat by MSF. One person narrated that at DH earlier there were no facilities and no staff. Now there is good staff and facilities have improved. They examine well and this has helped us lot. One person who had taken a patient to a state hospital said, *"He has got relief and is satisfied with the attitudes of health providers. Doctors speak very politely*". A few even appraised the RMP. One said, *"RMP is a very good person and even comes in the night to treat people in the village just by making a phone call to him"*. Another said, *"Unani RMP treats well. He deserves an award"* .

Many people reported that they were satisfied with the services they received and with the health providers. But many people showed their concern over the quality of services provided especially at government health facilities. Some level of dissatisfaction comes

from whether people have felt relief after taking medicines. For instance, one person said, "*We are satisfied with this doctor. But earlier they had consulted a Physician and Psychiatrist but there was no relief. Then they went to Neurologist and there is some relief*". Another added, "*we are not satisfied for not getting relieved at all. We feel little relaxed after taking medicines but then nothing has worked out*" . Another said, "*They give medicines but the patient doesn't feel relieved. We do not understand why he is not getting well*". One other person who has been visiting many doctors and didn't feel relieved said, "*Now I am hopeless*".

The question arises, is it a problem of diagnosis or ineffective medicines that do not work properly? Some people pointed to both these issues, that was the reason why few demanded intelligent and experienced doctors especially at DH, and some said that the doctors get commission on prescribing certain medicines and therefore, they prescribe only those medicines, even if they are ineffective. However, there was other concern that was relevant to diagnosis that people felt doctors don't examine properly, so they don't get relief properly. One woman who had just returned from the DH and had consulted the lady doctor there, told the researcher, *"The doctor was talking to somebody else and wrote a prescription for me. I am not satisfied with her examination. The staff hardly cares about people and doesn't examine properly"*. Another said, *"No we are not satisfied. The hospitals do not provide any medicine. The prescribe medicines which have no effect on our health. It is useless. The doctors work in a hurry, and don't take pains to look after patients"*. Another person when asked said in a very cynical way of being unsatisfied with health providers as, *"What can I say about a doctor by whom our child got worse"*.

The doctors get commission on prescribing certain medicines was best illustrated by a person, who said, "*The medicines prescribed are not good. We spend Rs 200 to go to hospital and then we return with a couple of pills, not even worth the Rs 200 we just spent on transport. He further explained that doctors are getting commissions for prescribing some medicines in terms of concessions and gifts. I was asked to do a sugar test and that was ok, but still was prescribed medicines. If test was to be done yet, how come he could prescribe medicines for the illness"*.

Was there a mismatch between the expectations of people and the facilities and quality care provided to the patients? Certainly it was. That was the reason many people were

much concerned about medicines not being provided at all and patients being asked to buy costly medicines from the market. One person said when asked if he was satisfied, "*No we are not. Whenever we go to DH, they prescribe medicines to be purchased from outside the market. Whenever we go to health centre, he will hand over two tablets and would say he doesn't get any other supply, whether injections or syrups*". Some people said there are no facilities in government hospitals, and even if there are, they do not provide. One person said that he went to Govt. Hospital in Baramulla district, a neighbouring district, because at DH, Handwara, there are no facilities of plaster for fracture. Another person said, "*They even charge for all tests and X-rays*". There was also a concern about the inadequacy of staff, as said by one person, "*There is only one doctor who attends OPD*". "*If they would have given half of the medicines I would have been satisfied. We have to purchase all medicines. They are not helping at all. They are even willing to drink our blood. If we would have been helping each other we would not have problems of Army here*", was stated by another person (by Army he meant conflict in Kashmir).

However, there are many other aspects of dissatisfaction among some of the people. There were concerns about medicines not being provided and long waiting hours. One old man said that he did not recover and it takes a full day to get treatment at CHC. At DH one has to wait for more than 2 to 3 hours to get their turn. Another said, "*It takes almost two hours to get our turn*". Further, few people said that at government hospitals they don't care and one has to wait for hours, even if the patient may be very serious.

There were questions raised also by the people on accountability, transparency and monitoring in government hospitals. A person best narrated this, as "*They don't provide medicines at all. There is no monitoring, if they feel like it they will treat, otherwise they will ask to come the next day. In the medical dispensary, I had gone yesterday; they provided few tablets but did not give any injection. They sell it to RMP*". Another said, "*The doctors do not give us satisfying services. They come at 12 a.m and leave by 3 p.m only and then run their private clinics. They don't provide us free medicines. However, if we go to see them in their private clinics, they give good services and examine properly for 10 minutes. In government hospitals same doctors don't examine properly*".

The impression this researcher got was that there was more of anger among people how they are being treated at hospitals and distress they suffer due to costly medicines, than just

being dissatisfied. This dissatisfaction was more because of no provisions of medicines at health facilities and instead of getting them to buy costly and huge medicines, for the sake of commission doctors get.

4.6.9. Changes to be introduced in Health Services:

Because of some of the people not being able to access treatment for their illness, and widespread anger and dissatisfaction among the people about the quality of services and provisions of free facilities at health facilities, people also expected that some reforms must happen in the health service system. Among the major changes that people wanted included some of the basic things like provision of free medicines, adequacy of staff, proper examination of patients, doctors come on time, and polite attitude among the providers.

One of the major demands that people put forth were for the provision of free medicines from health facilities. Some asked for all the medicines, some asked for at least half of the medicines, and some poor families looked for free medicines for the poor, who can't afford such costly medicines.

The other demand was that doctors must come on time and regularly to hospitals and should examine patients properly, What was important that some people said that medical staff should care about all people --poor and rich. This was best narrated by one person, and said, "*Medical staff should care about poor and rich people equally. They just put hand on pulse and give some lines in prescription. Doctors say that he will examine properly only if patients can come on Sunday to his clinic. This should not have been the case*". This reflects that some people perceive differences in treatment at public health facilities on the basis on class.

Few people demanded for adequate staff, and felt that there is an adequacy in staff in health facilities. One person said, "*There is shortage of doctors and even among few who are deputed, not all will be present and at maximum one doctor will come but there will many more patients to be examined*".

There was also an expectation from the health providers to be polite and explain to patients about the illness, which would encourage them rather their present attitude discourages them.

Importantly, some people raised the basic question what affects the quality services and put a strong demand that government must ban private practice. Few people felt that doctors working with government should not run their private clinics, and that affects the quality of services and their commitment to provide quality services in public hospitals. One person explained this as, "*The government doctors should not run their private clinics. They are paid heavily. If they do not run their private clinics, there will be huge differences in their services*". Another added, "*Government should completely ban private practice, as government is providing good money to them. They give two minutes and charge Rs 150 at private clinics, and in government hospitals they would come by 11.30 a.m only*".

Table 4.24: Details of Medical Services Received on Payment by Ailing Persons during the last 15 days

Medical Service	Frequency	Percent
Consultation		
Free	95	83.3
On payment	15	13.2
Not received	2	1.8
Don't Know/ Not Available	2	1.8
Total	114	100
Medicine		
On payment	95	83.33
Free	4	3.51
Partly Free	4	3.51
Don't Know/ Not Available	9	7.89
Total	114	100
X-ray/ECG/EEG/Scan		
Not received	96	84.21
On payment	6	5.26
Partly Free	3	2.63
Don't Know/ Not Available	9	7.89
Total	114	100
Other Diagnostic Tests		
Not received	88	77.19
On payment	13	11.40
Partly Free	2	1.75
Free	2	1.75
Don't Know/ Not Available	9	7.89
Total	114	100

4.6.10. Affordability to Outpatient Care:

The major issues about the affordability to health services have been mostly discussed and analysed from people's perception in the earlier section. People have explained how costly the health services have turned to and showed their inability to afford to such costly services, which has also resulted into increasing inaccessibility of some people to health services.

Therefore, two important questions need to be answered. *Firstly, how much money has to be spent on health care, and is there a difference in costs incurred while accessing health care from different sources. Secondly, how do people manage the costs that they incur on costly outpatient care?*

As can be seen from the *table 4.24*, that the consultations have been mostly free except in 15 cases, who had sought health care from private clinics/hospitals. However, most of the people have paid for medicines. Just four persons reported getting medicines free and four reported getting partly free. Those who had got absolutely free reported accessed health care from MSF and one from ASHA. The majority of people paying for the medicines would have been the reason that most of people did bother about quality, costs and provisions of medicines prescribed at health facilities. Further, a total of 9 persons had to make an X-ray/ECG/EEG/Scan and 17 had to do other diagnostic tests. Among all these, only three reported being charged partially for X-ray/ECG/EEG/Scan. Two others reported partially charges for other tests and another two reported free.

Amazingly the data also shows that 11 out of 15 who had paid for consultations were females, and the reasons seems to be that among those who had sought private care, most of them were females. There was no major different in paying for medicines along the lines of gender. Similarly, not a major difference was noted in paying for consultation and medicines along the line of socio-economic class. Further, that 9 out of 15 who had paid for consultation were Khan, as they had sought private care.

This may not necessarily mean that there are no disparities in charging people for services, rather it is because of the fact the paying to health care services is near to universal and almost everyone is being charged, which doesn't leave spaces for discrimination, inclusion or exclusion.

4.6.11. Costs Incurred on Outpatient care:

the NSSO report 507 reveals that the average expenditure (medical and other related expenditure but excluding loss of household income/wages) for non-hospitalised treatment per ailing person during last 15 days was high as Rs. 394 and 478 for rural and urban J&K, while as it was only Rs. 285 and 326 in rural and urban India (NSSO, 2006). That would mean outpatient health care is much expensive in J&K than India.

An attempt was also made in this study to make estimates about the costs incurred by the people on the inpatient care and detailed information was recorded on many aspects. However, there were problems in collecting precise information about the different types of

expenditures as not many respondents could remember the costs, in a detailed way. But most of them did remember the costs incurred by them in the last 15 days.

There are many direct and indirect costs people have to bear to seek health care including consultation, medicines, diagnostic tests, travel, food and costs of caretakers. Some of them also lose wages or have to bear loss in their household income.

Consultation: All those people who reported paying for consultation were asked how much did they pay, and a majority of them of about 10 cases (out of 15) had paid Rs 100, two each paid 50 and 60 Rs and one did pay Rs 150.

Medicines: Among those who paid for medicines, partly or full, a majority of 22 percent paid Rs 101 to 200, 19 percent paid Rs 201 to 400, 17 percent paid 401 to 600, and in 10 percent of cases, people have paid in the range of Rs 601 to 1600, which is huge amount. Across the sources of treatment, costs seem to be lesser for those who have sought health care from RMP (see table 4.25).

Table 4.25: Expenses Incurred on Medicines by Ailing Persons during the last 15 days

Charges in Rs	Frequency	Percent
100	11	11.1
1001 to 1600	6	6.1
101 to 200	22	22.2
201 to 400	19	19.2
401 to 600	17	17.2
51 to 100	2	2.0
601 to 1000	4	4.0
Up to 50	9	9.1
Don’t Know	9	9.1
Total	99	100

Table 4.26: Expenses Incurred on Diagnostic Tests by Ailing Persons during the last 15 days

Charges in Rs	Frequency	Percent
100 to 200	3	14.3
200 to 500	4	19.0
50 to 100	4	19.0
700 to 1200	2	9.5
Up to 50	6	28.6
Don’t Know	2	9.5
Total	21	100

Diagnostic tests: Only 21 persons had to pay for X-ray/ECG/EEG/Scan and other diagnostic tests, and among them six persons paid up to Rs 50, four persons paid Rs 50 to 100, three persons paid Rs 100 to 200, four persons paid Rs 200 to 500 and in two cases people have paid Rs 700 to 1200. Not only had a single who sought treatment from RMP did any test (see table 4.26).

Food Costs: Only 33 people reported bearing expenses for food/tea snacks, and among them a maximum of 25 cases reported paying up to Rs 50, four said Rs 51 to 100, and two reported paying Rs 101 to 300. The people who sought treatment from RMP did not report any expenses on food/snacks.

Travel/Ambulance: Among the 89 who said paying for the travel charges, a majority of almost 43 percent had paid Rs 31 to 50, 37 percent had paid up to Rs 30, 10 percent reported spending Rs 51 to 100 and almost 6 percent had spent Rs 101 to 200 (see table 4.27).

Table 4.27: Expenses Incurred on Ambulance/Travel by Ailing Persons during the last 15 days

Charges in Rs	Frequency	Percent
101 to 200	5	5.6
31 to 50	38	42.7
400 to 600	3	3.4
51 to 100	9	10.1
Up to 30	33	37.1
Don't Know	1	1.1
Total	89	100

Travel charges of Escorts/care takers: In many cases, the households had to bear the travel costs of caretakers who would accompany patients to health facilities. Among them 30 percent had spent up to Rs 30, 44 percent had spent Rs 31 to 50 and 12 percent had spend Rs 101 to 250 on travel (see table 4.28).

Table 4.28: Expenses Incurred on Travel of Escorts by Ailing Persons during the last 15 days

Charges	Frequency	Percent
101 to 250	6	12.0
31 to 50	22	44.0
51 to 100	7	14.0
Up to 30	15	30.0
Total	50	100

Some of the caretakers had to spend money on food/snacks while accompanying the patients, and in majority of cases people have spent Rs 10 (out of total 11 case who reported spending).

Loss of Household income: Seven people also reported that they had to lose some household income for accessing health care, and five of them said Rs 150, one person reported Rs 800 and another Rs 1000. A majority of people not reporting any loss of wages/household income is because this study was conducted in winter months, and most casual labourers don't find jobs during that time, and usually sit in their homes.

Total Expenditure on outpatient care: Even as the information on few aspects of costs have not been available for many patients, the recorded costs if added and taken an average for all 114 cases who sought treatment, the average costs per case are much higher of almost Rs. 449. The table 4.29 gives the detailed information about the expenditure people incurred in accessing health care.

Table 4.29: Total Expenditure on Inpatient Treatment by Ailing Persons during the last 15 days

Charges in Rs	Frequency	Percent
Zero	6	5.3
1 to 100	29	25.4
1001 to 1500	6	5.3
101 to 300	31	27.2
1501 to 2000	5	4.4
2501 to 4000	2	1.8
301 to 600	21	19.3
601 to 900	13	11.4
Total	114	100.0

However, the costs show a trend that private care involved relatively more costs, while the RMP's treatment much less, as can be seen in the *table 4.30* below:

Table 4.30: Total Expenditure on Inpatient Treatment by Source of Treatment												
Charges	***Public Health facilities***	***% Public facilities***	***Private Care***	***% Private care***	***Others***	***% Others***	***RMP***	***% RMP***	***Don't Know***	***% Don't Know***	***Total***	***%Total***
0	1	1.4	0	0.0	3	42.9	1	4.8	1	100.0	6	5.3
1 to 100	12	17.4	0	0.00	2	28.6	15	71.4	0	0.00	29	25.4
101 to 300	23	33.3	3	18.8	1	14.3	4	19.0	0	0.00	31	27.2
301 to 600	20	29.0	2	12.5	0	0.00	0	0.00	0	0.00	22	19.3
601 to 900	6	8.7	6	37.5	0	0.00	1	4.8	0	0.00	13	11.4
1001 to 1500	3	4.3	2	12.5	1	14.3	0	0.00	0	0.00	6	5.3
1501 to 2000	3	4.3	2	12.5	0	0.00	0	0.00	0	0.00	5	4.4
2501 to 4000	1	1.4	1	6.3	0	0.00	0	0.00	0	0.00	2	1.8
Total	69	100.0	16	100.0	7	100.0	21	100	1	100.	114	100

4.6.12. Source of Finance:

After looking into the primary question of extent of expenditure involved in outpatient health care, the second pertinent question to investigate into is whether people can afford such costly health care, and if not how do they cope. This was important considering that among the people who sought treatment, the illness was little more (but not a major difference) among the lower socio-economic classes with 41.3 percent (out of 225) reported being ill in the last 15 days proceeding to survey, while as 38.8 percent out of 116 persons in the middle socio-economic classes reported being ill in the same period. Further, prevalence of illness was more among poorer castes in the village as 48.4 percent reported being ill (out of 93 persons) among Gujjars/Ganaie, as compared to 39.6 percent among Khan (out of 149 persons) and 34.3 percent among other castes (out of 99 persons). Again, the illness was relatively more among those who were engaged in household work (mostly women), daily wage labourers and those who were old and not able to do anything.

Against the high costs of health care even at public health facilities, it was found that not a single person got a reimbursement and not a single person was provided any service by his/her employer. This is important to provide protection to people against certain risks, especially for which they will find difficult to afford.

The researcher felt that the outpatient care was not as compelling as hospitalisation has been, probably the cost involved in each hospitalisation are huge as compared to outpatient care. Many people told that they managed expenses from their savings. However, many others said that they borrowed money from their neighbours, relatives and friends. Few people said that they have not returned the money that they had borrowed for health care. One respondent said, "*I borrowed money from a local shopkeeper until my husband will return and he will repay him back*". Another person said, "*He owes almost Rs. 30000 to people for medical reasons*". However, the stories did not end. As with hospitalisation cases, some households had to take loan/credit in return of labour or agriculture/horticultural produce. One respondent said this, "*We have borrowed Rs 500 from a shopkeeper. We will have to work for him to repay his money*". Another said, "*Each time I had to borrow money from fruit traders, I would have to work for them to repay his debt*". Another said, "*I have borrowed money from a fruit trader and he will cut it from annual returns of the apple orchard*".

Few others cope with selling of agriculture/horticultural produce. This was narrated by one person who said, "*I had to sell a bag of walnut to manage expenses*" Another said, "*I had to sell four hens*".

Other person expressed their inability to afford health care but also showed dissatisfaction with the quality of care. He narrated, "*We borrow money from my friend for medicines. We are very poor but health is wealth and at the time of illness, we do everything to treat disease. But it is very unfortunate that the hospitals don't provide us proper services which we need. Doctors do not care about our pains. We borrow money but it is wasteful as prescribed medicines are not effective*".

In the 50 households, an enquiry was also made into the access of mothers to maternal health services. All those women who had given birth to a live child in the last three years preceding the survey were asked about their access to maternal health services, especially antenatal, delivery and postnatal care. Further, an enquiry was made into all the children who were under 3 years of age if they had access to child health services, in particular to immunisation and nutrition. A total of 19 children were under three years of age in these 50 households which were covered under this study. The next chapter presents the findings of the study on all these aspects.

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CHAPTER–5: MATERNAL AND CHILD HEALTH SERVICES

5.1. Access to Maternal Health Services:

Maternal health services are important aspects of health service system. This study attempted to explore the access of women, who had given birth to a live child in the last three years preceding the survey, to maternal health services, and the findings of the study are analyzed in this chapter. *The pertinent questions, which this section of this chapter attempts to answer included: whether all women from different socio-economic classes access maternal health services; if not, why; are there felt needs to access maternal health services; and what are the issues with access in terms of quality of services and affordability, among others.* As the sample turned very small, the attempt made is to present a discussion on the access issues with maternal health services.

5.1.1. Access to Antenatal Health Services:

The NFHS survey gives an account of access to maternal and child health services. The NFHS-3 data shows that among women with a live birth in the five years preceding the survey, the percentage of women who had access to three or more antenatal check-ups (ANC) during the pregnancy for their most recent live birth were 73.5 percent.

This village study has revealed only 10 women out of 19 reported registering their pregnancy with ANM (see table 5.1). Further only eight women out of 17 [34] reported having a registration card. However, irrespective of less registration with ANM, all of them reported being able to consult a health provider for antenatal check-up, and all of them had seen a doctor. The question arises if all of them had seen a doctor for ANC check-up, why were all not have a registration card and why not all were registered with the ANM. The reasons seems to be the fact that only 9 of them had utilised the health services from the public facilities and 8 women had consulted a private doctor for their ANC (see table 5.2).

Table 5.1: Access to ANC Services

Services	*Frequency*	*Percent*	*Total*
Registered Pregnancy with ANM	10	52.6	17
Registration Card	8	47.1	17
Consulted Anyone for ANC	17	100	17

[34] For two women information was not available at all, as they were not available at home, and the respondent did not know anything about their access to maternal health services. This implies that the maternal health services are treated as private matters, and men are not supposed to know this, even in same family.

It is being recommended that pregnant women must do her at least three ANC check-ups. However, there were only two women who reported that they had only two ANC checkups, and interestingly 12 of them said that they had four or more than four checkups, up to 15 for one case (see table 5.3). Instead of enquiring about a usually asked question why women didn't have access to a minimum three ANCs, the pertinent question here was to find out how women have been able to access more than 3 ANCs. For the two women, who had sought ANC only two times, one said she did not know that a woman should seek ANC thrice, and another said that money was not available and there was some work to do. For the others who had ANC more than 3 times from a private clinic, one woman narrated that, "*Dr Fareeda asked to come every month and advised to take medicines regularly, which included some tonics and some medicines to cure illness"*[35].

Table 5.2: Source of ANC Checkups

Source	Frequency	Percent
Govt. Hospital	9	52.9
Private Clinic/Hospital	8	47.1
Total	17	100.0

Table 5.3: Number of ANC Checkups

Number	Frequency	Percent
2	2	11.8
3	3	17.6
4	3	17.6
5	1	5.9
6	3	17.6
9	1	5.9
10	2	11.8
15	2	11.8
Total	17	100.0

In fact, seeking ANC was a felt need among many women and many perceived it good for health of women. This was best narrated by a woman, who said, "*Earlier there were many reasons that killed pregnant women and people never came to know any of problems. Now the ANC checkups ensure that both women and child are ok*". Even during an interview with a woman where her husband was sitting, the husband said, "*it is important to seek ANC"*.

It is important that as part of ANC whether important aspects of care are being provided and discussed. An attempt was also made to find out as part of ANC care what services provided (see table 5.4). Only abdomen has been checked for all, blood pressure has been checked for only 13 and the advise on nutrition has been given to only 11 women. Weight has been measured for only 7 women, among the 17 who accessed ANC. As a majority of

[35] Dr Fareeda, a gynaecologist, is working with government as well as is running a private clinic for maternal and child health services.

women are anaemic during their pregnancy, therefore, it is important to monitor weight of pregnant women if she is weak, which could have implications for her pregnancy and the child. The increase in weight over the months of pregnancy is also an indicator for monitoring the health of the pregnancy. More than 50 percent women have done ultrasound, which seems unnecessary. Only 11 women said that they were told where to go if they had any pregnancy complications.

Table 5.4: Nature of ANC Services Provided

Services	Received	Percent
Weight Measured	7	41.2
Blood Pressure Measured	13	76.5
Urine Test	15	88.2
Blood Test	15	88.2
Abdomen Checked	17	100
Advise on Hospital Delivery	14	82.4
Advise on Nutrition	11	64.7
Scan/Ultrasound	9	52.9
X-ray	9	52.9
Iron folic acid/syrup	10	58.8
Tetanus	14	82.4

Further only 10 women reported being given iron folic tablets or syrup. Fourteen women reported they were given any tetanus injection. Other than the services, it is also important that women have access to nutritious food during pregnancy, and they reduce physical work. That was the reason that ICDS entitles pregnant women to a meal. Not all the women felt that they had eaten nutritious food during their pregnancy. Only nine women said they had nutritious food more than normal during pregnancy. Further, not all women felt that they did reduce the amount of physical work during pregnancy. Four women said they did not reduce their workload.

To make the ANC services accessible and effective, the health service system relies on the grass root level workers like ANM, LHV, AWW and other community health workers, and it may be unnecessary to visit a hospital each time. However, it seems that they are not accessible at all, and not many women reported meeting them or even knowing them, as analysed later in this section. In fact, the researcher found that there has almost been no community meeting organised by any health worker. Further, there was no knowledge among these women about the minimum number of ANC checkups they should do. Therefore, it would depend on the doctor they consulted to determine their visits. *Why would a doctor like them to come as often as some of them have visited him/her?* All of the

8 women who had seen a private doctor have reported consulting him/her for four or more times (two reported for 15,other one reported for 9, another two reported for 6 times). All of them had actually gone to a female doctor, who has established a clinic at few kms distance from Handwara, but a location that is at easy reach to both Handwara and Kupwara tehsils. She is working with government but runs her private clinic as well, as it seems that she has acquired a good reputation that most of the women this researcher spoke with knew her clinic. So, each visit of a women to her would fetch her clinic for Rs 100 as consultation fee. A few women reported that they have been asked for such number of visits. In fact, her general recommendation seems to be one visit for each month of pregnancy, even if there are no complications. However, the private doctor may not be interested only in consultation fee but runs as part of her clinic a laboratory and a medical shop. It was interesting to find out that almost all women reported purchasing medicines as part of ANC. Pregnancy was being treated as an illness. *Why women still prefer to consult her only was also a result of another factor that she would not otherwise admit a woman for delivery in her clinic, even if it was an emergency.* This rule compelled the women to consult her for ANC, so that they can deliver baby at her clinic if needed to. This creation of dependency is further discussed in the section on delivery services.

An attempt was also made to see how much *women have to spend money on ANC services.* Among 17 women, 14 reported incurring expenditure on ANC services in terms of paying to doctor, medicines and diagnostic tests. Twelve women also reported bearing indirect costs in terms of travel, food and loss of wages for care takers/escorts.

Many women reported incurring costs on tests and medicines and in some cases where women sought private care, then consultation fee additionally. In almost all cases, women reported spending on travel as well, and for one ANC check-up to reach SDH hospital, it would cost Rs 30 for a woman on return fare, and if accompanied by any family member the cost would add up to be double. However, in cases the woman was consulting a private clinic (in most cases, it was Dr Fareeda's clinic at Chogal), the return fare for a person would be Rs. 70. In a few cases, women also reported that their husband lost wages as well for the days they accompanied them for ANC. Some women felt that although there are facilities for doing tests in hospitals, they are being asked to take a test outside hospital, and this is because the doctors get commission on each test they prescribe. One women best narrated this, and said, "*Although they have facilities but because they have tied up with*

private clinics, they send patients outside for tests". Another added, *"All tests were charged and done outside hospital"*

So, the next question was *how did they manage these expenses* of not only transport and consultation fee in case of private health care, but in majority of cases, medicines and tests have been done as part of ANC, which people felt was being done for getting commission from market or to earn money in cases of private clinics. A few said they managed the expenses from their savings, a few more said they borrowed money, and in one case, the woman said *she used to sell eggs to manage expenses for ANC*.

As the respondents turned to be very small in number, which further are divided into different categories, therefore, it was not possible to do any analysis along the line of caste and economic class. However, the data did show a trend towards favour of upper castes and higher socio-economic class. For instance, among the eight women who went to seek health care at private clinics, five women were APL, and among the nine who went to public facilities, seven were BPL. Further, among the 10 women who reported that their weight was not measured seven were BPL. All of the APL women had any family member/husband present during their ANC visits, while four among 10 BPL women reported not having anyone present from the family during the ANC visit. In most cases their husband are daily wage workers, who have to go to work and could not accompany them. Among the 17 women, the three who reported not being injected tetanus during their pregnancy were all BPL. Further, among the nine women who reported not being provided any registration cards for their pregnancy, included all the four women from Gujjar/Ganaie castes. Among the four women who reported meeting with any of the community health workers during the third trimester of their pregnancy, not even one was from Gujjars/Ganaie castes. Similarly, all of the seven women from middle socio-economic class reported having some family member present at the time of ANC visit, while it was only six women out of the other 10 who said so. Further, all the seven women from middle socio-economic class reported being injected tetanus, while as only 7 out of 10 among lower socio-economic reported being injected tetanus. Among the four women who reported meeting with any of the community health workers during the third trimester of their pregnancy, three belonged to middle class, and only one to lower class (out of 10).

5.1.2. Access to Delivery Care:

The women who had a live birth in the last 3 years were also asked where they had given birth to their baby. 41 percent reported giving birth in a private hospital, and an equal proportion of 29 percent each had given birth at home and public hospitals (see table 5.5). Nine of them were assisted by a doctor, three by ANM/Nurse and five by Dai (traditional birth attendant). All of those who were assisted by a Dai had delivered at home. Five women had a caesarean section.

Table 5.5: Place of Delivery

Delivery	***Frequency***	***Percent***
Home	5	29.4
Public Hospital	5	29.4
Private Hospital	7	41.2
Total	17	100.0

Out of the seven babies who were born in private hospital, six were male children. *Does it have any relation with sex of child?* It seems yes. Out of these six women, five had done ultrasonography and were therefore likely to know about the sex of their chid. All the five women who delivered their baby at home had reported that they did not do any ultrasound during their pregnancy. Further, among the five who delivered at home, four belonged to lower class.

The women were asked what do they feel about giving birth in health facilities, and many of them felt it is much better to go to a hospital than deliver at home, as they get relief and care at health facilities. One best narrated this as, "*The women and child may die during delivery so it is better to go to a hospital*". Another narrated, "*It is better to go to hospital, one would die at home without care*".

The researcher spoke to ASHAs about the reasons why did women choose to deliver at private institutions. One of the ASHAs explained that there was no Gynaecologist in SDH hospital (CHC) for long time, and most of the women would start doing ANC checkups in a private clinic (which was run by a female Gynaecologist) and then would choose to deliver baby at the same clinic. However, the ASHA felt a huge difference occurred after a female Gynaecologist was deputed at SDH hospital recently. Many women have shifted to SDH for ANC and delivery, and only a few would go to private clinic. Again, she said that a labour room has been constructed in a dispensary, where male staff is deputed, at a distance of 2-3 kms uphill from this village and ASHAs have been directed by BMO to take women to that dispensary only and not to SDH. However, as male staff is there, many

women don't agree going to that dispensary, and she said, ASHAs are being scolded by the BMO if they take a women to the SDH, as result many women are again going to private clinics.

Interestingly, there was one other factor that was discouraging women not to go to public health facility but would admit in a private clinic. Many women told this researcher that they do not go to DH for delivery as generally the delivery cases are referred to State maternity hospital at Srinagar. So, they choose to attend a private clinic only. Few husbands even justified this that going to private clinic turns to be less expensive for them as compared to visiting any state hospital. For Srinagar, they have to hire a car back and forth (will cost 2500 to 3000 Rs) and then bear the cost of caretakers/ escorts. Further, they find it difficult to arrange logistics for caretakers/escorts. The question raised, *why did DH refer most of the delivery cases*, and one women explained to this researcher that those women who will deliver during night time are being referred in the evening only by the staff, as they don't want to wake up during night-time. These referrals had nothing to do with any emergency or critical situation that has to be dealt at super speciality hospital, because many of them then go to a nearby private clinic (not comparable to district hospital in any case) and they deliver their baby without complications. One husband narrated this, *" We didn't know that a woman has to give birth at a health facility for JSY benefits. Finally we went to Doctor at DH but nurses didn't admit her and asked us to go to Lal Ded hospital as she may have some problems in delivery but then we went to a private clinic of Dr. Fareeda and she admitted her at her clinic only*" (Lal Ded is state maternity hospital at Srinagar). The husband further narrated, "*All those women who nurses feel may give birth during night-time are being referred to another hospital. Nurses don't want to work during night-time*".

Other than this push factor from government hospitals, there were pull factors as well from this private clinic. Many people told this researcher that the doctor at private clinic does not admit a pregnant woman easily at the time of delivery if she has not been consulting her for ANC, and would say to them that if there were any complication, who would take responsibility? One person who was father-in-law of an ASHA, sitting during an interview with ASHA, narrated, "*The women who go to government hospital/other places for ANCs are not admitted by Dr. Fareeda at her clinic at the time of delivery*". This was illustrated by another person who recalled his experience of taking his wife to Dr. Fareeda's clinic for

her delivery. He narrated that her wife was taken to CHC for delivery during late evening but they neither admit her nor was provided ambulance for referral. Then she was taken to Dr. Fareeda's private clinic. He said that he knew that Dr. Fareeda would not admit her, as she was not consulting her for ANCs, he lied to doctor that they have been consulting her for ANCs. However, they have forgotten registration card of her clinic in hurry. Only then, with lot of requests, the doctor allowed her to be admitted at her private clinic.

As people had experienced that in many cases District hospital refer the pregnant women to Srinagar, but to use the services from the private clinic, the only option left in Handwara, pregnant women would have been attending the clinic for ANC check-ups. This was in a way, that the private clinic, trying to control the choice of women, and exploit the situation that District hospital don't provide services, there was no other health facility nearby for handling deliveries, and going to Srinagar or nearby district Baramulla would be much costlier. This might be that ANC is fetching the private clinic more money than just delivering a child at her clinic, because, they get women to do many ANCs, a minimum recommendation of one visit each month of pregnancy. Each ANC visit pays Rs 100 as consultation fee, diagnostic charges to laboratory and medicine and tonics to the medical shop.

There was another angle to this. A few women felt that there is no privacy for women in most of the hospitals, and this is an important concern for women. One husband even explained that as his wife is very uncomfortable in sharing some of her problems with a male doctor and then he explains to a doctor himself. This adds to why some women prefer going to a private clinic, which is being run by a female doctor. One woman narrated this, "*At private clinic women are comfortable in sharing problems with a female doctor and at government hospital women are not comfortable in talking to a male doctor and many times husbands have to explain to the doctor about their problem and the women are embarrassed. Therefore, women in this village go to the private clinic only*".

In only four cases out of 12 women who delivered at health facilities, ASHA had accompanied pregnant women to the institution. Out of these four cases, three belonged to middle class and among castes, three belonged to Khan caste and one to other middle castes. On asking women *why did ASHA not accompanied them for their delivery at health institutions,* a few either didn't know who ASHA was and was she expected to accompany

them or reported that in their hamlet there was no ASHA appointed by then and a few others said that ASHA never turned up to see them. There was also sympathy for ASHA not accompanying women at the time of delivery. One woman said, "*She can't come during night time, otherwise she had come to motivate me earlier*". This researcher spoke to ASHA and was told that there were presently two ASHAs in the village, one had been working from last more than 5 years, and another recently appointed almost a year ago. The second is specifically appointed for the area, which includes the Gujjar hamlet (Shatigam Nagni) but she herself comes from a Kashmiri family. Among many others issues discussed, the new ASHA blamed the Gujjar community for not being willing to give birth at institutions. The same question was asked to many people in that Gujjar hamlet and most of them didn't know ASHA at all, one that she belongs to a Kashmiri family and comes from the main Shatigam village, secondly she visit the hamlet only occasionally, and therefore she misses many pregnancies in that hamlet, both to record and to accompany them. It may not be possible for the Gujjar community to call ASHA to accompany their pregnant woman for hospital especially during night. It is important to understand that Kashmiris do discriminate against Gujjars and some of them treat them not less than 'untouchables'. This was also obvious in the attitude of the newly appointed ASHA who blamed Gujjars for everything. This researcher asked the Namardar and Panch member why ASHA has been appointed from a Kashmiri hamlet, and they said when she was appointed there was no female who had passed matriculate from Gujjar community. Among all why this new ASHA was working, when she did not get many incentives (incentives for ASHA are performance based) and she doesn't like working with Gujjars. The reason was that both ASHAs spoke of the hope of being regularised in the health department in the future. So, this was a job that she wanted to hold, even if it takes to work with a community that she doesn't like.

The researcher also spoke to ASHA about the problems they face and how much their family supports them in this work. One of them narrated that her husband tells her that it would be much better if she can sit at home, and her husband would pay her more than what she is earning. However, she said that she has stuck to this job hoping that it may get regularised one day like the way it happened with AWWs. When they started their job, they were being provided small honorarium and now their salaries have increased to Rs 3700 per month. She also said that it becomes very difficult to leave home and accompany any women to hospital during night-time, and many people do not call them during night-time.

She further said it would be very difficult to motivate our own families to leave during nighttime, as everyone in Kashmir is scared of moving out in night due to the conflict situation prevailing in Kashmir.

Among the 17 women, only three reported receiving any benefit under JSY, though five had delivered in public hospitals. Infact the five women who delivered at home were entitled to Rs 500 under National Maternity Benefit Scheme but it seems that this has been stopped after JSY has taken off. All the three have received Rs 1400, and among them one reported paying bribe to get benefit. All the three belonged to middle class; two belonged to Khan and one to others castes. One woman who was eligible for this entitlement but did not receive, said, "*We had visited Sopore hospital three times but they make us run, so we gave up following the case*" (She had delivered at Sopore government hospital). Among the three who received money under JSY, one woman reported that her husband said that he paid bribe of Rs 60 to collect the money.

Women were also asked what they feel about JSY. Few of them said it is a very good scheme and provide much help during delivery. However, one woman said the JSY scheme is good but it is the workers duty to provide services to people, as she had felt that the benefits under the scheme don't get delivered to the people.

An attempt was also made to see *if women have to spend money for giving birth at health facilities and how much it is.* Among 17 women, 16 reported incurring expenditure on delivery services in terms of paying to doctor, medicines and diagnostic tests (see table 5.6). Twelve women also reported bearing indirect costs in terms of travel, food and loss of wages for care takers/escorts.

Table 5.6: Expenses Incurred on Delivery Services

Expenses	***Frequency***	***Percent***
Yes	16	94.1
No	1	5.9
Total	17	100.0

The main costs included consultation fee, bribe in few cases, medicines and diagnostic tests in few cases. The costs have added up to a huge amount. Two women, who had given birth at public hospitals, reported paying to nurses (in one case Rs 2000), other than incurring money on medicines. Few other women who had delivered at a private clinic reported spending Rs. 2400 to 5500 on medicines, consultation fee and diagnostic tests. On an average, the private clinic would charge Rs 1100 to 1400 as consultation fee, and other

charges for medicines and test. It seems that delivery was relatively much cheaper at home. One woman, who delivered at home, said they paid Rs 500 to Dai, and another had paid Rs 1000 to Dai.

Other than this, most women had to hire a car to reach the health facilities, and it costs Rs 800 to 1500 in most cases. In one case, the women reported that they had spend Rs 2550 on transport. With public hospital, as CHC and DH are nearer than the private clinic, the costs were lesser on transport.

The women were asked how they managed the expenses they incurred on delivery care. A few women (4 of them) said they managed expenses from their own savings. In majority of households, they had to borrow money either from their friends and relatives or took debt from employers/fruit traders. In one case, they had to sell a cow to manage expenses.

With such high costs involved in both public and private institutional delivery, provisioning of Rs 1400 under JSY as an incentive to promote institutional delivery seems to be not making much sense, as women have to incur more than what they are entitled under JSY – if at all they would be able to get the amount.

In the same context, women who delivered at home were asked *why they didn't deliver at institutions*. Two of them said that they felt labour pain and immediately delivered a baby at home. One another said the child was born 15 days earlier than the expected date given by doctors. One woman narrated that they had financial problems and could not have afforded delivering at a health facility. She further said, that her other two children were born in a private hospital. This is important experience and reflects how affordability influences the health behaviour of people, and determines their access to health care. For this woman who had delivered two children at a hospital, why she would have chosen to delivered her second baby at home. As mentioned earlier, that health experiences shape perception and health behaviour of people. This was explained by a woman, who stated, "*I had gone to deliver my first baby at private clinic, and she created huge problem. I lost blood and then she wanted us to go to Srinagar in the night. We fought with her and then treated me. After then I have chosen to deliver at home and given birth to three children at home. It was very bad experience"*.

5.1.3. Access to Post Natal Care:

An attempt was made to enquire if the women who had given birth to a baby did have access to PNCs. The women were asked before they were discharged from health facility after child was born did any health personnel checked on their health, and 10 out of 12 women who had institutional delivery women reported they had a check up before they were discharged. Further all the women were asked in the two months after child was born, did any health personnel, anganwadi worker, or traditional birth attendant check on their health, 13 out of 17 women said no one checked their health.

Women were asked if they had any complication during pregnancy, delivery or post partum period. Two women reported that they experienced pain in the body, but took medicines. However, in one case, a woman had complications after giving birth at home and then she was taken to SDH (CHC) hospital at Zachaldara, 5 kms distance, and was treated. This gives another set of illustration that if health facilities are accessible to women who are pregnant and even if they choose to give birth to the child at home, in cases of any complication they can be taken to health facilities, rather than urging all the pregnant women to give birth at health institutions, without looking into accessibility, desirability and affordability factors.

It is being recommended that women should make three PNC checkups after giving birth to a baby. Women were asked about how many PNC checkups they had, only 4 out of 17 had 3 or more PNC checkups. Five of them did not had any PNC check-up, including women who had delivered child at home, private and public health facilities (see table 5.7).

Table 5.7: Number of PNC Checkups

Number	***Frequency***	***Percent***
0	5	29.4
1	3	17.6
2	2	11.8
3	1	5.9
5	1	5.9
7	1	5.9
15	1	5.9
Don’t Know	3	17.6
Total	17	100.0

This was important question to investigate into why most of the women either had no PNC or less than what is recommended even when most of them had three or more than ANCs. It seemed that neither there was need felt among the women to have three or more PNCs nor there was a thrust to create demand among the women from the government. Few women explained that they did not go for PNC because they did not feet the need. In an FGD with

women from Gujjar community, *one of the women said that if a woman is recovering well there is no need to see doctor after delivery*. The ASHA said it was only recently that they were asked by the BMO to mobilise women for PNCs and she agreed that until the time of survey they were not focusing on motivating women for PNCs. ASHA get incentives for facilitating ANC and institutional delivery without any consideration to PNCs- if done or not. That may also be the reason why they don't focus on facilitating PNCs for women.

A few women told that they incurred expenditure on PNC in terms of paying to doctors and on medicines. Many of them had spent on travel to reach health facilities. However, the expenditures on PNC were not much as compared to ANC, delivery or treatment for illness, and in only one case, a woman reported that she to borrow money to manage expenses.

The postnatal care is not limited to ability of women to access any number of PNC checkups at a health facility. One of the aspects of postnatal care would also be if women get sufficient time to rest to recover herself. And it seems that not all the women are provided resting place and time (see table 5.8). A few women said that they started doing household work within 15 to 30 days of delivery. However, a majority of them said that they started doing household work only within one to one and half months of time. Further a majority of them (10 out of 17) reported they started non-household work outside home only after 2-3 months, and others reported more than 3 months.

Table 5.8: Engagement in Household Work after Delivery

Time Period	***Frequency***	***Percent***
15 to 30 days	1	5.9
30 to 45 days	10	58.8
More than 45 days	4	23.5
Don't know	2	11..8
Total	17	100.0

5.1.4. Grassroots level Health Functionaries

For the effective delivery of maternal and child health services to women and children, the role of grassroots level health functionaries is crucial including ANM, ASHA, anganwadi work or any other community health worker. As they work at grassroots level, they are expected to be accessible to all women, especially those who are pregnant, nursing and women who have children younger in age. Their roles are important in terms of motivating and educating women about different health services they would require, and facilitating

their access to health services. Infact, the success of maternal and child health services depends much on the grassroots level workers. For women who reported consulting a doctor more than 4 times and up to 15 times in few cases, it may be expensive and not always feasible to make it to a doctor at few kms distance. Even if it is becoming feasible for some women to make a high number of visits to the doctor, *the questions is whether it is desirable and if it is important.* The present maternal health programmes recommend a minimum of three ANC checkups, and depends much on the reach of grass roots level workers.

However, when asked to these women that during the last three months of their pregnancy, which are very much important, did they meet with any of the grass roots workers like ANM or AWW, a majority of 13 out of 17 women said 'No'. The four women who said meeting any of the community health worker was told if they discussed with her about breastfeeding, keeping the baby warm, the need for cleanliness at the time of delivery, advise on hospital delivery and advise on nutrition. All the four said they discussed about the breastfeeding, one reported she was advised for hospital delivery and all others reported they did not discuss any such issue. This reflects even of the few cases the community health workers reaches, the quality of service is so bad that it may compel women to seek ANC services at higher levels of health service system.

Table 5.9: Contacts with ANM

Contact	*Frequency*	*Percent*
Yes	3	15.8
No	16	84.2
Total	19	100.0

Further, an enquiry was made if these grass root levels workers are accessible to women in general, especially those who have children less than 3 years of age. As mentioned earlier there were 19 children under three years of age, and an enquiry was made about their mothers if they have been in contact with grassroots level health functionaries in the last three months preceding the survey. Only three women reported that they had met the ANM in the last three months (see table 5.9). Further, only three women reported they have met the anganwadi worker or ASHA in the last three months preceding the survey (see table 5.10). This was including one ASHA who was interviewed as mother as part of the household survey, and therefore, said that she has met

Table 5.10: Contacts with AWW or any other Community Workers

Contact	*Frequency*	*Percent*
Yes	3	15.8
No	16	84.2
Total	19	100.0

ANM as well AWW in the last three months. All the three women who reported meeting with ANM or ASHA or AWW were Khan.

The NFHS-3 have also enquired about the contacts women had with any health worker. The data revealed that the percentage of women with any contact with a health worker (auxiliary nurse midwife, lady health visitor, anganwadi worker, or community health worker) in the three months prior to the survey were only 4.1 percent in J&K, as against 17.3 in India (IIPS & Macro International, 2007). This implies that the low level of contact of women with health functionaries is the situation throughout Kashmir, as reflected by NFHS-3 data.

The low levels of contact of grassroots level health functionaries with women in general and pregnanct and nursing mothers in particular may be also the reason for low levels of access by women to institutional delivery, PNCs and to ICDS services in the state because these services depend heavily on the functions of grass root level health workers.

The women were asked what they feel about the grassroots level workers like ASHA, ANM and AWW. Most of them seemed be to not satisfied with them and said they don't work properly and don't provide any service to people. One said, "*... They just get their salaries*". Many had concerns that government has kept facilities but workers don't work properly. One person explained this as, "*There is no benefit of having them. They hardly visit and many times, you have to ask them if you have any concern*". One other added, "*Govt has made available health services but there are no services provided*". Another said about AWW that "*when there is any official visit they take children, even those who are older, and invite women to come to the centre to show that people get benefits"*.

Many women reported they did not know ANM or ASHA and felt that they never visited any of these families. Some said they only come to do the survey but never conducted any activity or any meeting. That many women did not know the ASHA/ANM further points to the fact that their outreach and contacts with women are very limited. A few felt that these grassroots level workers don't take pains for people. There was another woman who reported that she has never met any ANM or AWW and the ASHA who came last year to her and wrote the pregnancy details never returned. This woman was living in a Gujjar

hamlet and as mentioned earlier that ASHA appointed for that area do not visit that hamlet as required.

One women said that she didn't know any ANM or AWW but knew the ASHA who had registered her pregnancy, and narrated, *"I found problem that women who deliver at home or at private clinic are not contacted by ASHA. She may be feeling that there is no incentive"*. This is an important aspect that after a woman visits a private clinic for ANC or for delivery does not mean that health functionaries should not be in touch with her to oversee if the she is able to complete her recommended ANCs/PNCs as the case would be, and if the child is given all vaccinations. This is much more important in case of women giving birth at home, who are more vulnerable to miss PNCs and immunization for children.

Another woman felt that AWW and ASHA don't work properly in this village and don't pay attention to anyone. She narrated that in her parents' village (in Bandipora) ASHAs are working very well.

There were few women who discussed about the dysfunctioning of AWCs and reported ration at ICDS centre was being diverted. One woman reported that they have heard ICDS centres are providing biscuits and other different recipes to children. But, she added, that at their AWC they don't provide anything to children, not even to the poor. This family has children under 6 years, who look undernourished and weak, but they had never visited the ICDS centre. This woman felt, *"AWW takes the supply to her home"*. *Another narrated, "Yesterday the AWW had come to AWC at 6 p.m and took her share from the centre. She didn't come in the day because people would see that she was taking the supply home"*. *Another woman said, "In this village, AWWs take all supplies to their home*".

However, there was one woman who said that it was very good to have health functionaries in the village that could help, but they do not work at all. She expected that the BMO should organise a regular meeting with them and said, *"ASHA was very good for those whose husbands are away from home for work"*

5.2. Access to Child Health Services

The women who had given birth to a live child were asked if their child fell ill or had any complication in the first month of their birth, and a few women reported that their child had faced complications. One woman recalled that her child was in coma when he was born, and was underweight too. He was then admitted in a hospital for 20 days and recently again he was hospitalised. He is still very weak and not able to crawl even after 1 year of birth. The other woman recalled that her child was coughing, as the season was rainy. She further said that they did not take the child to hospital as many said to them that they should not expose child to environment/air for 40 days. They gave him Dalchin tuth (Cinnamon black tea) and he got cured. Another woman recalled that her child was severely malnourished and was taken to a private doctor, but now they have taken her to state child hospital in Srinagar. Another woman reported that her first baby had pain, second baby was coughing, and both were given treatment. Two other women recalled that their children had fallen ill late. One said that her child was ill in the third month and suffered from cold and cough but he was taken to DH and was cured. Another recalled that her baby used to have pain in the abdomen and had constipation regularly, and was treated at DH.

Therefore, it is important to see how accessible are the health services for children. The basic child health services include health check-ups at regular intervals, immunization, growth monitoring and nutrition services.

5.2.1. Health Check-ups and Growth Monitoring:

The first question which was asked was if the children were also checked each time when mothers health was checked after the delivery. As mentioned earlier in maternal health services that not all mothers had a health check-up after the child was born, and there were 5 of 17 women who reported having no PNC. Out of 12 women who had reported any PNC, only 7 reported that their child's health was also examined each time when their own health was checked.

Women were also asked when was their child's weight taken first time after birth, and it is supposed that it must have happened on the first day. However, only three women said that it happened on first day, for another it took 2 days, for another it took a month, for another it took 2 years and for 11 women it never happened.

Those six women who reported that their child was weighed at anytime, were asked about where was the weight taken, and 5 of them reported hospital at the time of birth or later, and only one woman said that her child was weighed at ICDS centre. This gives a clue to the dysfunctioning of the ICDS centres. All of them were told about the nutrition/weight status of their children except the one who was weighed at ICDS centre.

5.2.2. Breastfeeding:

A majority of women started breastfeeding their child immediately after birth, and in two cases, the women started on the next day after birth, and in another case it was 15 days, since she had some problem. In eight cases, women had continued breastfeeding for up to three years, and 9 were still continuing as their children were younger at the time of survey.

5.2.3. Access to Immunisation Services:

An enquiry was made if the children under three years of age in the 50 selected households had ever received any vaccination, including polio drops. In most cases, the immunisation card was also seen to cross check information provided by the respondents. All the 17 children who were under three years of age were reported to have received vaccination. Sixteen children had immunisation cards (for one child, information was not available). Further, all of them had received BCG vaccine, 16 had received DPT and polio vaccine (see table 5.11). As measles vaccine is given only after 9 months, and there were only 15 children who were above this age and were enquired about did they received measles vaccine, four of them had not received measles vaccine, as can be seen from the table 5.12.

Table 5.11: Access to Different Vaccines

Vaccines	*Frequency*	*Percent*
BCG	17	100
DPT	16	94.1
Pulse Polio	16	94.1

Table 5.12: Access to Measles Vaccine

Access	*Frequency*	*Percent*
Yes	9	60.0
No	4	26.7
Dont Know	2	13.3
Total	15	100.0

Table 5.13: Access to Vitamin A

Access	*Frequency*	*Percent*
Yes	6	40.0
No	9	60.0
Total	15	100.0

Further, only 6 of 15 children who were above 9 months of age, reported that they were given Vitamin A (see table 5.13). Five out of 17 reported that their child was given de-

worming pills/syrup in the last 6 months preceding the survey, as can be seen from the table 5.14.

Table 5.14: Access to De-worming Drug		
Access	***Frequency***	***Percent***
Yes	5	29.4
No	12	70.6
Total	17	100.0

In all cases, the children have received most of their vaccinations from public hospitals. However, the major issues seems to be that a majority of them have travelled to CHC/PHC, 6 to 7 kms distant, and only 4 children have received most vaccinations from Sub-centre, even when the Sub-centre was in the village (see table 5.15). This was because the vaccinations were not delivered through the sub-centre until recently.

Table 5.15: ***Source of Vaccinations***		
Source	***Frequency***	***Percent***
CHC/PHC	12	70.6
SC	4	23.5
Govt Dispensary	1	5.9
Total	17	100.0

Most of the respondents reported incurring expenses on vaccination. The vaccination was free, but they paid Rs 10 for immunization card, and all of them who were travelling to CHC/PHC had to incur money on travel (on an average would have cost Rs 30 for one persons on return fare) and occasionally on food/snacks.

5.2.4. Integrated Child Health Services (ICDS)

The ICDS is the only scheme in the country providing comprehensive services to address the health, nutrition and development needs of children under six. It provides in fact a range of services, which are vital for children, and includes Supplementary nutrition, Pre-school education, Immunization, Referral services, Nutrition and health counselling and Health checkups.

In the context of 46 percent children under three years are malnourished in India, the ICDS scheme achieves significance, as it is the only scheme to cater to malnourishment among children. The Supreme Court is monitoring the scheme along with other six food and social security schemes under the Right to Food case and 2001 onwards, the Supreme Court has passed many significant orders in relation to the ICDS. Most importantly, through the orders of the Court the services of the ICDS have become legal entitlements for all children under six, all pregnant and lactating mothers and all adolescent girls (Right to Food Campaign, 2007).

This study also investigated into the access of children to ICDS services. There were only 19 children under three years but as the ICDS scheme extends to all children under 6 years, therefore, some of the children in the age group of 3 to 6 years in the selected 50 households were also covered under this study (for some children in this age group information could not be collected). This added up to a total of 31 children whose information was recorded. Among the 31 children whose details were collected from respondents, only about one third (11 out of 31) reported received any benefit from the anganwadi centre (see table 5.16). It is pertinent to mention that in most of the Indian states, the norms of providing nutrition are different for children below 3 years group and children who are above 3 years and in most cases children under 3 years are not provided a cooked meal. In J&K, the provisions are different and all children under six years are provided cooked food only, therefore, this section analysis the findings of all the cases together.

Table 5.16: Access of Children to any ICDS Service

Any Service	*Frequency*	*Percent*
Yes	11	35.5
No	19	61.3
Don't Know	1	3.2
Total	31	100.0

Table 5.17: Regularity of SNP Provided at ICDS Centres

SNP	*Frequency*	*Percent*
Not at all	15	50.0
Almost Daily	10	33.3
At least once a week	3	10.0
Less often	2	6.7
Total	30	100.0

Although the ICDS is supposed to provide SNP regularly to the children, not all of them received supplementary nutrition (SNP) regularly in the last three months preceding the survey (see table 5.17). Fifteen children didn't receive SNP for any day and only 10 children reported being provided SNP for all days. Those who did receive any SNP or were not provided regularly were asked the reasons why didn't they receive SNP regularly. Many respondents reported that there was no food supply available at ICDS centres from last one to three months. Amazingly, the researcher was told there are winter vacations in the ICDS centre, which was very difficult to relate with ICDS, as there are no provisions for winter vacations. Later, it was explained that because there was no supply and AWWs might have told to people, as there are winter vacations, so ICDS centres will not open (as schools have winter vacations, so it was easy to make people believe this). After talking to AWWs in the village, the researcher was told that there are often irregularities in the availability of supply at ICDS centres. One respondent said that the AWWs divert supplies and do not provide to children, and narrated that, "*They sell biscuits to shopkeepers. We came to know*

recently that they have biscuits and other food items as well". This was not the only reason, some felt that centres were inaccessible to small children and if they are not accompanied to a centre, they cannot go alone. Therefore, in cases there is no one available at home, the child cannot go to the ICDS centre. This was narrated by one respondent, who said, "*ICDS centre is very far and topography is very hilly. Our house had been burnt and all were engaged in house construction*". He meant that because all were engaged in house construction so no one could accompany the child to the ICDS centre, which is very far and a child could not go alone considering the hilly terrain in the village.

It is important that the weight of the children is monitored regularly to keep a track on their growth and development, a minimum of once in a three months. However, among the respondents, a majority reported their children were not weighed at all in the last three months preceding the survey. Only six of them reported being weighed once and one reported being weighed twice in last three months (see table 5.18). Further, it is equally important that the parents of children are informed about the growth of child, and only one respondent said that they were conveyed about the weight of the child.

Table 5.18: Weighing of Children at ICDS Centres

Weight Done	***Frequency***	***Percent***
Not at all	20	66.7
Once	6	20.0
Twice	1	3.3
Don't Know	3	10.0
Total	30	100.0

As ICDS programme also extends to cover the pregnant and nursing mothers, an enquiry was made about the mothers of these children, if they received any service from ICDS centres when they were pregnant with the last child, and only four women have been provided any service from ICDS centres. Three among them had received SNP, 2 have been provided health and nutrition counselling, one health check-up and two were visited at home (see table 5.19).

Table 5.19: Access of Pregnant Women to any ICDS Service

Any Service	***Frequency***	***Percent***
Yes	3	10.0
No	24	80.0
Don't Know	3	10.0
Total	30	100.0

They were also asked if they received any service from ICDS centres when they were nursing their last child, and only three women have been provided any service from ICDS centres. Two among them had received SNP, and one was visited at home (see table 5.20).

Table 5.20: Access of Nursing Mothers to any ICDS Service

Any Service	***Frequency***	***Percent***
Yes	4	13.3
No	25	83.3
Don't Know	1	3.3
Total	30	100.0

When asked what are the reasons why they were not provided any service when they were pregnant or nursing, few of them said they were not aware if they were entitled. Few said there was no ICDS centre in their hamlet. Few more blamed for Anganwadi workers for diverting the supplies. A few more said that the AWWs are more concerned about making records and visit their families only during a survey. One woman said there were two ICDS centres in other two hamlets but did not provide services to their hamlet. One woman recalled that she had gone to ICDS centres but was denied any ration, and narrated, "*We had asked them to give her ration, but AWW said they cant give take home ration, otherwise they will be dismissed. Those who come to the ICDS can take ration*". The other woman opens occasionally only when some official is visiting to the centre. "*The AWW and helper come to each house and take children for those days. For other days, they don't provide anything*", was added by her.

The NFHS-3 also reveals the low levels of coverage of ICDS centres. The percentage of children under six -years of age who had received any service from an Anganwadi centre (AWC) in the past year prior to survey were only 16.6 percent (28.4 % for India) (IIPS & Macro International, 2007). Further, the report, '*Hunger in the Valley'*, which covered 50 villages selected randomly across 10 districts in Kashmir has also shown the weak performance of the ICDS in Kashmir. The reports revealed that only 58.7 percent of children (out of 201) reported that the SNP was given regularly and 18.4 said it was occasionally. The report finds that one of the reasons for not providing regular SNP was that AWCs didn't open regularly. One fifth (22.2%) of the respondents had reported that the AWCs are open only occasionally. The report also reveals that the procurement of ration for AWCs in Kashmir is done centrally at district level through a long and delayed process of tendering, and is one of the reasons that procurement doesn't happen at regular intervals timely, which results in irregularities in supplies in AWCs at the grassroots level. Further, the report shows, that almost 58 percent reported that their child was never

weighed in the AWC and only about 16.2 percent of respondents said that their children are being weighed once a month. The report finds that one of the reasons for children not being weighed in AWCs may be the lack of weighing machines in AWCs, as in 35 percent AWCs (19 out of 54) it was reported that weighing machines were not available (Dar, 2009).

There also seems to be a caste dimension to this. One woman, from a Ganaie caste, felt that they were poor and as the AWW was from a higher caste, she does not visit her. She narrated this as, *"AWW is from Geelani clan, and they are not willing to visit poor households, who are Ganaie*". Another woman felt that the workers do not visit the poor families and said, *"I don't feel they do any work. Even if they come to our house, they would never go to a poor household. The ICDS is close to our house, how would she be helping one who is living up hill and far"*. The data also points to an unfavourable trend towards the children of Ganaie and Gujjars. Only 3 children out of 11 (27 percent) had reported received any service from ICDS among Gujjar/Ganaie castes, where as 6 out of 15 children (40 percent) reported any service from ICDS among the Khan caste. Further, while only 3 children out of 11 from Gujjar/Ganaie castes reported being weighed, it was 13 out of 15 children for Khan caste. Similarly, among the four women who reported received any service from ICDS centre during their pregnancy, three were Khan and one belonged to other higher castes. All the four belonged to middle socio-economic class as well.

Besides, what is also important is the location of ICDS centres, considering the hilly terrain of the many villages in Kashmir. Although the ICDS guidelines mention that one ICDS centre will be established in a population of 800, the Supreme Court order on the ICDS specifically mentions that each hamlet must have an anganwadi centre. The village in which this study was conducted had three ICDS centres for a population of about 875 only. As detailed in Chapter-3, that the village had hilly terrain and was divided into many hamlets. All Ganaie except one family were localised in a Ganaie hamlet and all Gujjars were located in Shatigam Nagni hamlet. Neither of them had an ICDS centre. With more than one ICDS centre being established in villages, the area is being distributed among the different AWCs in a village, and supposedly each family should fall in any jurisdiction. However, due to the recent guidelines in Kashmir that each ICDS centre would cater to 40 beneficiaries. In a way for 40 beneficiaries there would be one ICDS centre, but at ground,

so many ICDS centres were not established that each beneficiary will be covered under ICDS as per these guidelines. As a result, many of the children fall out of the coverage of the ICDS centres and many ICDS centres have limited their services to their own hamlets only. In this way, as there was no ICDS centre in Ganaie or Gujjar hamlets, most of their children are excluded from the ICDS services.

There was an interesting aspect in the location of the ICDS centre. A recently sanctioned ICDS centre was supposed to cater to the Gujjar hamlet as well, and its major population falls in the Gujjar hamlet, but the ICDS centre has been located in another Kashmiri hamlet, more than a km before which is also hilly, and therefore, the children under 6 years cant be expected to come down the hill for ICDS services. The sanction of ICDS centre meant for Gujjar population in a Kashmiri hamlet was for the reason that each ICDS centre provides job to two persons, one for AWW and another for helper, and infact the centre will be placed in helpers house and would be paid rent. These two people are appointed within the hamlet. Therefore, if the ICDS centre would have been established in Gujjar hamlet, the two persons would have been appointed from there only, and because the Kashmiris are politically strong and influential, they had through the influence of MLA sanctioned the ICDS centre in a different location. This was verified during one of the interviews in a family who narrated another story of how the anaganwadi helper of this centre had fudged the records to be appointed as helper, and the informant had petitioned her appointment in the high court because he wanted his daughter-in-law to be appointed as a helper in that ICDS centre. This informant told the researcher that this all was done under the directions of the MLA.

5.2.5. Mid-day Meal Scheme (MDMS)

MDMS was started to enhance enrollment, retention and attendance of children in schools as well as to improve nutritional levels among children. Currently, each child in the primary and upper primary school is to be provided with a hot cooked meal on all school working days. The MDMS is one of the schemes covered under the Right to Food case, and the Supreme Court has passed few interim orders related to MDMS, which made the mid day meal a legal entitlement of every child in India attending a Government or Government aided primary school (and now upper primary school) (Right to Food Campaign, 2005). This scheme has important significance to reduce classroom hunger among children, and therefore, arguably becomes a vital child health programme.

This study looked into the access of school going children in the 50 households covered under the study. Among the children who were attending government school in these fifty households were asked if they get a mid day meal in the school, and a majority of almost 93 percent reported being provided MDM in the school (see table 5.21). MDM is one of the relatively better-implemented schemes.

Table 5.21: Access of School Going Children to MDM

Access	*Frequency*	*Percent*
Yes	52	92.9
No	4	7.1
Total	56	100.0

However, only 18 percent children said that the meals were given regularly (see table 5.22). A majority of children in this study said that the meals are not provided during examinations (the examinations are held twice a year). Some children also noted that meals are not given on Fridays. Many said that meals are also not provided after exams and before winter vacations (during October and November). Few children said that meals are given on for four days a week and a few said that meals are provided for fifteen days a month. The confirmation that MDM was not provided during exams and before winter vacations was provided by a woman who was working as a cook in school. She said, "*They don't provide meals during exams and November*". However, the feelings were not same for every respondent, and one narrated that many times it is a mistake of the teachers who get supplies delayed. One respondent said that if there is supply the teachers provide meals to children. However, he further added, the supplies are not always available. However, he said that the quality was not as good as that children eat at home.

Table 5.22: Regularity of MDM in Schools

Regular	*Frequency*	*Percent*
Yes	10	17.9
No	46	82.1
Total	56	100.0

The report, '*Hunger in the Valley'*, which covered 259 children in 50 villages selected randomly across 10 districts in Kashmir has also shown the widespread implementation of MDMS in Kashmir and pointed out similar issues. The report revealed almost 98 percent children reported being provided MDM in the school. However, the report revealed that the quality of meals provided under MDMS is compromised as almost one-third (32 %) of the respondents reported not liking the meal provided under MDMS. Further, 13 percent of the respondents had reported that the meal was not provided regularly. The report revealed that the meal was not provided on Fridays, and pointed out that intermittently there are shortages of food supplies in schools (Dar, 2009).

The question to be asked here *is why the meals are not provided regularly and do the supplies really fall short at school.* The researcher spoke to some teachers about this and was told that there two important components under this scheme – food grains which are provided through PDS system, and cooking costs which is provided for vegetables, condiments, fuel, etc. Although the food grains are provided through the PDS system, the cooking costs are to be met by teachers and are later reimbursed. However, they said that there are huge delays in reimbursement of payment to teachers, and in some cases, the delays are up to six months or more. In such cases, the quality is compromised and in many cases, they have to stop mid-day meal preparation. In extreme cases, where a Rehbar-e-Taleem (paid Rs 1500 per month for five years) teacher is running the mid-day meal, it becomes very difficult for him to manage midday meal for six months without any reimbursement from the state. There are stories that the shopkeepers stop lending them cooking material. As a result, the mid-day meal is not being provided regularly. However, there were stories of mismanagement of midday meals by teachers and leakages as well, and were told by few teachers, which also results in irregularities in mid-day meals.

Further, only 41 percent said that the child was examined by health personnel in school, but 91 percent of them (21 out of 23) said that the health examination was not regular. But people didn't know who had come, and said that it was an occasional visit. Someone had come to school and injecting children with some vaccine (see table 5.23). One person, however, said it was the MSF team that had visited the schools and were vaccinating children.

Table 5.23: Health Examination of Children in Schools

Health Examination	***Frequency***	***Percent***
Yes	23	41.1
No	31	55.4
Don't Know	2	3.6
Total	56	100.0

They findings of this study pointed out to the limited outreach of grass roots level workers. The delivery of maternal and child health services are dependent on the outreach and functioning of grass root level workers in the present structure of health service system. Therefore, the limited outreach of grass roots level workers with women has affected the access of women and children to health services as well as the quality of services provided. The study also pointed out the importance of 'felt needs' in determining the utilisation of maternity services, and that was the reason why all the women had gone for ANC checkups and most of the women had either no PNC or less than recommended checkups because for

ANC there was strong need being felt by women, and not for PNCs. The study also showed the poor performance of child health services, even in comparison to maternal health services. Among the women who had any PNC, not in all cases their child's health was also examined.

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CHAPTER 6: DISCUSSION AND CONCLUSIONS

The macro level data suggest that Jammu and Kashmir provides a better picture on many of the health indicators as compared to India as a whole. For instance, the Neo-Natal Mortality rate in J&K was 29.8 (39 in India), Infant Mortality rate was 44.7 (57 in India), Child Mortality rate was 6.8 (18.4 in India) and Under-five Mortality rate was 51.2 (74.3 in India). Similarly, the proportion of under-weight children less than three years was 29.4 percent, as compared to 40 percent in India[36](IIPS & Macro International, 2007). One of the reasons for J&K to achieve relatively better health outcomes than India as a whole, may be because of the better socio-economic conditions of the people in the state. The data at all India level shows that percentage of people living under the official poverty line were only 4.5 percent in 2004-05 in rural J&K, as against 28 percent in rural India (Saxena, 2009). The low poverty rate in the state may be because of the rigorous land reforms implemented in the state. The proportions of people who are landless are only 33.9 percent in the state (16.8 % in rural and 71.6 % in urban areas), which is quite high, but markedly less than 54.4 percent in India (both rural and urban together) (IIPS & Macro International, 2007).

The other aspect of having relatively better health status may be also because of the better access to public health services, including livelihood, food, nutrition, social security, health services, hygiene, sanitation, etc. For instance, the Public Distribution System (PDS) is universalized in J&K, among other few states of India, and each household is entitled to subsidized ration every month at differential rates, AAY and BPL get more subsidy and APL get relatively less subsidy but up to 50 percent of the economic cost of ration (Dar, 2009). Although the officially recognized poor people were only 4.5 percent in rural J&K, the NFHS-3 data shows that the proportion of households owning a BPL card is 27 percent. Further, the proportion of households with electricity is 93.2 percent, as against 67.9 percent in India. The proportion of households having access to toilets is 61.7 percent, as against 45 percent in India (IIPS & Macro International, 2007). J&K holds a special status within the constitutional framework of India because of the political arrangements (temporary accession) and conflict in the state, which has resulted into enhanced financial arrangements and special provisions for J&K as compared to other states in India. Some of these special provisions have led to better services in J&K, for instance, universal PDS

[36]There was a change in reference standards after the NFHS data was released and the adjusted figure adds up to 46 percent for India, but the figure was not able for J and K.

system and much higher proportion of BPL quota than the estimated poverty. However, the conflict has resulted into many other problems in the state – killings and disappearances of thousands of people, widespread prevalence of mental trauma, stress, anxiety and depression, diversion of state finances by the state for managing political conflict in the state, failure of generating economic avenues, non-accountability and mis-governance.

The NSSO data shows that the levels of access to treatment are high in J&K to the level of almost 82 percent, as high as in India as a whole (NSSO, 2006). Importantly, the NSSO reports, NFHS-3 data and planning commission study revealed that a majority of people access public health services in J&K, than in India as a whole. Although the average health expenditure in J&K for outpatient care is more than in India for both public and private services, the calculations show that a majority of people in J&K have to incur lesser amounts than in India for treatment because a majority are able to access public health services. The considerably higher levels of access to public health care in J&K than in India, where a major section depends on private health care, may also be the reason for relatively better access to health services in J&K than in India as a whole. But at the same time, a significant proportion of ailing persons have received treatment from private facilities in J&K, which are much more expensive than in India. Therefore, other than the accessibility to government health services in J&K, which has led to higher levels of access to treatment, the role of relatively better socio-economic conditions of people in the state than India as a whole also seems to be significant.

One of the important issues with access to health services was a significantly large population accessing private care up to 48 percent in rural areas. The issues including poor quality of health services, limited outreach of grassroots level workers, costly treatment, inability to pay, lack of nearby facility or inconvenient timings, long waiting hours, among others, which affect the access of people to public health services may push the people to private health care. This has been shown by NFHS survey that among those households, which do not access public health facilities, 55.3 percent reported poor quality of care as the main reason for not accessing government health facilities (46.8 % for India). Further, 33.2 percent reported lack of a nearby facility (46.8 % for India), 22.4 percent long waiting times (24.8 % for India); 9.3 reported facility timing not convenient (13.1 % for India); 5.9 percent reported health personnel often absent (9.2 % for India); and 7.3 reported other reasons (3.9 % for India) (IIPS & Macro International, 2007). However, the Planning

commission's study, revealed that people who suffered from chronic diseases reported non-availability of medicines in public health facilities, public health facilities located far and emergency as major reasons (67.7 %) in J&K for availing treatment from private health facilities (GoI, 2011). The important question to be asked here is that the private health sector also does not given free medicines, and then how come not providing medicines at public facilities have become a reason for accessing treatment from private care. The research has shown that a major part of expenditures on treatment is on medicines, and if medicines are to be purchased from market, the actual difference between receiving treatment from public health services or private facilities is just the consultation fee in major cases (Rs. 50 to 150 in most cases in Kashmir). However, paying this consultation fee can make a difference in receiving treatment in a short span of time and people do not have to wait for hours of time, as in public health sector. In many cases, people may be giving more value to saving time as compared to cheaper but longer waiting hours of the public facility, corroborating findings from other parts of India.

The NFHS-3 data also reveals that the levels of access to institutional delivery, ANC, vaccination, and treatment to children, who suffered diarrhoea and ARI, were better in J&K than in India. However, the data raises some of the important questions about the quality of maternal and child health services and outreach of grassroots level workers. The data shows that a significant proportion of women do not utilise the maternal and child health services, and this could *be because there was no 'need felt' for such services.* However, the utilisation of maternal services also depends on the quality of services, outreach of maternal health services, affordability as well as socio-cultural factors, which determine the access of women to maternity health services. As the health behaviour of people is shaped by their experiences and perceptions about the health services and by the quality of care, they receive, the role played by the grassroots health functionaries is very important. For instance, in areas where ANM, ASHA and AWWs have contacts and are reaching out to more women, there is higher probability of increased access to ANC, delivery and PNC care as well as to immunization and treatment for diarrhoea. However, the NFHS-3 data revealed that the percentage of women with any contact with a health worker (auxiliary nurse midwife, lady health visitor, anganwadi worker, or community health worker) in the three months prior to the survey was only 4.1 percent in J&K, as against 17.3 percent in India. This low proportion of women with any contact with a health worker in J&K signifies the limited outreach of health functionaries at the grass root level in J&K. This

may be one of the reasons for low levels of access by women to all recommended types of ANC, institutional delivery and PNC and other child health services in the state because these services depend heavily on the functions of grass roots level health workers. Further, the data has revealed that there is a significant gap between women who had three or more ANCs (73.5 %) and women who had received all recommended ANCs at proper time, two or more tetanus injections and iron folic acid tablets/syrup (17.5 %). This points to the fact there are quality issues with ANCs, which would certainly affecting the utilisation of maternity health services.

More importantly, the access of women to maternal health services also depend on status of women and their freedom to travel alone (or accompanied by other person) to health facilities, which are outside the village. The NFHS-3 data reveals that there is a high exposure to media among women in the state to the level of 82.4 percent, and the data on other indicators of women's autonomy and decision-making powers shows a better picture in the state than in other parts of India. These are crucial factors for accessing health care, and may be the reasons for relatively higher levels of utilisation of maternal services in J&K than India. However, the NFHS fails to record the influence of the conflict in the state on the mobility of people especially women. The armed conflict has had its affect on the mobility of women very drastically, especially in far off and rural areas, where movement sets with the sunset bringing death like silence to Kashmir. The blocking of the roads by putting barricades and gates on the roads after the sunset and frequent frisking of vehicles on the road in the daytime as well have considerably affected the mobility of women. Therefore, this has hampered the access of women to maternal health services to some extent, and one of the reasons for women health providers not to travel to field areas, especially those located at far off places. There are also incidents of Indian security forces barging into hospital premises and creating an environment of fear, stopping ambulances and beating up the medical staff, and breaking the panes of ambulance, especially during strikes and protests in Kashmir. As a result, the conflict has resulted in many structural constraints and has created many barriers that shape the access of people to health services. Though the conflict has affected all sections of population, the impact has been relatively more on women and lower socio-economic sections. This may have resulted in growing inequities in access to health care along the lines of gender and class.

Another important dimension to provisioning of health services that this study brings out clearly is that J&K is a very diverse state with three regions -- Jammu, Ladakh and Kashmir -- vary a lot in terms of geography, population composition, food habits, climatic conditions, political situation and nature of economic activities as well as in the development patterns and public services. These variations make the three regions different from each other and have its impact on the health system, health status of people and access to health services. The DLHS data shows that the access of people to antenatal checkups, child vaccination, children who suffered diarrhea and sought treatment, and children who suffered ARI and sought treatment is little better in Kashmir region than Jammu. Further, the data on access to basic amenities like possessing pakka house, LPG, toilet facility, drinking water and electricity facilities and access to BPL card shows a better picture in Kashmir as compared to Jammu. The data also show that Kashmir has availability of facilities in relatively more villages, like sub-centre, PHC, doctor, ASHA and AWW, than Jammu, which may be for the reason that the villages in Kashmir are relatively bigger in size than in Jammu, and therefore, the probability of such facilities increases in villages in Kashmir. However, the availability of specialists – gynecologists, pediatricians, anesthetists and health managers at CHC are better in Jammu than Kashmir. The reasons for better availability of health facilities in Kashmir region than in Jammu may be the political influence of Kashmir over Jammu region (Kashmir is politically strong region than Jammu).

These disparities in socio-economic conditions and access to health services are not at the regional level only, but are of severe nature at further disaggregated level down to the district level. In fact, it is the inter-district disparities, which give rise to the inter-regional disparities. Kupwara, as an illustration, provides a picture of how some of the districts show a completely different picture than the state as a whole. For instance, the crude birth rate and death rate of Kupwara district are 28 and 8, as against 18.9 and 5.5 in the state. The IMR in Kupwara was 60, as against 50 in the state in 2005 (SRS, 2005 cited in District Administration Kupwara, 2007). Similarly, the socio-economic conditions of the people living in Kupwara are not as good as in rest of the state. The state poverty ratio in the district is 31.8 percent, as against 21.6 percent in the state. The per capita income in the district is only about Rs. 12672 at current Prices for the 2004-05, as against Rs 22642 in the state (Govt of J&K, 2009). The other districts also show disparities in terms of socio-economic context, health infrastructure, and access to public health services.

Further, the study found that the districts are not homogenous and at further disaggregated block and tehsil levels, the significant disparities exist in the spatial arrangements of health services. The study examined, for illustration, the availability of health facilities in Kupwara district, and found that the Handwara tehsil had better availability of health facilities than Kupwara tehsil, even when Kupwara is district head quarter, for political influence of Handwara tehsil. For instance, in Kupwara district, the average population covered by each PHC at district level is 19427.8 but the average population coverage by each PHC in blocks like Tanghdar (52360), Trehgam (27745), Sogam (25858) and Villigam (22071) is much more than average population covered by a PHC in Kralpora (14992), Zachaldara (15309) and Handwara medical block (16325). Further, the average population coverage by each PHC in Handwara tehsil (17643.2) is much lesser than average population covered by a PHC in Kupwara tehsil (19197.4) (District Administration Kupwara, 2007). *Therefore, it is important that the district, tehsil and block level disparities are also highlighted, not assuming that regions are homogenous.* The disparities that exist at regional, district and block/tehsil levels in availability of and access to health services raise an important issue of political influence in health service structure in the State, which is corroborated by the Planning Commission study and NRHM's third common review mission. The planning commission study pointed out the political interference in appointment of ASHAs and transferring of ANMs that makes it difficult for effective functioning of grassroots level health workers. The third common review mission report observed that a number of health facilities are clustered within a limited geographical area close to Handwara.

The data has also reflected a better availability of secondary and tertiary health care in Kashmir which is the reason for higher level of utilization of public facilities, where as the primary health care is ridden with infrastructural issues, compromised quality of services and limited outreach of health providers. The poor performance of primary health care has led to high levels of dissatisfaction among the people and may be the one of the important reason for low levels of access to maternal and child health services and use of private health care for these.

The overall impression of the village level study was that the access to health services was better in the village than as reflected by the macro-level data at the state and regional level or at the district level. One of the primary reasons for the better access was the availability

of many health facilities, including CHC and district hospital, at a reachable distance. This was the main reason that a majority of people have been able to access public health care. This in a way explains that if services of better quality (like CHC and DH) are physically accessible at closer distances, the access to health services will increase, and this is corroborated with empirical research that has shown that health services shape the perception and health behaviour of people.

However, the study showed that the expenditure, both inpatient and outpatient, was very high, and majority of households had to borrow money to cope up. For some, the costly expenditure may have a catastrophic impact and may have led them to destitution, and compelled some families to sell their little assets, at distress sale, to repay the debt. Therefore, as majority of households were BPL and fell into lower socio-economic class, they were able access treatment only because either they had borrowed money or had sold assets to manage the expenses. Therefore, the better socio-economic conditions in terms of a relatively higher proportion of people in the state own some assets like land and farm animals, have helped them to manage expenses for the treatment.

What was important to understand, with such a high expenditure on hospitalisation, some of the middle class people were not also able to afford and had borrowed money. In poor families, they borrowed money but they had sold their assets to repay their debt, which in turn makes them more vulnerable to poverty. *Therefore, the concept of affordability has to be looked relative to level of health expenditures*. What we may call middle socio-economic class or APL family, may not be able to afford health care if the costs are high, but if the costs would have been low even the poorer families could have been able to afford health care. Therefore, it seems that to make health care accessible to all socio-economic classes, the health care costs have to be reduced, otherwise at any point of time and at any costs there would be some sections of people who would be excluded from services or pushed to further poverty for paying to costly services. As the costs will lower, more sections of society can afford health care, irrespective of their socio-economic conditions.

Although a higher proportion of people had access to treatment, the reasons for those who didn’t had access to treatment included that either there was no need felt by people, or adopted local remedial practices and most importantly inability to afford health care.

Among the important was the utilisation of private services by a significant proportion of 14 percent of ailing person. The study found that the main reasons for a significant portion of people to access private health care included: dissatisfaction with quality of care at public health facilities like doctors don't examine well in public facilities; logistic related issues like unavailability of transport and its huge costs; unavailability of medical staff in the late hours; issues of affordability like inability to pay for expensive treatments at public health facilities because doctors prescribe more and expensive medicines, and money not available on time. The reasons for accessing treatment from local chemist included its accessibility in terms of close proximity; logistic related issues like availability during late hours; and affordability related issues like inexpensive treatment and opportunity of taking medicines on credit.

Further, the study found that there were serious quality issues with the treatment, and people felt that the doctors prescribed extensive medicines intentionally. The study found that the doctors working with government ran most of the private clinics in Handwara tehsil, and people reported that doctors attend their private clinics in the mornings and in late evening every day. The private practice by government doctors affected the quality of care for two reasons, one that they wanted to provide better care at their clinics to attract more patients, and second they would be overworked by running their clinic in the mornings and evenings and on holidays which would have its impact on their examination and diagnosis in the government hospitals. One person said, "*The doctors do not give us satisfied services. They come at 12 a.m and leave by 3 p.m only and then run their private clinics... However, if we go to see them in their private clinics, they give good services and investigate properly for 10 minutes. In government hospitals same doctors don't examine properly*". The example of private clinic for maternal and child health services around Handwara which is being run by a gynaecologist working with government, demonstrated how the private sector was tending to control choice of people towards their favour and exploitation the situation that public health facilities were not providing better services.

The study also found that although there was clearly a felt need for ANCs and institutional delivery among most women, which lead to increased access to ANC and institutional deliveries, there was no felt need for PNCs. As a result, the utilisation of PNC services was low in the village.

The study also showed the poor performance of child health services, even in comparison to maternal health services. Among the women who had any PNC, not in all cases their child's health was also examined. Further, ICDS, though the only scheme in the country providing comprehensive services to address the health, nutrition and development needs of children under six, showed weak performance and coverage. A majority of children didn't receive SNP for any day. Those who receive did receive any SNP were not provided regularly. The reasons were irregularities in ration supplies to ICDS centre. Besides, the MDMS showed relatively better performance and a majority of school going children reported being provided a meal at school. However, many students reported irregularities in meals provided at school.

Importantly, the study found that 'caste' had a significant relevance to the socio-economic conditions of people, as Ganaie and Gujjars were the poorest and powerless in the village, while as Khan were better economically and powerful in the village. The caste, gender and socio-economic class had a major influence in access to health services, and the data showed that there were disparities along the lines of gender, class and caste with prevalence of disease as well as with access to health services, Khans had favourable picture and Ganaie/Gujjars were disadvantaged.

There was also a mismatch between the expectations of people and the facilities and quality care provided to the patients. That was the reason many people were much concerned about medicines not being provided at all and patients are asked to buy costly medicines from market. Some people said there are no facilities in government hospitals, and even if there are, they do not provide. Some people were dissatisfied with the long waiting hours. Question were raised by the people about accountability, transparency and monitoring in government hospitals. A person best narrated this and stated, "*They don't provide medicines at all. There is no monitoring, if they feel they will treat, otherwise will ask for next day. In the medical dispensary, I had gone yesterday; they provided few tablets but they did not give any injection. They sell it to RMP*". The impression the researcher got was that there was more of anger among people how they are being treated at hospitals and the distress due to costly medicines, than just being dissatisfied. This dissatisfaction was more because of no provisions of medicines at health facilities and instead of getting them to buy costly and huge medicines, for the sake of commission doctors get from market.

Because of some of the people not being able to access treatment for their illness, and widespread anger and dissatisfaction among the people about the quality of services and provisions of free facilities at health facilities, people also expected some of the reforms that must happen in the health service system. Among the major changes that people wanted included some of the basic things like adequacy of staff, proper examination of patients, doctors come on time, and polite attitude among the providers. Another major demands that people put forth was for the provision of free medicines from health facilities. Some asked for all the medicines, some asked for at least half of the medicines, and some poor families looked for free medicines for the poor, who can't afford such costly medicines. Importantly, some people raised the basic question what affects the quality services and put a strong demand that government must ban private practice. Few people felt that doctors working with government should not run their private clinics, and that affects the quality of services and their commitment to provide quality services in public hospitals. There was also high demand about regulating private medical shops. However, people felt that doctors have a vested interest in government not providing medicines. This was corroborated by the fact that the beginning of this year saw the government putting up a drug policy before cabinet for approval. The drug policy was intended to check the spurious drugs in the market; lay down guidelines for prescriptions and rationalise the use of drugs in both public and private sector (Akmali, 2011). The policy was to check the dispensation of drugs in Kashmir as the drug abuse has tremendously increased in Kashmir after conflict started in. However, just after announcement was made by government the pharmaceutical retailers protested for long time (even went for hunger strike) against the policy and didn't let the government to take a final call on the policy.

6.1. Methodological Observations:

This study raised some of methodological issues that may have implication for the quality of data in studies of such nature and therefore, may be consider while designing studies to investigate into access to health services. Some of the important ones are mentioned here briefly:

1. The study found that there would be many issues particular to the area that would emerge after discussion with people in their socio-economic and political context and would be very important to provide understanding about health behavior, perceptions and access to health services. But usually studies of quantitative in nature don't provide

flexibility to add these emerging issues in the interview schedule/questionnaire. The researcher in this study, facilitated discussion in almost each household interviewed under this study on the issues related to health and their access to health services, which emerged in the field that enriched the data and provided a broader understanding into the access of people to health services, than being limited to questions raised in the interview schedule.

2. The researcher observed that women were better respondents than men in sharing the personal information and negative experiences with health services. However, the researcher could feel, that the responses of the women were highly restricted whenever a man was sitting around in terms of illustrating their experiences with health services. Therefore, the influence of men over women has to be considered while designing any such study and may also led to some under-reporting of illness or negative experiences with health services by the women.

3. The researcher observed that in many cases the informants would simply dismiss the question that they were not ill in the reference period and it was only when a set of probing questions were put to the informant, information on many illnesses they would have suffered would come out. The reason primarily seemed to be that some of the people didn't consider minor ailments like head ache, cough, body ache, fever, viral infection, etc. as illness, probably for the reason that the regular prevalence of some of these illnesses make people start considering them as normal or routine. There was also a feeling that for the illnesses for which treatment was not sought were not being reported as illness, and it was only after probing that the informants would say that they had suffered from such illnesses. The researcher felt that this may be the reason why the access to treatment in this study and other similar designed quantitative studies like NSSO, has turned out to be of a higher level, for some of the illnesses which were not cured were not being recorded. The researcher felt that it would only be a qualitative study design, which could bring out the issues of untreated morbidity among people in J&K. It was only after the continuous probing to enquire about untreated morbidity that informants would recall that there are occasions that they are not able to seek health care but that was not reflected in the row of quantitative questions about their ability to access treatment for the illnesses, if any, in the reference period.

This is also important to understand that the perception of what would be considered as illness varies among the communities and among the people from different socio-economic classes and regions, depending on their experiences with illness, health services and other cultural factors. As a result, the perception of the researcher and the respondents in village may mismatch, *giving rise to a perception gap*, and if researcher cannot understand their perceptions of illness, there are greater chances of under-reporting of data. Therefore, if not probed and explained what does illness means for this study there is a higher probability of underreporting.

Thirdly, it really matters whether the person who has suffered illness and has sought treatment is available at the time of interview. The kind of respondent interviewed has huge influence on the quality of information recorded. In many cases, especially when adults are not available at home, the information recorded from young people in the families looses many things. In many cases, not even all the family members would know the illnesses and treatment sought, especially about women, because in societies like Kashmir, women related health issues are not discussed in families, so some of the family members may not knew about their women suffering from any disease.

4. As the study was designed to investigate into the access of health services along the lines of gender, caste and class, the actual operationalisation of these concepts in the field study found it very difficult to design the tools to bring out the disparities in access to health services along such parameters. Class as such is very complex in nature. In social science research, although many scholars use proxy indicators to class like ownership to assets and access to services, it loses some of the important issues like being powerful and influential, and nature of relationship between different classes (service providers and recipients), among other issues, which are important factors to consider and may heavily influence the spatial arrangements of health facilities and appointments of health providers. Further, 'caste' can not be taken as an entire criterion to divide the village into different socio-economic groups, and it warranted the use of multiple criteria together, which can capture the social complexity in the village. For instance, this study found that among the Khan households, though majority of them have better socio-economic conditions, there were few who were poor, and similarly among the other castes. In addition, the researcher felt the disparities in access along the lines of gender were difficult to record for the reasons of strong influence of men

while being present during the interviews. In most cases, that there was no escape from men and their presence was inevitable. This might be the reason why NSSO survey does not show any significant gender gradient in the prevalence of illness or in access to health services.

6.2. Limitations of the Study:

1. There are wide disparities in the socio-economic, ecological, and political conditions between the different regions of state – Jammu, Ladakh and Kashmir, therefore, undertaking a study in Kashmir, limits the generalizability of the study to the other two regions – Jammu and Ladakh, provided some measures to verify its validity in these two areas are conceptualized and undertaken.

2. As the study was conducted in only one village in Kashmir, and the village selected had hilly topography, with majority of the households falling under poverty line, the conditions of health services in the towns, cities, and the areas near to towns may be much better than what is reflected in this study. Therefore, the generalization of any inference to Kashmir have to be done with caution, and considering the socio-economic and political context of the areas, in which this study was undertaken and the areas to which the generalizations are validated.

3. There were chances of under-reporting of morbidity as the methodology involved recorded the data only on self-reported basis, and no medical examination or any verification was undertaken. However, some probing questions were put to the informants during data collection to improve reliability and accuracy as possible. Nevertheless, as envisaged, there would be some under reporting but that should not affect the analysis of the data to understand the issues of access to health services and factors affecting the access in the state.

Secondly, there were chances of under-reporting of morbidity by the women; in particular, due to the reason that a male investigator was undertaking this research and some women may have been hesitant to share information about their health concerns with a male investigator. This issue was genuine and in many studies of such nature, like one undertaken by NSSO on morbidity and treatment, the intermediaries are allowed to take interviews in such cases. However, in this study, an attempt was made

to make the tools very sensitive, and in a few cases, where women showed some reluctance or hesitancy to discuss the nature of problems, the investigator just recorded the illness without going into the nature of illness. The hesitancy might have been also because of male members of the family being present while interviewing. Nevertheless, the researcher felt that considering the level of rapport he could develop with the respondents and the level of comfort of the respondents with which they shared their information, the under-reporting may not be of any serious level that would have affected this study, especially in understanding the issues of access to health services, which was the focus of this study.

4. The study design also included visiting the health facilities including sub-centres, CHC and District Hospital in Kupwara district that the village residents accessed. A discussion was to be conducted with officials and other providers at these different health institutions, and an assessment was to be made about the availability of facilities and infrastructure at health institutions. This also included visiting a dispensary run by MSF and meeting one local person who was regarded as a Peer (mendicant or fakir). However, due to the time constraints that emerged out of limited work output in the winter months due to transport and other logistic inconveniences, visits to health facilities were not undertaken and no discussion were held with health providers. Although the researcher went to the sub-centre several times, he always found it closed and could not meet the staff. The research felt that it was important to record the problems the health providers face in delivery of services as well as their experiences and thinking about availability of and accessibility to health services in the area. That is missing in this study.

6.3. Issues for Future Research:

This study had raised some of the important questions and attempted to explore few of them. However, there are many research questions, which this study has further raised, providing an agenda for future research along the following lines of inquiry:

1. The conflict has resulted many structural constraints and has created many barriers that are likely to shape the access of people to health services. Though the conflict has affected all sections of population, the impact is likely to be more on women and lower socio-economic sections. This may have resulted in growing inequities in access to

health care along the lines of gender and class, and needs to be explored. What also needs to be explored are the processes of how the conflict has affected the socio-economic conditions and access to public services including health services in a more systematic and comprehensive way. The impact of widespread Army presence on the socio-economic development of the region and access to livelihoods has to be examined.

2. The data shows that there are disparities in health services and socio-economic conditions between three the regions of the state of J&K. Though this study explored some of the possible reasons, it would require a micro-level household study in all three regions to examine further reasons for such differences. The other aspects that have to be explore include: What is the contribution of each of these socio-economic and political factors to the inter-district and inter-regional disparities in the availability of health services and access of people to these health services. To what extent the geographical factors contribute to the existing disparities across districts and regions in the availability of health services and access of people to these health services. What is the role of political factors, in terms of protests and strikes in Kashmir, feeling of alienation in Kashmir, Jammu and Ladakh and the attempts of government to maintain regional balances, in determining the availability of health services and access of people to these health services?

3. The data has shown that J&K has better health outcome than India as whole. However, this has to be examined at the grassroots level, if it is better accessibility to public health services or better socio-economic conditions or an inter-play of both factors that leads to better health outcome and higher levels of access to treatment in J&K.

4. The study pointed out the political influence in spatial arrangements of health facilities between regions, districts and blocks/tehsils, but it would require to be examined further in other areas than this study explored. Further, the political influence in the infrastructural availability of other public health services would also be interesting to be explored along similar lines.

5. Importantly, the proportion of population living below the poverty line is much lower (5.4 percent) than the aggregate in India as a whole (27.5 percent). The commonly held

opinion about the low poverty levels in Kashmir that land reforms were the prime reason does not seem to be the only major reason. Land reforms have happened in 1950s, but the data shows that major changes in poverty reduction have resulted in the 1990s. *Does it have any relation with conflict, as the conflict started in the state in 1989*? It may but is to be explored and researched.

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Appendix –A: Inter-State Disparities in Access to Health Services

Table A.1: Early childhood mortality rates by state				
State	***Neo-Natal Mortality***	***Infant Mortality***	***Child Mortality***	***Under-five Mortality***
India	***39***	***57***	***18.4***	***74.3***
Delhi	29.3	39.8	7.3	46.7
Haryana	23.6	41.7	11.1	52.3
Himachal Pradesh	27.3	41.7	11.1	52.3
J&K	***29.8***	***44.7***	***6.8***	***51.2***
Punjab	28	41.7	10.8	52
Rajasthan	43.9	65.3	21.5	85.4
Uttaranchal	27.6	41.9	15.5	56.8
Chhattisgarh	51.1	70.8	21	90.3
Madhya Pradesh	44.9	69.5	26.5	94.2
Uttar Pradesh	47.6	72.7	25.6	96.4
Bihar	39.8	61.7	24.7	84.8
Jharkhand	48.6	68.7	26.1	93
Orissa	45.4	64.7	27.6	90.6
West Bengal	37.6	48	12.2	59.6
Arunchal Pradesh	34	60.7	28.8	87.7
Assam	45.5	66.1	20.2	85

Manipur	18.7	29.7	12.6	41.9
Meghalaya	23.6	44.6	27.1	70.5
Mizoram	16.3	34.1	19.5	52.9
Nagaland	19.8	38.3	27.5	64.7
Sikkim	19.4	33.7	6.7	40.1
Tripura	33.1	51.5	8.2	59.2
Goa	8.8	15.3	5	20.3
Gujarat	33.5	49.7	11.9	60.9
Maharashtra	31.8	7.5	9.5	46.7
Andhra Pradesh	40.3	53.5	10.2	63.2
Karnataka	28.9	43.2	12.1	54.7
Kerala	11.5	15.3	1	16.3
Tamil Nadu	19.1	30.4	5.3	35.5
Source: IIPS and Macro International, 2007				

Table A.2 : Antenatal Care and Institutional Delivery by State		
State	***No ANC (1)***	***Delivery in a Health facility (2)***
India	***22.8***	***38.7***
Delhi	9.6	58.9
Haryana	10.1	35.7
Himachal Pradesh	10.4	43
J&K	***14.7***	***50.2***
Punjab	9.7	51.3

Rajasthan	25.1	29.6
Uttaranchal	25.9	32.6
Chhattisgarh	11.3	14.3
Madhya Pradesh	20.3	26.2
Uttar Pradesh	33.5	20.6
Bihar	65.7	19.6
Jharkhand	40.6	19.9
Orissa	12.7	18.3
West Bengal	7.7	35.6
Arunachal Pradesh	42.6	42
Assam	27.8	28.5
Manipur	13.4	22.4
Meghalaya	31.7	45.9
Mizoram	25.1	29
Nagaland	42.2	59.8
Sikkim	10.4	11.6
Tripura	21.1	47.2
Goa	1.4	92.3
Gujarat	12.6	52.7
Maharashtra	7.3	64.6
Andhra Pradesh	5.2	64.4
Karnataka	9.4	64.7
Kerala	0.1	99.3
Tamil Nadu	1.1	87.8
Notes --- (1): Percent distribution of women who had a live birth in the five years preceding the survey but didn't receive any ANC for their most recent live birth. ; (2): Percent distribution of live births in the five years preceding the survey percentage delivered in a health facility.		
Source: IIPS and Macro International, 2007		

Table A. 3: Child Health Services by State				
State	***Vaccination***	***Percentage of children with diarrhoea taken to a health provider***	***Percentage of children under-five with symptoms of ARI***	***Percentage of children with ARI for whom treatment was sought from a health facility or provider***
India	***43.5***	***59.8***	***5.8***	***69***
Delhi	63.2	75	6.4	89.3
Haryana	65.3	81.7	2.7	(88)
Himachal Pradesh	74.2	68.9	1.3	*
J&K	***66.7***	***67***	***7.67***	***1.6***
Punjab	60.1	75.2	6.9	87.1
Rajasthan	26.5	56.7	6.9	64.7
Uttaranchal	60	61.7	4.3	74
Chhattisgarh	48.7	61.6	4.4	66.8
Madhya Pradesh	40.3	58.1	3.7	51.5
Uttar Pradesh	23	58.3	7.1	73.4
Bihar	32.8	53.9	6.8	70.2
Jharkhand	34.2	44.1	5.2	67
Orissa	51.8	58.9	2.8	(76.5)
West Bengal	64.3	67.4	13	69.1
Arunachal Pradesh	28.4	35.5	6.7	43.6
Assam	31.4	31.4	7.3	34.3
Manipur	46.8	37.8	4.7	45.1
Meghalaya	32.9	72.2	1.9	*
Mizoram	46.5	27.4	4.1	(61.5)
Nagaland	21	17.6	4.2	27.1

Sikkim	69.6	33.4	5	(45.8)
Tripura	49.7	64.5	14.2	81.2
Goa	78.6	72.1	3.6	(83)
Gujarat	45.2	56.8	4.7	63
Maharashtra	58.8	77.3	4.6	71.8
Andhra Pradesh	46	65.3	2	(58.5)
Karnataka	55	65.6	1.7	(68.9)
Kerala	75.3	63.3	2.7	(88.8)
Tamil Nadu	80.9	63.3	3.7	75.3
Source: IIPS and Macro International, 2007				

Appendix –B: Inter-Regional and Inter-District Disparities in Socio-Economic Conditions, Availability of Health Facilities and Access to Health Services

Table B.1: Socio-economic and Demographic Indicators across Districts in J&K

District/ Region	*Total Population*	*Population in Percent*	*People living in Urban Areas (%)*	*SC Population (%)*	*ST Population (%)*	*Hindus (%)*	*Other Religions*	*Per Capita GDDI*	*Poverty Ratio*	*Literacy (%)*	*Female Literacy (%)*
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Kupwara	650393	6.41	3.9	0.01	7.96	2.0	0.7	16360	31.82	43.24	28.68
Baramula	1169780	11.53	16.8	0.03	7.17	4.1	1.3	20957	26.49	45.41	32.28
Srinagar	1202447	11.85	78.7	0.09	3.78	1.3	1.1	30052	15.37	59.75	48.07
Badgam	629309	6.20	11.2	0.08	2.31	1.0	0.9	22416	26.64	42.53	30.57
Pulwama	652607	6.43	10.5	0.01	3.29	0.9	1.5	23986	21.30	49.6	37.73
Anantnag	1172434	11.56	14.4	0.05	8.63	1.0	0.5	23392	18.60	46.54	34.42
Kashmir Region	***5476970***	***53.99***	***26.9***	***0.05***	***5.81***	***1.8***	***1.0***	***N.A***	***21.37***	***48***	***36.00***
Leh	117232	1.16	24.4	0.53	82.04	8.2	78.1	20237	22.07	65.34	52.7
Kargil	119307	1.18	8.9	0.12	88.32	4.3	15.3	11922	31.90	60.85	42.38
Ladakh Region	***236539***	***2.33***	***16.6***	***0.32***	***85.21***	***6.2***	***46.4***	***N.A***	***27.03***	***63.50***	***48.00***
Kashmir Division*	5713509	56.33	26.5	0.06	9.10	2.0	2.9	23125	21.60	51.66	38.35

Doda	691929	6.82	6.9	9.10	11.53	41.5	0.6	20442	34.84	47.9	29.9
Udhampur	743509	7.33	15.7	19.11	14.78	73.0	1.5	23104	31.25	55.2	41.2
Punch	372613	3.67	6.4	0.26	39.99	5.2	2.9	22312	33.67	51.2	36.0
Rajauri	483284	4.76	7.0	7.97	33.12	37.3	2.5	23634	25.10	58.0	44.5
Jammu	1588772	15.66	44.1	24.86	3.36	86.0	8.3	28712	12.93	77.02	68.55
Kathua	550084	5.42	14.3	23.15	6.21	89.8	2.1	27696	11.72	65.57	54.44
Jammu Region	***4430191***	***43.67***	***22.6***	***17.3***	***13.23***	***65.2***	***4.1***	***25260***	***21.67***	***60.0***	***46.0***
J&K	**10143700**	**100.00**	**24.8**	**7.6**	**10.90**	**29.6**	**3.4**	**24398**	**21.63**	**55.5**	**43.0**

Notes -- 8-Other religions include Buddhists, Sikhs, Jains and Christians

**Kashmir region includes only 6 districts of Kashmir, however, Kashmir division includes Leh and Kargil as well. Jammu region is though equivalent to Jammu Division*

Source: RGI, 2001 for columns 2 to 8,11 & 12; Govt. of J&K, 2009 for column 9; Govt. of J&K, 2008 for column 10

Table B.2: Availability of Health facilities* across Districts in J&K

District/ Regions	***Sub-centre***	***PHCs***	***Any Government Facility*****	***Doctor***	***ASHA***	***AWW***	***JSY Beneficiary***	***VHSC***	***Sampled Villages***
Kupwara	43.8	20.8	66.7	8.3	66.7	95.8	31.3	10.4	48
Baramula	38.1	7.1	45.2	11.9	76.2	100	23.8	14.3	42
Srinagar	54.5	36.4	72.7	0	63.6	90.9	27.3	18.2	11
Badgam	40.9	15.9	54.5	9.1	63.6	97.7	29.5	4.5	44

Pulwama	42.2	8.9	55.6	13.3	86.7	100	35.6	8.9	45
Anantnag	58.1	11.6	67.4	16.3	90.7	97.7	16.3	9.3	43
Kashmir Region	***46.3***	***16.8***	***60.4***	***9.8***	***74.6***	***97.0***	***27.3***	***10.9***	***233***
Leh	78.9	15.8	94.7	2.6	92.1	100	60.5	21.1	38
Kargil	78.3	6.5	91.3	0	73.9	93.5	30.4	17.4	46
Ladakh Region	***78.6***	***11.2***	***93.0***	***1.3***	***83.0***	***96.8***	***45.5***	***19.3***	***84***
Kashmir Division	53.94	13.23	67.8	8.51	77.61	97.47	31.86	12.30	317
Doda	34	8.5	59.6	4.3	57.4	89.4	34	8.5	47
Udhampur	40.5	7.1	57.1	0	83.3	97.6	45.2	0	42
Punch	57.4	23.4	72.3	2.1	70.2	93.6	4.3	4.3	47
Rajauri	34	8.5	42.6	0	59.6	76.6	17	0	47
Jammu	32.1	3.6	39.3	17.9	75	85.7	25	7.1	28
Kathua	37.2	14	53.5	4.7	60.5	90.7	25.6	20.9	43
Jammu Region	***39.74***	***11.42***	***55.1***	***3.95***	***66.92***	***88.98***	***24.80***	***6.69***	***254***
J&K	**47.6**	**12.4**	**62.2**	**6.5**	**72.9**	**93.7**	**28.5**	**7.3**	**571**

*Notes--*Facilities as reported by village pradhan/any other panchayat member/teacher/gram sevak/aganwadi worker; ** Includes Sub-Centre, Primary Health Centre (including Block PHC), Community Health Centre or referral hospital, government hospital, and government dispensary ithin the village.*

Source: IIPS, 2010

Table B.3: Population Strength of Villages across Districts in J&K

District/ Region	***No. of villages less than 500 persons***	***% of villages less than 500 persons out of total***	***No. of villages (500 - 999 persons)***	***% of villages (500-900 persons) out of total***	***No. of villages (1000 - 4999 persons)***	***% of villages (1000-4999 persons) out of total***	***No of villages (4999 to 10000 and above persons)***	***% of villages (4999 above) out of total***	***Total Villages***
Anantnag	103	17.0	144	23.8	335	55.37	23	3.8	605
Badgam	153	32.6	121	25.7	189	40.21	7	1.5	470
Baramula	160	25.0	153	23.9	295	46.17	31	4.9	639
Kupwara	84	23.2	90	24.9	167	46.13	21	5.8	362
Pulwama	158	29.4	189	35.1	187	34.76	4	0.7	538
Srinagar	41	24.4	41	24.4	79	47.02	7	4.2	168
Kashmir Region	***699***	***25.1***	***738***	***26.5***	***1252***	***45.00***	***93***	***3.3***	***2782***
Kargil	51	40.2	38	29.9	38	29.92	0	0.0	127
Ladakh	53	47.3	26	23.2	33	29.46	0	0.0	112

Ladakh Region	***104***	***43.5***	***64***	***26.8***	***71***	***29.71***	***0***	***0.0***	***239***
Doda	287	43.9	163	24.9	191	29.20	13	2.0	654
Jammu	470	45.1	309	29.6	253	24.26	11	1.1	1043
Punch	25	14.5	30	17.4	104	60.47	13	7.6	172
Rajauri	118	31.3	96	25.5	158	41.91	5	1.3	377
Kathua	268	48.2	110	19.8	176	31.65	2	0.4	556
Udhampur	205	34.5	154	25.9	227	38.22	8	1.3	594
Jammu Region	***1373***	***40.4***	***862***	***25.4***	***1109***	***32.66***	***52***	***1.5***	***3396***
J&K	**2176**	**33.9**	**1664**	**25.9**	**2432**	**37.90**	**145**	**2.3**	**6417**
Source: RGI, 2001									

Table B. 4: Access to Basic Amenities across Districts in J&K							
Districts/ Regions	***Electricity***	***Drinking water (1)***	***Toilet facility (2)***	***LPG***	***Pakka House***	***BPL Card***	***Sample Households***
Kupwara	92.3	64.5	93.7	12.4	39.6	66.7	1297
Baramula	93.7	78.8	94.6	19.9	32.2	51.1	1048
Srinagar	99.7	97.4	98.7	51.8	72.7	18.9	1236
Badgam	93	87.4	96.9	17.6	65.1	43.7	1264
Pulwama	96.1	87.4	86.3	12.1	77.5	42.8	1297
Anantnag	91	81.5	69.3	14.3	66.9	45	1288
Kashmir Region	***94.3***	***82.8***	***89.9***	***21.4***	***59***	***44.7***	***7430***
Leh	92.7	56.1	96.9	56	12.9	31.3	1190
Kargil	88.6	76.7	96.6	20	22.1	56.1	1163
Ladakh Region	***90.7***	***66.4***	***96.8***	***38***	***17.5***	***43.7***	***2353***
Kashmir Division	93.4	78.9	91.4	25.3	49.6	44.43	9783
Doda	78.0	69.6	18.9	10	14.3	52.4	1268
Udhampur	86.7	45.5	13.6	16.8	25.1	27	1314
Punch	81.6	81.3	22.2	15	22.4	52.3	1267
Rajauri	89.6	53.4	13.9	13.8	28.8	35	1617
Jammu	99.8	91.1	46.6	49.6	69.9	13.2	1015
Kathua	99.4	90.5	24.2	26.9	53.8	13.2	1594
Jammu Region	***89.3***	***71.1***	***22.1***	***21.0***	***35.0***	***32.10***	***8075***
J&K	**91.4**	**75.1**	**60.2**	**22.8**	**43.5**	**38.4**	**17858**

Notes---1: Includes piped water, public tap/sand pipe, hand pump, tube well/bore well;

2: improved source of sanitation, flush not to sewer/septic/pit/twin pit, or pit without slab or dry toilet.

Source: IIPS, 2010

Table B. 5 : Availability of Human Resource at PHCs across Districts in J&K					
District/ Regions	***MO at PHC***	***Lady MO at PHC***	***AYUSH MO at PHC***	***Pharmacist***	***Sample PHCs***
Kupwara	52.6	26.3	5.3	89.5	19
Baramula	70.0	55.0	35.0	95.0	20
Srinagar	83.3	50.0	0.0	100.0	12
Badgam	52.4	42.9	4.8	100.0	21
Pulwama	33.3	44.4	22.2	94.4	18
Anantnag	60.0	33.3	93.3	93.3	15
Kashmir Region	***58.6***	***42.0***	***26.8***	***95.4***	***105***
Leh	25.0	50.0	0.0	87.5	8
Kargil	40.0	20.0	20.0	100.0	5
Ladakh Region	***32.5***	***35.0***	***10.0***	***93.8***	***13***
Kashmir Division	54.24	41.53	23.73	94.92	118
Doda	35.7	21.4	64.3	92.9	14
Udhampur	47.4	21.1	47.4	94.7	19
Punch	22.2	33.3	44.4	100.0	18
Rajauri	40.0	20.0	33.3	100.0	15
Jammu	76.5	82.4	58.8	88.2	17
Kathua	66.7	38.1	33.3	95.2	21
Jammu Region	***49.04***	***36.54***	***46.15***	***95.19***	***104***
J&K	**51.8**	**39.2**	**34.2**	**95.0**	**222**
Notes --* *MO* = Medical Officer.					
Source: IIPS, 2010.					

Table B. 6 : Availability of Human Resource at CHCs across Districts in J&K					
Districts/ Regions	***Obstetric/ Gynaecologist***	***Paediatrician***	***Anaesthetist***	***Health Manager***	***Sample CHCs***
Kupwara	20.0	0.0	40.0	0.0	5
Baramula	12.5	0.0	75.0	37.5	8
Srinagar	33.3	33.3	100.0	0.0	3
Badgam	66.7	0.0	50.0	0.0	6
Pulwama	40.0	0.0	40.0	0.0	5
Anantnag	33.3	16.7	33.3	8.3	12
Kashmir Region	***34.3***	***8.3***	***56.4***	***7.6***	***39***
Leh	0.0	0.0	0.0	0.0	1
Kargil	33.3	0.0	0.0	0.0	3
Ladakh Region	***16.7***	***0.0***	***0.0***	***0.0***	***4***
Kashmir Division	32.56	6.98	46.51	9.30	43
Doda	28.6	14.3	57.1	0.0	7
Udhampur	40.0	20.0	80.0	20.0	5
Punch	33.3	0.0	66.7	33.3	3
Rajauri	83.3	16.7	16.7	0.0	6
Jammu	100.0	100.0	100.0	16.7	6
Kathua	100.0	66.7	100.0	0.0	3
Jammu Region	***63.33***	***36.67***	***66.67***	***10.00***	***30***
J&K	**45.2**	**19.2**	**54.8**	**9.6**	**73**
*Source: IIPS, 2010**.***					

Table B.7: Access to Antenatal Care across Districts in J&K					
Districts/ Regions	***ANC at Govt Facility***	***ANC at Private Facility***	***Any ANC***	***Full ANC***	***Sample Women***
Kupwara	72.2	33.9	81	33.8	555
Baramula	63.8	42.7	84.5	38.6	366
Srinagar	82.1	25	99.3	32	302
Badgam	86.8	19.5	94.4	27.3	414
Pulwama	72.7	30.9	93.8	32.6	386
Anantnag	63.6	34.2	92.1	48.8	512
Kashmir Region	***73.5***	***31.0***	***90.9***	***35.5***	***2535***
Leh	95.3	9.2	93.9	15.9	232
Kargil	88.7	9	79.5	18	381
Ladakh Region	***92.0***	***9.1***	***86.7***	***17.0***	***613***
Kashmir Division	76.46	27.02	89.07	32.39	3148
Doda	93.5	6.7	64.6	23.2	354
Udhampur	85.1	14.9	88.9	28.8	336
Punch	91.7	6.3	62.9	11.5	306
Rajauri	94.9	5.2	63.4	9.7	475
Jammu	68.9	26.8	95.3	34.2	244
Kathua	77.4	22.7	95	47.5	324
Jammu Region	***86.67***	***13.77***	***76.57***	***24.40***	***2039***
J&K	**79.2**	**22.7**	**84.3**	**29.1**	**5187**
Source: IIPS, 2010.					

Table B.8: Access to Vaccination across Districts in J&K				
Districts/ Regions	***Full Vaccination***	***None Vaccination***	***One Dose of Vitamin A***	***Sample Children***
Kupwara	54	7.3	53.7	197
Baramula	53.4	3.1	62.7	101
Srinagar	78.1	0	71.4	72
Badgam	71.5	0	57.4	134
Pulwama	76.9	0.8	63.6	120
Anantnag	56.2	3.1	42.2	147
Kashmir Region	***65.0***	***2.4***	***58.5***	***771***
Leh	83.3	0	76.2	63
Kargil	82.8	1.3	69	117
Ladakh Region	***83.1***	***0.7***	***72.6***	***180***
Kashmir Division	66.94	2.58	59.36	951
Doda	39.2	8.7	22.9	78
Udhampur	61.5	0	68.5	90
Punch	28.2	13.3	31.8	116
Rajauri	48.2	20.3	56.2	112
Jammu	73.5	0	43.7	82
Kathua	87.1	0	70.1	93
Jammu Region	***54.97***	***7.87***	***49.10***	***571***
J&K	**62.2**	**4.6**	**56**	**1522**
Source: IIPS, 2010				

Table B.9: Disparities in Morbidity by Districts in J&K				
	Prevalence of Morbidity			
District/ Regions	***Tuberculosis (1)***	***Malaria (2)***	***Partial Blindness***	***Complete Blindness***
Kupwara	869	19	1664	43
Baramula	0	0	0	11
Srinagar	213	130	2275	269
Badgam	104	20	942	59
Pulwama	845	11	1773	34
Anantanag	82	198	678	73
Kashmir Region	*N. A*			
Leh	60	136	217	214
Kargil	273	209	337	246
Ladakh Region	N. A			
Kashmir Division	*N. A*			
Doda	27	14	26	15
Udhampur	129	25	390	190
Poonch	18	18	18	34
Rajauri	25	160	373	80
Jammu	96	139	161	619
Kathua	401	376	249	871
Jammu	*N. A*			
J&K	234	108	799	248

Notes --(1) and (2) Prevalence Rate is per 100000 populations.
Reference period: January 1999 to survey date (December 2002) for phase-1 and January 1st, 2001 to survey date (December2004) for phase-2. However, for Malaria, reference period is last two weeks prior to the survey.; Sample size was 15,087 households in J&K

Source: IIPS, 2002-04

Table B.10: Place of Delivery by Districts in J&K			
District/ Region	*Percentage of women* (15-49) who had*		
	Institutional Delivery	***Home Delivery***	***Sample Women***
Kupwara	56	42.9	555
Baramula	54.7	43.2	366
Srinagar	87.3	10.9	302
Badgam	74.9	23.8	414
Pulwama	77.5	22.2	386
Anantanag	63.3	36	512
Kashmir Region	***69.0***	***29.8***	***2535***
Leh	71.9	27.4	232
Kargil	54.5	44.3	381
Ladakh Region	***63.2***	***35.9***	***613***
Kashmir Division	67.5	31.3	3148
Doda	30.9	68.8	354
Udhampur	27.7	72	336
Punch	23	77.3	306
Rajauri	33.9	65.4	475
Jammu	65.4	30.8	244
Kathua	55.1	43.5	324
Jammu Region	***39.3***	***59.6***	***2039***
J&K	**54.9**	**44.1**	**5,187**
Notes -- Percentage of women who had institutional and home delivery may not add to 100.0, as some deliveries took place on the way to the institute, working place, other place etc. **Women who had their last live/still birth since 01-01-2004.*			
Source: IIPS, 2010			

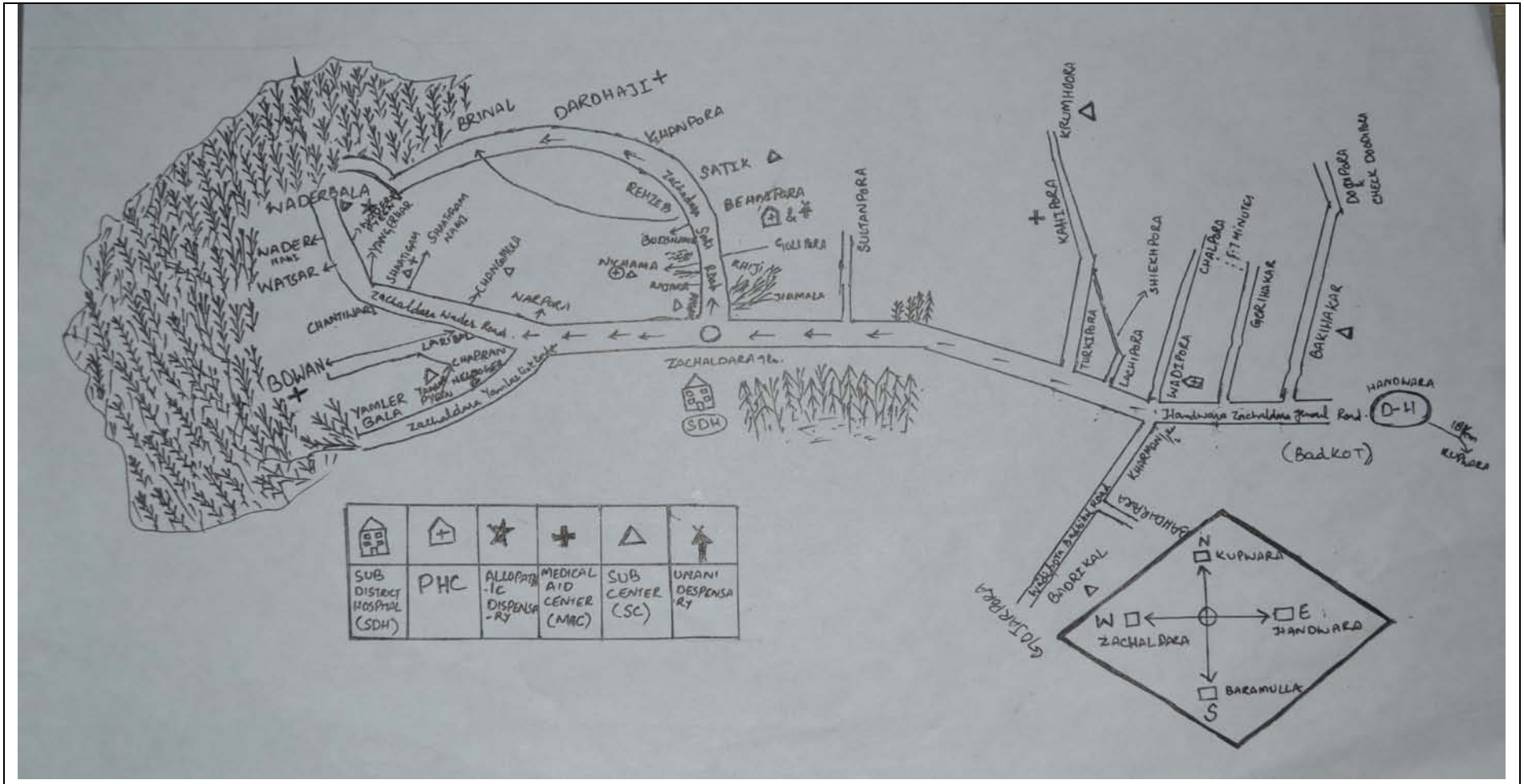
Table B.11: Access to Treatment across Districts in J&K					
Districts/ Regions	***Children Suffered Diarrhoea***	***Children Sought Treatment***	***Children Suffered ARI***	***Children Treated for ARI***	***Sample Children***
Kupwara	16.5	54.2	33.4	84	767
Baramula	16.6	80.4	18.9	89.2	489
Srinagar	15.6	84.2	10.3	85.3	379
Badgam	12.3	65.6	19.7	82.1	532
Pulwama	19.4	75.7	12.5	87.1	453
Anantnag	13.1	71.7	10.7	92.7	623
Kashmir Region	***15.6***	***72.0***	***17.6***	***86.7***	***3243***
Leh	14.5	67.5	7.9	75	275
Kargil	5.1	45.1	2	83.3	499
Ladakh Region	***9.8***	***56.3***	***5.0***	***79.2***	***774***
Kashmir Division	16.51	66.65	16.12	85.50	4017
Doda	5.7	48.4	4.6	93	449
Udhampur	10.4	64.3	2.2	60	398
Punch	11.5	72.3	12.1	81.8	391
Rajauri	8.9	66.4	2.1	67.6	610
Jammu	6.2	66	4.5	82.4	303
Kathua	17	83.8	6.5	92.9	386
Jammu Region	***9.88***	***66.39***	***5.06***	***78.71***	***2537***
J&K	**12.3**	**68.7**	**11.7**	**84.1**	**6554**
Source: IIPS, 2010					

Table B.12: Coverage of Population by Health Institutions across Districts in J&K			
District/ Regions	Average Population covered by		
	Sub-centre	***PHC***	***CHC***
Kupwara	3211	19474	76852
Baramula*	4265	72267	129935
Srinagar	6895	53232	131533
Badgam	4122	10221	53866
Pulwama	3833	20604	101590
Anantnag	3678	21619	75250
Kashmir Region	***4334***	***32903***	***94838***
Leh	718	2087	593
Kargil	961	6491	56751
Ladakh Region	***840***	***4289***	***28672***
Kashmir Division	3460	25749	78296
Doda	2571	17649	82478
Udhampur	3580	29018	83233
Punch	2568	16220	119683
Rajauri	3572	39818	75271
Jammu	2987	14570	130442
Kathua	2984	18081	78311
Jammu Region	***3044***	***22559***	***94903***
J&K	**3499**	**25802**	**89659**

Notes --*The average coverage of a sub-centre in Baramulla has been reported to be 42650, which seems to be a data error, and the value has been assumed to be around 4265 for this table, otherwise if considered the original value of Baramulla, the average population coverage by Sub-centre will be 8259 in Kashmir and 6011 in J&K.*

Source: IIPS, 2010.

Appendix –C : Health Institutional Map of Zachaldara Medical Block, Kupwara District



Source: Block Medical Office, Zacahaldara, Kupwara District

Annexure – A: Interview Schedule for Socio-Economic Survey

Note: Respondents are any adult male or adult female in a household.

Section 1: Identification

Household ID	District	VLG	H. No.		

	Date of Interview:	
	Name of Respondent:	Relationship of Respondent with Head of family:
	Name of Household Head:	

Section 2: Socio-Economic Characteristics:

(Tick the relevant score against each option after thorough investigation only. In case of any confusion, please take detailed notes)

	Socio-Economic Index				
	Socio-economic Indicators				***Score***
1	**Type of House**	Houseless			**0**
		Kutcha			**1**
		Semi Pucca			**2**
		Pucca			**3**
		Urban type			**4**
2	**Land Holdings**	**Unirrigated Land**	**Irrigated Land**	**Ind. Score**	**Final score**
		Nil holdings	Nil holdings	**0**	
		Less than 4 Kanals unirrigated	Less than 2 Kanals irrigated	**1**	
		More than 4 and Less than 8 Kanals unirrigated	More than 2 and Less than 4 kanals irrigated	**2**	
		More than 8 and less than 16 Kanals unirrigated	More than 4 and less than 8 Kanals irrigated	**3**	
		More than 16 and less than 24 Kanals unirrigated	More than 8 and less than 12 Kanals irrigated	**4**	

		More than 24 Kanals unirrigated	More than 12 Kanals irrigated	**5**	
3	**Sanitation**	Open defecation			**0**
		Group Pit latrines with no or irregular water supply			**1**
		Group Pit latrines with regular water supply			**2**
		Pit latrine (only used by this household)			**3**
		Flush			**4**
4	**Ownership of Consumer durables**	**Viz: Colour TV, Refrigerator, Computer, Washing Machine**			
		Nil			**0**
		Any one item			**1**
		Two items only			**2**
		Any three			**3**
		All items			**4**
5	**Literacy status of highest literate**	Illiterate			**0**
		Up to primary/passed 5th			**1**
		Up to middle/passed 8th			**2**
		Completed secondary/passed 10th			**3**
		Higher Secondary/passed 12th			**4**
		Graduate/Professional			**5**
		Post Graduate/Professional			**6**
6	**Means of livelihood**		**Number of Persons involved**	**Individual Score**	**Final Score**
		Living on Alms/Begging/Charity		**0**	
		Casual labour		**1**	
		Artisan/ Small Business		**2**	
		Low salaried (equivalent to 4th class in govt.)		**3**	
		Middle Salaried/ Medium Business		**4**	
		High Salaried/ High Business		**5**	
7	**Status of Children** (5 to 18 yrs)		**Number of Children**	**Individual Score**	**Final Score**
		Not going to school and/or working		**0**	
		Going to school and working		**2**	
		Going to school and not working		**4**	
8	**Drinking water**	Stream/river/spring			**0**
		Piped water/tube well to be fetch from longer distance			**1**
		Piped water/tube well inside the yard			**2**

		Piped water/tube well inside the house	**3**
9	**Cooking fuel**	Dung Cake	**0**
		Wood	**1**
		Kerosene	**2**
		LPG	**3**
10	**Ownership of costly durables**	No tractor	**0**
		Tractor or equivalent	**4**
		No Car	**0**
		Car or equivalent	**3**
		No Motor Bicycle/scooter	**0**
		Motor Bicycle/scooter	**1**
11	**Observation Remarks**	Poorest	**0**
		Slightly Better off	**1**
		Middle class	**2**
		Upper class	**3**
12	**Ration card** (just for comparison)	None	**0**
		AAY	**1**
		BPL	**2**
		APL	**3**
	Total Score ***(to be calculated after the survey is completed)***		

Annexure – B: Interview Schedule for Access to Health Services[1]

Introduction and Informed Consent

Asalaamu Alaikum,

My name is *Tanveer Ahmad Dar* and I am doing M.Phil at Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. I am conducting a survey about the health of women, men, and children, including information on household membership, living conditions, and use of health facilities.

I would very much appreciate the participation of your household in this survey. I would like to ask you some questions about your household and health of Individuals and access to health services. The survey usually takes about one hour to complete. Whatever information you provide will be kept strictly confidential. Participation in this survey is voluntary and you can choose not to answer any question or all of the questions. However, I hope that you will participate in this survey since your participation is important.

Do you want to ask me anything about the survey?

May I begin the interview now?

Respondent agrees to be interviewed... 1 Respondent doesn't agree to be interviewed...2

Note: 1. Respondents are any adult male and adult female in a household.
2. For some questions, multiple answers are possible. In that case, encircle multiple codes or fill multiple codes in boxes as applicable but separate with vertical lines.
3. In case the space provided in any section is not enough, use additional sheets but mention it on the questionnaire.

Section 1: Identification

Household ID	District	VLG	H. No.		

[1] This interview schedule has been constructed based on the interview schedules of NFHS (on utilization of health services) and NSSO (on morbidity and access to treatment)

	Date of Interview:	Name of Investigator:
	Name of adult Female Respondent:	Adult Male Respondent:
	Relationship of Respondent with Head of family:	
	Name of Household Head:	

Section 2: Socio-Demographic Information

1	1. Caste . . . . . 2. Tribe . . . . . 3. No Caste /Tribe . . . . . 4. Don't Know		
2	Is this a scheduled caste, a scheduled tribe, other backward class, or none of them?	1. SC 2. ST 3. OBC	4. General 5. OSC 6. Not Applicable
3	Religion of the head of the household?	1. Hindu 2. Muslim 3. Christian	4. Sikh 5. No Religion 6. Other (specify) _____
4	Nature of Family [*Nuclear is husband-wife and unmarried children, nuclear extended is husband-wife, unmarried children and parents-in-law (either or both), Joint is husband-wife, parents-in-law, unmarried children and others*] 1. Nuclear 3. Joint 2. Nuclear-extended 4. Other _____		

5. Household Members[2] Information

ID No	**Name** *(Start with H. Head)*	**Relation to Household Head**	**Sex** M/ F	**Age** (in complete years)	**Marital Status**	**Education level** (the last completed Level)	**If currently studying,** which level/class	**Usual Activity Status**
1								

[2] Only those persons will be recorded whom does the household record as members of family, including women who are married elsewhere but have given birth to child while being in the village surveyed and are living there until the day of survey.

2								
3								
4								
5								
6								
7								
8								

Codes:

Relation to Household Head: *self - 1, spouse of head - 2, married child - 3, spouse of married child - 4, unmarried child - 5, grandchild - 6, father/mother-7, father-in-law/mother-in-law - 8, brother/sister-9, brother-in-law/sister-in-law-10, other relatives –11 (specify . . . . . .), servant/employees/other non-relatives – 12 (specify . . ..)*

Marital Status: Currently *married -1; Widowed –2; Divorced- 3; Separated; Never married -4*

Educational Level: *not literate - 01; literate: without formal schooling - 02, below primary - 03, primary - 04, middle - 05, secondary - 06, higher secondary - 07, diploma/certificate course – 08, graduate – 10, post-graduate & above - 11*

Usual activity status: *worked in hh enterprise (self-employed): own account worker – 11, employer – 12, worked as helper in hh enterprise (unpaid family worker) – 21; worked as regular salaried/wage employee – 31; worked as casual wage labour: in public works – 41, in other types of work – 51; did not work but was seeking and/or available for work –81, attended educational institution – 91, attended domestic duties only – 92, attended domestic duties and was also engaged in free collection of goods (vegetables, roots, firewood, cattle feed, etc.), sewing, tailoring, weaving, etc. for household use – 93, rentiers, pensioners, remittance recipients, etc. – 94, not able to work due to disability – 95, beggars, prostitutes – 96, others – 97 (specify .. . . . .)*

Section 3: Socio-economic Characteristics: Access to Sanitation, Housing, Water, Cooking fuel, Electricity, PDS AND Ownership of Assets

6	Do you have a ration card?	1. Yes 2. No
7	If yes, what kind of a card do you have?	1. APL 2. BPL 3. Antodaya 4. Other _____

8	During the last three months did you buy any item from the PDS?	1. Yes 2. No	
9	During the last three months, how many times did you purchase the following from PDS? _____ times	a) Rice	
		b) Wheat	
		c) Edible Oil	
		d) Sugar	
		e) Kerosene	
		f) Other	
10	What kind of a house do you live in?	1. Kachcha 2. Pakka 3. Semi-pakka 4. Urban type Pakka 5. Other _____	
11	Does your family own the house you live in?	1. Yes 2. No 3. Rented	
12	What are the main sources of water for members of your household?	1. Piped water/ Tap 2. Tube well or borehole 3. Dug well 4. Water from spring 5. Tanker truck 6. Surface water (river/Lake/pond/stream/canal) 7. Other (specify) _____	
13	What are the main source of water used by your household for other purposes such as cooking and hand washing?	1. Piped water/ Tap 2. Tube well or borehole 3. Dug well 4. Water from spring 5. Tanker truck 6. Surface water (river/Lake/pond/stream/canal) 7. Other (specify) _____	
14	Where is the water source located?	1. In own building/yard 2. Outside home	
15	Do you treat your water in any way to make it safer to drink?	1. Yes 2. No 3. Don't Know	
16	What do you usually do to the water to make it safer to drink?	1. Boil 2. Use alum 3. Add bleach/chlorine tablets	

		4. Strain through a cloth 5. Use water filter (ceramic/sand/composite/etc.) 6. Use electronic purifier 7. Let it stand and settle 8. Other (specify)_____ 9. Don't know		
17	What type of fuel does your household mainly use for cooking?	1. Wood 2. Dung cakes 3. Kerosene 4. LPG 5. Electricity 6. Coal 7. Others (Specify)_____		
18	Do you have electricity in your house?	1. Yes 2. No		
19	What kind of toilet facility do members of your household usually use?	1. Flush or pour Toilet 2. Pit Latrine 3. Dry latrine 4. No facility/use open space 5. Other (Specify)_____		
20	Is the toilet facility in your house or shared with others?	1. In house/in yard 2. Community toilet 3. Shared with other few households 4. Other (Specify)_____		
21	Does your family own any agricultural land?	1. Yes 2. No 3. Don't know		
22	How much agricultural land does your family own? [*Note down the units in which the respondent reports and later convert to Kanals*]	_____ Kanals		
23	Out of this land, how much is irrigated or under apple cultivation?	_____ Kanals is irrigated *(irrespective of type of cultivation)* _____Kanals under apple cultivation		
24	Does your household own any of the following animals? *If yes, write the number of animals owned. In case of none, write '0'*	1) Cows/bulls/Buffaloes _____ 2) Goats/Sheep _____ 3) Chicken/Ducks _____ 4) Horses/Donkeys _____ 5) Other _____		
25	Do you or anyone in your household own	1. A mattress	Yes -1	No—2

	any of the following?	2. A pressure cooker	1	2
		3. A chair	1	2
		4. A cot or bed	1	2
		5. A table	1	2
		6. An electric fan	1	2
		7. A watch or clock	1	2
		8. A Radio or transistor	1	2
		9. A black and white TV	1	2
		10. Colour TV	1	2
		11. A Sewing machine	1	2
		12. A Mobile telephone	1	2
		13. Any other type of telephone	1	2
		14. A Refrigerator	1	2
		15. A water pump	1	2
		16. A computer	1	2
		17. An animal-drawn cart	1	2
		18. A Bicycle	1	2
		19. A Motorcycle/Scooter	1	2
		20. A car	1	2
		21. A thresher	1	2
		22. A tractor	1	2
26	Does any usual member of this household have a bank account or a post office account?	1. Yes 2. No 3. Don't Know		
27	Does this household have any mosquito nets that can be used for sleeping?	1. Yes 2. No		

Section 4: Morbidity Profile of Household Members:

(Women have to be given assurance that the information provided by them will be kept strictly confidential and if they are not comfortable to talk about some of their health problems, they can just mention that they had suffered from some health problem and if they were able to seek treatment, without giving the details about the nature of the ailment)

ID No	**Name** *(Start with H. Head)*	***28. During Last 365 days***		***29.Whether Ailing***	
		Whether hospitalised (yes-1, no-2)	**if yes, no. of times hospitalised**	**Anytime during last 15 Days (yes-1, no-2)**	**on the day before the date of survey (yes -1, no -2)**
1					
2					
3					
4					
5					
6					
7					
8					

Section 5: Mortality Information and Access to treatment: Particulars of Household Members who died during last 365 days (*As the number of persons who would have died in the 50 households (or in the entire village) in the last one year would be a few, considering the death rate of 8 per 1000 population, it would be better to take a detailed note of the narratives of the household)*

30	Whether any member of the household has died during the 365 days? 1. No ⟶ **Skip to Section 6** 2. Yes (fill the details below in the table)								
ID No	**Name of deceased member**	***Sex (Male – 1, Female-2)***	**Age at death** (in complete years)	***Reason of Death***	***Medical attention received before death (yes -1 ; no- 2)***	***whether hospitalised (yes-1, no-2)***	***if 1 in col. 7, no. of times hospitalised***	***if 2 in col. 3,***	
								whether pregnant (yes-1, no-2)	***if 1 in col. 9, time of death (code)***
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

1									
2									
3									

Codes: ***col. 9 - time of death:*** *for deaths relating to pregnancy/delivery/abortion: during pregnancy – 1, during delivery – 2, within 6 weeks of delivery – 3; other deaths – 9 (specify.....)*

Section 6: Access to *Inpatient* treatment: Particulars of medical treatment received as inpatient of a hospital during the last 365 days

31. Srl. no. of the hospitalisation case		**1**	**2**	**3**	**4**
32. First Name of person					
34. type of hospital (code)					
35. nature of ailment (code)					
36. duration of stay in hospital (days) / put 1 in the next box if not discharged yet					
37. whether treatment availed before hospitalisation (yes - 1, no - 2)					
if 1 in item 37	38. source of treatment (code)				
	39. duration of treatment (days)				
40. whether treatment continued after discharge from hospital (yes - 1, no - 2)					
if 1 in item 40	41. source of treatment (code)				
	42. duration of treatment (days)				

CODES:

item 34 - *type of hospital: public hospital (incl. PHC/ sub-centres/CHC) - 1, public dispensary (incl. CGHS/ESI) – 2, private hospital – 3; others –4 (specify . . .*

item 35 - *nature of ailment: code list is given on last page*

items 38 & 41 - *source of treatment: public hospital (incl. PHC/ sub-centres/CHC) - 1, public dispensary (incl. CGHS/ESI)– 2, private hospital – 3, private doctor – 4; others -5 (specify . . . . E.g: staff nurse, chemist, traditional heeler, etc)*

43	If the patient was not hospitalised in government health facility, why not?

44	Were you satisfied with health services and health providers at the hospital?
45	If No, why not and what else could have been done better?

Section 7: Expenses Incurred on Inpatient treatment*:* *Particulars of expenses incurred for treatment of members treated as inpatient of hospital during the last 365 days and source of finance*[3]

	Details of medical services received (not received - 1; received: free - 2, partly free - 3, on payment - 4)						
46	Consultation						
47	surgery						
48	medicine						
49	X-ray/ECG/EEG/Scan						
50	other diagnostic tests						
51	type of ward (free - 1, paying general - 2, paying special - 3)						
If partly free or on payment for any of the above services, ask for Medical expenditure for treatment (Rs), otherwise skip to 62 Q.							
doctor's / surgeon's fee	52. hospital staff						

[3] Put G or P with code to indicate if the source of service was Government or Private.

	53. other specialists					
medicines	54. from hospital					
	55. from outside					
56. diagnostic tests						
57. bed charges						
58. attendant charges						
59. physiotherapy						
60. personal medical appliances						
61. Ward charges						
others	62. food and other materials					
	63. blood, oxygen cylinder, etc.					
	64. Services (ambulance, etc.)					
65. expenditure not elsewhere reported						
66. total (items 52 to 65)						
Other expenses incurred by the household (Rs) (not included in item 66)						
67. Food and transport (other than ambulance) of escort(s)						
68. lodging charges of escort(s)						
69. Others (specify)						
70. total (items 67 to 69)						
71. loss of household income, if any, due to hospitalisation including wages (Rs)						
72. total expenditure incurred by the household (sum of items 66 & 70 for all cases of hospitalisation taken together)						
73. How did you manage the expenses in item 72 incurred on treatment [by source of finance (Rs)]?						
74. household income/savings						

75. borrowings						
76. contributions from friends and relatives						
77. other sources (incl. sale of ornaments and other physical assets, draught animals, etc.) [specify]						
78. total (items 74 to 77)						
79. Any amount of reimbursement (Rs) out of total expenses: Yes- 1, No- 2						
If YES, amount reimbursed by (Rs)	employer	80. Government				
		81. private				
	82. medical insurance companies					
	83. Other agencies [specify].....					
84	whether any medical service provided free by employer: Yes: Govt -1 , Private- 2; No-2; Not Applicable -3					

Section 8: Access to Outpatient treatment*: Particulars of spells of ailment of household members during the last 15 days (including hospitalisation)*

85. Srl. no. of spell of ailment	**1**	**2**	**3**	**4**
86. First Name of person				
87. number of days within the reference period you have been ill				
88. nature of ailment (code)				
89. status of ailment (code)				
90. total duration of ailment (days)				
91. whether treatment taken on medical advice (yes - 1, no - 2)				
92. If Yes, from where 1. Public hospital 4. Public dispensary 2. Sub-centre 5. Private hospital/doctor 3. Local Chemist 6. Other (specify) - - - - - - - 7. RMP				
93. If not from government, what were the reasons?	94. If Private, why sought treatment from private?			

95. If not sought any medical advice, what were the reasons? [code] _ _ _ _ _ — _ _ _ _ _ — _ — _ _ _ _ — _ _ _ _ _ _ _ _ _ — _ _ _ _ — _ _					
96	Whether any other measure taken for recovery/relief? Whom did you consult (**codes**) and what did you do? _____ _ _ _ _____ _ _ _ _ _____ _ _ _ _____ _ _ _ _ _ _				
97	expenditure incurred, if any (Rs)				
98	Were you satisfied with health services and health providers at the health facility?				
99	If No, why not and what else could have been done better?				

CODES: item 88 *- nature of ailment: code list is given on separate page.*

item 89 *- status of ailment: started more than 15 days ago and is continuing -1, started more than 15 days ago and has ended -2, started within 15 days and is continuing -3, started within 15 days and has ended – 4*

item 93 *- reason for not availing govt. sources: Govt. doctor/facility too far-1, not satisfied with medical treatment by Govt. doctor/facility -2, long waiting -3,required specific services not available - 4, others - 9*

item 95 *- reason for no treatment: no medical facility available in the neighbourhood - 1, facilities available but no treatment sought owing to: lack of faith - 2, long waiting - 3, financial reasons - 4, ailment not considered serious - 5, others - 9*

item 96 *- whom consulted: self/other household member/ friend - 1, medicine shop - 2, others - 9*

Section 9: Expenses Incurred on Outpatient treatment: *Particulars of expenses incurred during the last 15 days for treatment of members (not as inpatient of hospital) and source of finance.*

Details of medical services received (not received - 1; received: free - 2, partly free - 3, on payment - 4)					
100. Consultation					
101. surgery					
102. medicine received					
103. X-ray/ECG/EEG/Scan					
104. other diagnostic tests					
If partly free or on payment for any of the above services, ask for Medical expenditure for treatment (Rs), otherwise skip to 113 Q.					
doctor's / surgeon's fee	105. hospital staff				
	106. other specialists				
medicines	107. from hospital				
	108. from outside				
109. diagnostic tests					
110. attendant charges					
111. physiotherapy					
112. personal medical appliances					
others	113. food and other materials				
	114. blood, oxygen cylinder, etc.				
	115. services (ambulance, etc.)				
116. expenditure not elsewhere reported					
117. total medical expenditure (items 105 to 116)					
Expenditure reported in	118. Govt. sources				

item 117 from	119. other sources				
Other expenses incurred by the household (Rs) (not included in item 117)					
120. transport charges (other than ambulance)					
121. food and lodging charges of ailing person and escort(s)					
122. Others (specify)					
123. total (items 120 to122)					
124. loss of household income, if any, due to ailment (Rs) including wages					
125. total expenditure incurred by the household (sum of items 117 & 123 for all persons taken together)					
126. How did you manage the expenses in item 125 incurred on treatments [by source of finance (Rs)]?					
127. household income/savings					
128. borrowings					
129. contributions from friends and relatives					
130. other sources (incl. sale of ornaments and other physical assets, draught animals, etc.) [specify]					
131. total (items 127 to 130)					
132. Any amount of reimbursement (Rs) out of total expenses: Yes- 1, No- 2					
If YES, amount reimbursed by (Rs)	employer	133. Government			
		134. private			
	135. medical insurance companies				
	136. other agencies [specify]				
137	whether any medical service provided free by employer (yes: Govt. -1, pvt. - 2; no - 3, not applicable - 4)				

Section 10: Maternal History: *Respondents are any adult female in the household interviewed. (Let me assure you again that your answers are completely confidential and will not be told to anyone. If you do not want to answer any question, just let me know and I will skip to the next question).*

138	How old were you when you got married?	_____in years
139	How old were you during your first pregnancy?	_____in years
140	How many total children do you have?	No _ _ _ _ _
141	Are you pregnant now? Yes - - - 1 No - - - - 2 Unsure/Don't Know - - - 8	*Very Sensitive Questions.*
142	How many months pregnant are you? Months - - -	
143	Has any of your children died (***or any of your pregnancy didn't mature***)? No- 1 ⟶ **Skip to** Yes – 2 (ask the details in the table below)	

144	**What name was given to you first/next baby?**	**Sex M/F**	**What was the age at death?** Record days if less than month, months if less than 2 yrs, or else yrs (completed only)			**Place of birth** (1) Home (2) Govt. Hospital (3) Pvt. Hosp (4) Other_____	**Place of birth** (1) Marital village (2) Parents' village
			D	**M**	**Y**		

145. In case of any infant mortality, stillbirth or miscarriage please make a note of the reasons for this:

(Note: Ask for any hospitalisation history; any problem with birth itself; any infection; any other reason)

Section 11: Access to Maternal Health Services: ***Antenatal, Delivery, Postnatal care and New Born Care***

The following questions are in relation to the last pregnancies/deliveries in the last three years that resulted in a live birth and the child is still surviving. To reconfirm please note name of children in relation to whom these questions were asked.			Youngest Child _____	2nd Ygst Child _____ _
146	Was this pregnancy registered with the ANM?	1. Yes 2. No		
147	Did you get a card from the ANM?	1. Yes 2. No		
148	Did you see anyone for antenatal care?	1. Yes 2. No		
149	If yes, whom did you see?	1. Doctor 2. ANM/Nurse/Midwife/ LHV 3. Dai/TBA 4. Anganwadi worker 5. Other (specify) - - - - -		
150	Where did you receive antenatal care?	1. At home 2. Sub centre 3. PHC 4. ICDS 5. Private clinic/Hospital 6. Govt. Hospital 7. Other (specify) - - - - - - - - - -		
151	Why you wanted to receive ANC (explore significance of ANC to women)?			

152	How many months pregnant were you when you first received antenatal care for this pregnancy?	1. In months - - - 2. Don't know		
153	How many times did you receive antenatal care during this pregnancy?	1. Number of times _______ 2. Don't know		
154	If less than 3 ANCs, what were the reasons for not having 3 ANCs? ____ _ _ _ _ _ _ _ _ _ _ — _ _ _ _ _ _			
155	As part of antenatal care during this pregnancy, What services were you provided at least once? Record the details below : ___ _ _ _ _ _ _ _ _ _ _ _ __ __________ _____ ______________ _	(1) Weight Measured Yes --1 ; No --- 2		
		(2) Blood Pressure Measured Yes --1 ; No --- 2		
		(3) Urine test: Yes --1 ; No --- 2		
		(4) Blood test : Yes --1 ; No --- 2		
		(5) Abdomen Checked Yes --1 ; No --- 2		
		(6) Advise on hospital delivery Yes --1 ; No --- 2		
		(7) Advise on Nutrition: Yes --1 ; No --- 2		
		(8)Scan/Ultrasound Yes --1 ; No --- 2		
		(9) Expected delivery date Yes --1 ; No --- 2		
		(10) X-Ray; Yes --1 ; No --- 2		
156	At any time during the pregnancy, have you had an ultrasound test?			

	Yes --1 ; No --- 2			
157	Were you told where to go if you had any pregnancy complications?	1. Yes 2. No		
158	Was your husband/any-family member present during any of your antenatal visits?	1. Yes 2. No		
159	When you were pregnant, were you given Iron folic tablets or syrup? 1 -- Yes; 2----No ; 3 - ---Don't Know			
160	When you were pregnant, were you given an injection in the arm to prevent you and the baby from getting tetanus?	1. Yes 2. No		
161	How many times did you get this injection?	_____ times		
162	During the last three months of this pregnancy, did you meet with an ANM, LHV, AWW, or other community health worker?	1. Yes 2. No		
163	IF YES: Where did you meet this/these person (s)?	1. Home only 2. Elsewhere only (specify) - - - - - - - - 3. Both home and elsewhere		
164	During any of these meetings in the last three months of this pregnancy, what did they talk to you? _____ _	Breastfeeding? Yes - -1, No- - 2		
		Keeping the baby warm? Yes - -1, No- - 2		
		The need for cleanliness at the time of delivery? Yes - -1, No- - 2		
		Advise on hospital delivery Yes --1 ; No --- 2		
	_____ ___ ___ _	Advise on Nutrition: Yes --1 ; No --- 2		
		Other (Specify) ______		
165	Are you satisfied with ANC health services? Yes -1, No -2. If no, what were the reasons? __ _ _ _ _ _ _ _			

	____		
166	Have you incurred any expenditure on ANC in terms of paying to doctor, hospital, medicines, diagnostic tests, etc? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip to**		
167	Did you have to borne any indirect cost in terms of loss of wages, food and lodging of escorts, etc for accessing ANC? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip to**		
168	How did you manage expenses to be incurred for accessing ANC checkups? ____		

169	During your pregnancy, did you eat more nutritious food than normal?	1. Yes 2. No		
170	If yes, Describe:			
171	During your pregnancy, did you reduce the amount of physical work you did?	1. Yes 2. No		
172	If yes, Describe:			

	Delivery Care					
173	Where did u give birth to your last child? 1. Home 2. Public hospital 3. Public dispensary 4. Sub-centre 5. Private health facility - - - - - - - 6. Other (specify) - - - - - - - - - -	1. Marital Village 2. Parent's village				
174	Who assisted with the delivery?	1. Doctor 2. ANM/NURSE/ MIDWIFE/LHV 3. Other health personnel 4. Dai (TBA) 5. Friend/relative 6. Other (specify) - - - - -- - 7. No one				
175	Was the child delivered by caesarean section?	1. Yes 2. No				
176	If the last delivery was in an institution, did the ASHA accompany you for the delivery? 1. Yes 2. No					
177	If No, why? _					
178	Did you get any amount of benefit under JSY? 1. Yes 2. No					
179	If No, Why not?					

	. . . .		
180	If Yes, How much? ___ RS		
181	Have you bribed or any amount has been cut from your entitlement?		
182	What do you feel about JSY?		
183	What are your experiences of birthing in health facility? (Did they treat you with dignity, was privacy provided, etc.)		
184	Have you incurred any expenditure on delivery in terms of paying to doctor, hospital, medicines, diagnostic tests, etc? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip to**		
185	Did you have to borne any indirect cost in terms of loss of wages, food and lodging of escorts, etc for accessing delivery care? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip to**		

186	How did you manage expenses to be incurred for giving birth in health facility?			
187	If the delivery was at home, Why didn't you deliver in a health facility?	1. Costs too much . . . . 2. Facility not open 3. Too far/ no 4. Transportation 5. Don't trust facility/poor 6. Quality service 7. No female provider at facility 8. Husband/family 9. Did not allow 10. Not necessary 11. Not customary 12. Other (specify)----------		
	Post Natal Care			
188	Before you were discharged from health facility after child was born did any health personnel check on your health? 1. Yes 2. No			
189	In the two months after child was born, did any health personnel, anganwadi worker, or a traditional birth attendant check on your health? 1. Yes 2. No			
190	How long after delivery (after discharge if you gave birth at institution), did the first check take place?	1. Hours . . 2. Days . . . . . 3. Weeks . . 4. Don't know		
191	Who checked on your health at that time?	1. Doctor 2. ANM/Nurse/Midwife/LHV 3. Dai/TBA 4. Anganwadi worker 5. Other (specify) - - - - - - - -		
192	Where did this first check	1. At home 2. Sub centre		

	take place?	3. PHC 4. Dispensary 5. ICDS 6. Private clinic/Hospital 7. Govt. Hospital 8. Other (specify) - - - - - - - - - - - - - -		
193	How many total PNC checkups take place?	No of times	______	______
194	If less than 3 PNCs, why : ___ _ _ _ _ _ _ __ _ _ _ _ _ __ _ _ _ __ _ _ _ _ _ _ __ __ __ ___ _ _ _ _ _ _ _ _ _ _ __ _ _ _			
195	Have you incurred any expenditure on PNC in terms of paying to doctor, hospital, medicines, diagnostic tests, etc? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip**			
196	Did you have to borne any indirect cost in terms of loss of wages, food and lodging of escorts, etc for accessing PNC checkups? 1. Yes .. record the details below (on the pattern of format used for outpatient care). 2. No ..... **Skip**			
197	How did you manage expenses to be incurred for accessing PNC checkups?			

198	How soon after the delivery did you start doing household work?	1. Less than 15 days 2. 15-30 days 3. 30-45 days 4. More than 45 days		
199	How soon after the delivery did you start doing non-household work (for which you had to go outside the house), including working on own farm or taking out own animals to graze	1. Less than 30 days 2. 1-2 months 3. 2-3 months 4. More than 3 months 5. Still not working 6. Never worked		
200	How do you feel about PNC services and providers? _____			
201	Did you have any problem/complication during the pregnancy, delivery or post partum? Write down details on what problem, treatment taken, etc. _____			
202	*Was the health of child also checked each time your health was checked?*.	1. Yes 2. No		
203	If No, how many times the health of child was checked?	_____ times		
204	What were the reasons? _____			
205	When was your baby weighed at first time after birth?	1. Days ___Months __ __ Years _____ 2. Days ___Months __ __ Years _____		
206	Where was the	1. Home		

	weight done ?	2. Hospital at the time of delivery 3. Hospital at other times 4. ICDS centres 5. Others _____		
207	Were you told about weight/nutritional status of child?	1. Yes 2. No		
208	When did you start breastfeeding your baby?	1. Immediately after birth (within one hour) 2. The day of the birth (within 24 hours) 3. Others (specify no of days) . . . . . . 4. Did not breastfeed		
209	For how many months did you exclusively breastfeed? (*explain 'exclusively')*	1. _____ months/Days 2. _____ months/Days 3. Did not breastfeed		
210	For how many months did you continue to give breast milk?	1. _____ months 2. _____ months 3. Still Giving Breast milk		
211	In the first month after birth, did the baby fall ill or face any complications? Write down details on what problem, treatment taken, etc.			
212	Can you travel alone to health facility for treatment or health services or do you need permission from family?			
213	Do you feel safe travelling alone to health facility?			
214	Has been there any kind of problem that you faced in accessing health care for yourself or for your children born in last three years?			

215	**Probing Question:** Many different factors can prevent women from getting medical advice or treatment for themselves. When women in the village are sick and want to get medical advice or treatment, is each of the following big problem, a small problem, or no problem? BIGPROBLEM - 1 SMALL PROBLEM - 2 No PROBLEM - 3	a. Getting permission to go?	
		b. Getting money needed for treatment?	
		c. The distance to the health facility?	
		d. Having to take transport?	
		e. Finding someone to go with you?	
		f. Concern that there may not be a female health provider?	
		g. Concern that there may not be any health provider?	
		h. Concern that there may be no drugs available?	

Section 12: Child Health Services: ***Access to Immunisation***

216	*The following questions are all in relation to all the children who are under three years of age. Ask for the name of the children and write the names in the columns given, start with the youngest child. If there are more than 2, use an additional sheet.*		Youngest Child _____	2nd Ygst Child _____
217	Has your child ever received any vaccinations to prevent him/her from getting diseases, including vaccinations received in a Pulse Polio campaign? *Record yes only if respondent mentions BCG, Polio 0-3, and/or measles vaccines.*	1. Yes 2. No 3. Don't know		
218	If not, why not? ___ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ___ _ _ ___ _ _ ___ _ _ _ _ ___	**Probe List** 1. Mother/ household not interested 2. Service not available		

		3. Not aware of the service at the right time 4. Inconvenient timings 5. Need to pay money to Anganwadi/ health workers 6. Other (specify)_____		
219	Was your child given an immunisation card? *Ask for the card and see it. Record any observation:*	1. Yes 2. No 3. Don't know		
	Please tell me if your child has received any of the following vaccinations:			
220	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulders that usually causes a scar?	1. Yes 2. No 3. Don't know		
221	Polio vaccine, that is, drops in the mouth, including vaccine received in a Pulse Polio campaign?	1. Yes 2. No 3. Don't know		
222	Was the first polio vaccine received in the first four weeks after birth or later?	1. First four weeks 2. Later		
223	How many times was the polio vaccine received?	No. of times		
224	A DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops?	1. Yes 2. No 3. Don't know		
225	How many times was a DPT vaccination received?	No. of times		
226	An injection to prevent measles?	1. Yes 2. No 3. Don't know		
227	Has your child ever received a Vitamin A dose?	1. Yes 2. No 3. Don't know		
228	If Yes, how many times has your child received Vitamin A dose?	1. Times . . . . . . 2. Don't Know		

<table>
<tr><td>229</td><td colspan="4">If the child has missed any dose of vaccine, what were the reasons?

. . . .</td></tr>
<tr><td>230</td><td>Is your child currently taking any iron pill or iron syrup)?</td><td>1. Yes
2. No
3. Don’t know</td><td></td><td></td></tr>
<tr><td>231</td><td>Has your child taken any drug to get rid of intestinal worms in the past 6 months?</td><td>1. Yes
2. No
3. Don’t know</td><td></td><td></td></tr>
<tr><td>232</td><td>Where did your child receive most of his/her vaccinations?</td><td>Public medical sector
1. Govt. hospital
2. Govt. Dispensary
3. CHC/rural hospital/PHC
4. Health sub-centre
5. Govt. Mobile clinic
6. Anganwadi/ICDS centre .
7. NGO or trust hospital/clinic

Private medical sector
8. Pvt. Hospital
9. Pvt Doctor/clinic
10. Pvt. Mobile clinic
11. Pharmacy/drugstore . . . . . .
12. Other_______________</td><td></td><td></td></tr>
<tr><td>233</td><td colspan="2">Have you incurred any direct expenditure (including travel) on the Child’s immunisations?
1. Yes - - - record the details below
2. No -- - - Skip to</td><td></td><td></td></tr>
<tr><td>234</td><td colspan="4">Expenses :</td></tr>
<tr><td>235</td><td colspan="4">Have you incurred any indirect cost - lost any household income or wages, incurred on food and lodging, etc ?
1. Yes - - - record the details below
2. No -- - - Skip to</td></tr>
</table>

236	Expenses :

Child Health Services: ***Access to ICDS and School Health Programs***

	The following questions are all in relation to the children who are under three years of age. Ask for the name of the children and write the names in the columns given, start with the youngest child. If there are more than 4 in the household, use an additional sheet.	**Youngest Child** _____	**2nd Yngst Child** _____
	Integrated Child Development Services (ICDS)		
237	During the last 3 months, has your child received any benefits from the anganwadi centre? 1 --- Yes 2 --- No *Probe for any benefits such as supplementary food, growth monitoring, immunizations, health check-ups or education?*		
238	In the last 3 months, how often has your child received food from the anganwadi centre? 1. Not at all 2. Almost daily 3. At least once a week 4. At least once a month 5. Less often 6. Don't Know		
239	If not regularly, why not :		
240	In the last 3 months how often did your child go to the anganwadi centre for early childhood care or pre-school? 1. Regularly 2. Occasionally 3. Not at all 4. Don't know		
241	In the last 3 months, has your child been weighed at the anganwadi centre? 1. Not at all 2. Once 3. Twice 4. Three times		

	5. Don't know			
242	After your child was weighed, did you receive any counselling from the anganwadi worker? 1. Yes 2. No			
243	In the last 12 months, how often your child had a health check up from ICDS centre? 1. Not at all 2. At least once a month 3. Less often 4. Don't Know			
244	When you were pregnant with (name of child) did you receive any benefits from the anganwadi centre? 1. Yes 2. No			
245	Did you receive any of the following benefits?	Supplementary Nutrition 1. Yes 2. No		
		Health and Nutrition Counselling 1. Yes 2. No		
		Health Check up 1. Yes 2. No		
		Home visits 1. Yes 2. No		
246	If no for any service, why?			
247	When you were breastfeeding (name of child) did you receive any benefits from the anganwadi centre up to 6 months after delivery? 1. Yes 2. No			
248	Did you receive any of the following benefits?	Supplementary Nutrition 1. Yes 2. No		

		Health and Nutrition Counselling 1. Yes 2. No		
		Health Check up 1. Yes 2. No		
		Home visits 1. Yes 2. No		
249	If no for any service, why?			
	School Health Programme			
250	If any of the children in the household go to government school, do they get a mid day meal in the school? 1. Yes 2. No			
251	Is the MDM given regularly (everyday) to child whenever he attends school? 1. Yes 2. No			
252	If not regular, please record the observations:			
253	In the last 12 months, has your child ever been examined by a doctor/paramedic in a school? 1. Yes 2. No			
254	If Yes, whether the health checkups are regular? 1. Yes 2. No			
255	If Yes or No, Please record the observations:			

Section 13: Grassroots level health functionaries: *Access and contacts with ASHA, ANM, AWW, MPW, LHV and any community health worker. (The questions are to be asked about the women who have given birth in last 3 yrs)*

256	In the last three months, have you met with an	Yes - - 1, No - - 2

	ANM or LHV?	
257	In the last three months, how many times did you meet with (this person/these persons):	a. At home? - - - - - - - - - - - - - -- b. At the anganwadi centre? - - - - c. At a health facility or camp? - - d. Anywhere else? (specify) - - - - - - --
258	In the last three months, have you met with an anganwadi worker or other community health worker?	Yes - - 1, No - - 2
259	Who did you meet?	Angnawadi Worker - - - - - - - - - - - - - -1 ASHA - - - - - - - - - - - - - -- - - - - - - -- - 2 MPW - - - - - - - - - - - - -- - - - - - - -- - - 3 Others [specify -------------------- -----] - -4
260	In the last three months, how many times did you meet with (this person/these persons):	a. At home? - - - - - - - - - - - - - b. At the anganwadi centre? - - - c. At a health facility or camp? - d. Anywhere else? (specify) - - - - - - --
261	During (this contact/all these contacts) with any community health worker in the last three months, what were the different services provided and matters talked about? __ __ _ __ _ _ _ _ _ _ _ _ _ _ _ __ _ _ _ _ _ _ _ _ _ _ _ _ __ _ __ _ __ _ _ _ _ _ _	**Probing List** 1. Family Planning 2. Immunisation 3. ANC 4. Delivery Care 5. PNC 6. Medical treatment for Self 7. Treatment for Sick Child 8. Supplementary food 9. Growth monitoring of child

	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	10. Nutrition/health education 11. Others (specify) _____
262	What do you feel about the grassroots level health workers – ASHA, ANM, MPW, etc __ _	
263	In the last three months, have you visited a health facility or camp for any reason for yourself (or for your children)?	Yes . . . . . 1 No 2
264	If yes, What type of health facility did you visit most recently for yourself (or for your children)? specify _____	
265	What service did you go for? _____	**Probe List** 1. Family planning 2. Immunization 3. Antenatal care 4. Delivery care 5. Postnatal care 6. Disease prevention 7. Medical treatment for self 8. Treatment for child 9. Treatment for other person 10. Growth monitoring of child 11. Health check-up
266	How long did you have to wait before you received the service you went for?	1. Minutes - - - - - - - - 2. Hours - - - - - - - - - 3. No wait at all 4. Did not receive service
267	What do you feel about health services provided, health providers and health	

	institutions?	
260	In the last three months, how many times did you meet with (this person/these persons):	a. At home? - - - - - - - - - - - - - b. At the anganwadi centre? - - - c. At a health facility or camp? - d. Anywhere else? (specify) - - - - - - --
261	During (this contact/all these contacts) with any community health worker in the last three months, what were the different services provided and matters talked about? __ __ _ __ _ _ _ _ _ _ _ _ _ _ _ __ _ _ _ _ _ _ _ _ _ _ _ __ _ __ _ __ _	**Probing List** 12. Family Planning 13. Immunisation 14. ANC 15. Delivery Care 16. PNC 17. Medical treatment for Self 18. Treatment for Sick Child 19. Supplementary food 20. Growth monitoring of child 21. Nutrition/health education 22. Others (specify) _________________

Section 14: Opinions about Health Services system:

268. What do you feel about the health services provided by the government in your area?

269. What do you feel about the health providers?

270. What do you feel about the private health care?

271. What changes you would like to see in the present structure of health services in your area (private as well as government)?

272. Any other comment:

273. Investigators comments/observations:

CODES FOR NATURE OF AILMENT:

Ailment	**Code**	**Ailment**	**Code**
Gastro-intestinal			
Diarrhoea/ dysentery	1	*Diabetes mellitus*	22
Gastritis/gastric or peptic ulcer	2	*Under-nutrition*	23
Worm infestation	3	*Anaemia*	24
Amoebiosis	4	*Sexually transmitted diseases*	25
Hepatitis/Jaundice	5	*Febrile illnesses*	
Cardiovascular Diseases		*Malaria*	26
Heart disease	6	*Eruptive*	27
Hypertension	7	*Mumps*	28
		Diphtheria	29
Respiratory including ear/nose/throat ailments	8	*Whooping cough*	30
Tuberculosis	9	*Fever of unknown origin*	31
Bronchial asthma	10		
Disorders of joints and bones	11	*Tetanus*	32
Diseases of kidney/urinary system	12	*Filariasis/Elephantiasis*	33
Prostatic disorders	13	*Disabilities*	
Gynaecological disorders	14	*Locomotor*	34
Neurological disorders	15	*Visual including blindness (excluding cataract)*	35
		Speech	36
Psychiatric disorders	16	*Hearing*	37
Eye ailments		*Diseases of Mouth/Teeth/Gum*	38
Conjunctivitis	17	*Accidents/Injuries/Burns/ Fractures/Poisoning*	39
Glaucoma	18	*Cancer and other tumours*	40
Cataract	19	*Other diagnosed ailments*	41
Diseases of skin	20	*Other undiagnosed ailments*	99
Goitre	21		

Annexure –C: Interview Guide - List of Questions for Discussion

S. No	Questions
A	***Regarding Treatment to Illness:***
1	What is the first thing you do when you or any of your family members feel ill? (Do you initially go to seek health care or try local remedies)?
2	Do you access services from the Sub-centre of your village?
3	What do you feel about the services provided at the Sub-Centre?
4	What do you feel about services provided at ICDS centres?
5	What do you feel about the work of grassroots level health functionaries like ANM, ASHA, AWW or any other community health worker?
6	Do you know about the dispensary at Bowan run by MSF? If yes, have you ever visited this dispensary and what do you feel about its services?
7	Do you take Unani or Aurvedic medicines for treatment? If yes, what do you feel about it?
8	What do you feel about the services provided by RMP/local chemist?
9	When you are ill, do you seek help from Peer/Faqirs?
10	If yes, where do you go and what do you feel about Peer/Faqirs? Does it help cure your illness?
B	***Maternal and Child Health Services:***
11	Do you feel that IMR and MMR level have gone done or remained same or increased over the time?
12	Are health checkups done for children?
13	Are children weighed regularly?
14	Are women provided privacy in hospitals?
15	Are there any labour rooms at PHC, CHC and DHC?
16	Are there lady doctors at PHC, CHC and DH?

17	Do women feel uncomfortable or shy about seeking health care from male health providers?
18	Do women feel the need for ANC, Institutional delivery and PNC?
19	Do women feel significance for ANC, Institutional delivery and PNC?
20	Why do a majority of pregnant women go to private clinic for delivery?
21	Why are many women referred to Srinagar for delivery?
22	Do women have to do same level of physical work during pregnancy as they do during normal times?
23	Do women take some extra nutrition during pregnancy?
C	***Barriers to Health Services:***
22	What are the barriers to seeking health services when required?
24	Are there occasions when you are not able to seek timely treatment for your illness? If yes, what are the reasons and barriers?
25	Are women able to seek health care with same frequency, quality, and requirement and as timely as men do? If no, what are the reasons?
26	Is the presence of Army (and the roads being closed) affecting the ability of people to access health services?
27	Are you able to manage expenses to seek health care?
D	***Opinions about Health Services:***
28	What do you feel about government health services?
29	What do you feel about private health services?
30	What do you feel about health providers at public and private health facilities?
31	In your opinion, is it better to seek health care from private or government health facilities? Why is it so?
32	What are the changes you would like to see in health service system?

E	***For Scheduled Tribes:***
33	Do you feel any kind of discrimination while accessing health services at government health facilities for being STs?
34	When you migrate to Bangus, what do you do when you are ill?
35	Do wild animals create problems for you?
36	Does the fear of wild animals at night become barrier to access health services during?

Annexure –D : List of Probing Questions[4]

For ascertaining whether an individual had suffered from any ailment during the reference period and whether she/he had received any medical treatment on that account, the following set of probing questions was put to the informant:

1. During the reference period, did the member feel anything wrong relating to skin, head, eyes, ears, nose, throat, arms, hands, chest, heart, stomach, liver, kidney, legs, feet or any other organ of the body?
2. Does the member suffer from any disease of a chronic nature relating to stomach, lungs, nervous system, circulation system, bones and joints, eye, ear, mouth or any other organ of the body?
3. Does the member have any kind of hearing, visual, speech or locomotor disability?
4. Did the member take, during the reference period, any medicine or medical advice for his/her own ailment or injury?
5. Did any of the children suffer from diarrhoea, persistent cough, fever, fever with difficulty in breathing, eye infection, skin rashes or other illnesses during the last 15 days?
6. Have any of the members visited any health facility – chemist, ANM, ASHA, MPW, LHV, paramedic, private doctor/clinic, hospital, hakim, peer/fakir, etc -- in the last one year for any reason?
7. If yes, what services did they go for?
    a. Immunization
    b. Disease Prevention
    c. Medical treatment for self
    d. Treatment for child
    e. Treatment for other person
    f. Growth monitoring of child
    g. Family planning
    h. Health check-up
8. Has any women given birth to a baby in the last three years, and did she visited any health facility for ANC, delivery, PNC, new born care, immunisation for self or for child, growth monitoring, family planning, etc ?

[4] This interview schedule has been constructed based on the interview schedules of NFHS (on utilization of health services) and NSSO (on morbidity and access to treatment)